The British Neuropsychiatry Association – Annual Meeting

Day 1 – 7th March 2019

The Neuropsychiatry of epilepsy, clinical research updates, global neuropsychiatry

1 THE NEUROLOGICAL, PSYCHIATRIC AND THEOLOGICAL SIGNIFICANCE OF MYSTICAL SEIZURES

Alasdair Coles. *Consultant Neurologist, Cambridge University Hospitals*

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Alasdair Coles is an academic neurologist in Cambridge, mainly working on experimental therapies in multiple sclerosis. He is also an Anglican priest. Funded by the Templeton Foundation, he has led two studies of the effect of neurological diseases on spirituality: Parkinson's disease and temporal lobe epilepsy. He has edited 'Neurology and Religion', to be published by CUP in 2019.

Since Dostoyevsky's seminal descriptions of mystical seizures in *The Idiot*, based on his own epilepsy, there has been considerable lay interest in the significance of these seizures. But, they have been little studied. We have conducted a prevalence study of seizures with spiritual content at epilepsy centres in UCL and Cambridge and asked whether their phenomenology is homogeneous and comparable with mystical experiences outside of neurological disease. We have explored their meaning for the individual affected and their families.

2 EPILEPSY IN PEOPLE WITH AN INTELLECTUAL DISABILITY- MANAGING THE NEUROPSYCHIATRIC CHALLENGES!

Mike Kerr. *Cardiff University, Department of Psychological Medicine and Clinical Neurosciences*

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Professor Mike Kerr studied medicine in Bristol (UK), General Practice in York and Psychiatry in Cardiff. His clinical practice is in the epilepsies associated with intellectual disability and in the assessment and treatment of epilepsy and psychiatric disorder. He has been closely associated with initiatives in improving the public health of people with an intellectual disability including developing the Cardiff Health Check, which is used across England and Wales. Academically he has published widely on healthcare, epilepsy and intellectual disability and held research grants from many funding bodies. He is vice chairperson of SUDEP ACTION. He is chair of the International League Against Epilepsy (ILAE) commission on psychiatric aspects of epilepsy. He has been appointed as an Ambassador for Epilepsy by the ILAE and International Bureau for Epilepsy.

There is a close relationship between epilepsy and people with intellectual disability, with an estimated 22% prevalence of epilepsy. The epilepsy is also known to be more severe with an increase in likelihood of chronicity and early mortality. From a neurological point of view the group presents challenges in diagnosis, investigation and treatment choice.

Especially as so many individuals have childhood severe epilepsies, with seizure freedom a challenging goal. A specific management issue is that the population presents a range of neuropsychiatric challenges in terms of diagnosis, behavioral co-morbidity, and the presence of psychiatric comorbidity. These conditions significantly hinder the ability to manage patients and intensify the impact of epilepsy on the individuals and carers. To some degree this would appear no different to the challenges posed within the epilepsy population without intellectual disability. However, issues of communication need, varied aetiology of the intellectual disability and care provision intensify the complexity of neuropsychiatric presentation.

In the era of personalized and precision medicine people with an intellectual disability are now at the forefront of medical practice. With individual aetiology, in particular, driving assessment and intervention. This paradigm can be applied to neuropsychiatric disorders in people with an intellectual disability, expanding our knowledge of the conditions and improving our clinical formulations and interventions. In this presentation I will discuss the nature of neuropsychiatric presentations in people with an intellectual disability, its aetiology and how clinicians may manage these conditions within the setting of epilepsy care.

3 THE COMORBIDITY BETWEEN EPILEPSY AND DISSOCIATIVE SEIZURES

Markus Reuber. *Professor of Clinical Neurology, University of Sheffield, Honorary Consultant Neurologist, Sheffield Teaching Hospitals NHS Foundation Trust, Editor-in-Chief, Seizure European Journal of Epilepsy*

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Professor Reuber joined the Univ of Sheffield in 2005. He also works at the Royal Hallamshire Hospital and the Chesterfield Royal Hospital as an Honorary Consultant Neurologist. His clinical work focuses on the treatment of patients with epilepsy and other seizure disorders. He leads the Epilepsy Research Group in the Academic Neurology Unit and is the Epilepsy Research Theme Lead in the Clinical Neuroscience Directorate at Sheffield Teaching Hospitals. He is chair of the Neurosciences Local Priority Group of the Comprehensive Local Research Network and represents South Yorkshire on the National Speciality Group for Nervous System Disorders. He completed his undergraduate medical education in Cologne, Germany, and Nottingham. He pursued neurological training in Leeds, and at the Department of Epileptology of the University of Bonn, Germany.

Dissociative seizures are experiential and behavioural responses to internal or external triggers. They superficially resemble epileptic seizures in terms of their subjective and objective manifestations. Although they are theoretically distinct from epileptic seizures in which seizure manifestations are related to hypersynchronous and excessive discharges in the brain, there is a complex relationship between epileptic and dissociative seizures, which extends beyond the (clinically extremely important) problem of misdiagnosis. While epilepsy is more closely associated with clinically detectable structural or biochemical abnormalities than dissociative seizures, the sort of experiential factors which are widely recognized as predisposing individuals to the development of dissociative seizures (such as trauma and neglect in early life) also increase the risk of developing epilepsy. The similar (albeit not

identical) developmental background of patients with epilepsy on the one hand and dissociative seizures on the other is reflected by similar (but not identical) psychiatric comorbidity profiles. More specifically, epileptic seizures are a risk factor for the development of dissociative seizures, may precipitate or trigger dissociative seizures, and comorbid epilepsy may contribute to the perpetuation of dissociative seizures disorders. My talk will provide some food for thought about two seizure disorders often associated with high levels of disability which are theoretically different but which - in practice - have much in common.

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4 PSYCHOLOGICAL THERAPIES IN PARKINSON'S DISEASE

Richard Brown. Professor of Neuropsychology and Clinical Neuroscience, Head of Department of Psychology, King's College London, Institute of Psychiatry

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Richard Brown is Professor of Neuropsychology and Clinical Neuroscience and Head of Department of Psychology, at the Institute of Psychiatry, Psychology and Neuroscience at King's College London. He is a faculty member of National Institute of Health Research Maudsley Biomedical Research Centre. He has worked extensively in the field of clinical neuroscience and his primary interest is the field of movement disorders and particularly Parkinson's disease. He undertook his PhD with Professor David Marsden and worked for 10 year at the MRC Human Movement and Balance Unit, Queen's Square. He has published over 200 scientific works and his research has involved laboratory-based and clinical research and spanned a range of movement, cognitive, emotional and social aspects of brain disorder. He has been involved in the development and evaluation of novel psychological approaches to management of non-motor symptoms in patients with Parkinson's disease including depression, anxiety and impulse control disorders. He is also an Honorary Consultant Clinical Psychologist with the South London and Maudsley NHS Foundation Trust, Neuropsychiatry Service, where he supports the psychological management of patients with acquired brain injury and neurodegenerative disorders, with a particular focus on Parkinson's disease.

Non-motor symptoms (NMS) are ubiquitous in Parkinson's disease and are increasingly seen as core features of the disease. Often predating the onset of motor symptoms, they typically increase in number and severity as the disease progresses, increasing disability and overall disease burden. The high prevalence of psychiatric disturbance in PD and its impact on outcome has been recognised for many years, with increasing recognition of the emotional distress and social impact associated with other disabling motor and non-motor symptoms.

While medical treatments are available to ameliorate many NMS, management remains problematic. Psychological approaches are increasingly common in the field of long-term conditions; for symptom management as well as tackling wider psychological issues such as adjustment and relationship function. However, they continue to play a relatively minor role (or are inaccessible) in routine PD care. This presentation will summarise some of the main areas where psychological approaches have demonstrated or potential value. Depression, and more recently anxiety, has been the subject of study for many years and supplies most of the existing (if limited) empirical evidence for psychological approaches. The strengths and limitations of that research will be considered to suggest how we might best meet the existing needs of patients using existing treatments, particularly CBT.

Even though evidence is limited or lacking, the talk will consider the potential for psychological approaches to contribute to the management of neurocognitive symptoms including impulse control behaviour and apathy, as well as other disabling and distressing problems such as sleep disturbance, fatigue, pain and motor fluctuations.

The presentation will conclude by considering some of the new or emerging treatment approaches offering alternative to CBT that may have advantages in terms of efficiency, accessibility and acceptability.

5 DEEP BRAIN STIMULATION FOR OCD: AN UPDATE

Eileen Joyce. Professor of Neuropsychiatry at The Institute of Neurology and Honorary Consultant Neuropsychiatrist at the National Hospital for Neurology and Neurosurgery

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Professor Joyce's research focuses on neurocognitive dysfunction in the early stages of schizophrenia and how this relates to brain structural changes and clinical manifestations of the disorder. Professor Joyce received a degree in psychology from the University of Cambridge where she also completed her PhD in dopamine psychopharmacology with Susan Iversen. She went on to study medicine at Cambridge and trained in psychiatry at the Maudsley Hospital. She spent her higher clinical and research training in the neuropsychiatry department of Professor Alwyn Lishman which was followed by a period of time as a research associate at The National Institute on Alcohol Abuse and Alcoholism, USA. She returned to the UK in 1991 to take up a senior lectureship at Imperial College and remained there until 2005 when she moved to University College London.

Deep brain stimulation (DBS) is an emerging treatment for people with severe OCD who have not responded to SSRI medication, prescribed either at high doses or augmented with additional medication, and several courses of CBT including inpatient treatment. Since it was first described in 1999, there have been 5 randomised controlled trials comparing sham and active DBS at two brain targets: the ventral capsule/ventral striatum site (VC/VS) and the anteromedial subthalamic nucleus (amSTN). A study directly comparing DBS at both sites in the same 6 patients with very severe OCD found that they have equivalent efficacy for reducing OCD symptoms.* Neuroimaging evidence suggested that DBS at each site modulates different brain circuits and has different behavioural actions. VC/VS DBS was much more effective than amSTN DBS at improving mood and affected a circuit connecting the