

A new look into neurophysiological biophysical efficacy cure of Charles bonnet syndrome: theory and practice?

Abstract

Background: Since 1760 first description up to date varieties of neuropathological mechanisms for Charles Bonnet syndrome were proposed and ineffective treatment methods still exist worsening patients' daily quality of life.

Objectives: To describe real practical experience with electrical bioimpedance across a cluster of migraine paroxysmal headache attacks due to cerebral edema resembling such in Charles Bonnet syndrome and using macro neurophysiological biophysical psychotherapy safety and efficacy to treat both disorders.

Methods: Author's personal practice with Charles Bonnet syndrome rely on 3 geriatric patients of above 80 years of age, three women who were Holocaust Survivors. And an Internet search for research articles disclosing the neuropathophysiological determinants contributing and treatment approaches for the given syndrome.

Results: All listed references described or identified varieties of local brain matter impairments accountable for neuropathophysiological factors of Charles Bonnet Syndrome. Ineffective pharmacological treatment characterized these cases. Rest knowledge provided an extra insight on their main visual hallucinatory dynamic or static or mixed problem came from scientific articles on the essences and manifestation of the given morbidity. My three patients favorably react to the macro neurophysiological biophysical psychotherapy and had insight on family worries like those identified across other Holocaust survivors.

Discussion: Charles Bonnet syndrome, migraine paroxysmal headaches, epileptic auras, multiple sclerosis, lung tumor and PTSD terror nightmares, have a common neuropathophysiological mechanism alternating from relapse and remission and vice versa. The ocular neuronal webs connectivity must have similar changes during chronic distress like other morbid entities. The author observed and described for epilepsy local brain electrical bioimpedance drop in affected areas favorably responding to brain electrical bioimpedance units non-invasively induced to the head surface in migraineurs patients. Macro neurophysiological biophysical psychotherapy alone show beneficial effects in neuropsychiatric subjects.

Conclusion: Both new methods must be considered for research and objective measurement of intensity and duration of Charles Bonnet syndrome. A biophysical analyzer must be able to provide treatment safe non-invasive electrical currents to be diagnostically identifying the treatment effect. Complementary, macro neurophysiological biophysical psychotherapy must enable to train caregivers and patients having Charles Bonnet syndrome to possess therapeutic tooling strategies and techniques for sustaining remission.

Volume 2 Issue 1 - 2019

Naisberg Yakov

Psychiatrist/Neurologist, AMCHA- Netanya branch, National Israeli Center for Psychosocial Support of Survivors of the Holocaust and the Second Generation, Israel

Correspondence: Naisberg Yakov, Psychiatrist/Neurologist, AMCHA- Netanya branch, National Israeli Center for Psychosocial Support of Survivors of the Holocaust and the Second Generation, Israel, Email naisberg@012.net.il

Received: December 20, 2018 | **Published:** January 18, 2019

Introduction

Despite the disease described two hundred years ago, the true pathogenesis is not identified, and treatment is still not practical in practice.^{1,2} Clinical expression has been well described^{3,4} and the discriminatory insight of Charles Bonnet syndrome, which has partial or complete self-awareness of the nature of their hallucinations, is still unknown.^{5,6} There have been several reviews on the syndrome,^{7,8} and there is no need to maintain recurrent publication on neuro-pathogenic neuroscience.⁹⁻¹⁶ Therefore, the main purpose of this article is to put in practice the new neuro-pathophysiological biophysical model that already offers a treatment approach with macro neurophysiological biophysical neuro-psychotherapy which relies on favorable placebo effects at the base of many strategies, tools, techniques and self-motivating skills to promote benefits in treating such patients. Another

objective method¹⁷ proposes to complete the treatment of Charles Bonnet syndrome with electrophysiological bio-impedance units, which were induced non-intrusively and safely to patients head treated to track electrical impedance in the brain to reach unimaginable levels of objective remission.

Methods

The main cause of neuro-pathophysiology in Charles Bonnet syndrome must be in the details presented to patients to provide them with sound tools to neutralize the pathological process. So, how and why did such people experience persistent stressors and get sensitivity to normal stress? Practice shows that such individuals have fallen into the preclinical category of predisposed subjects or acquired genetic mutations maintaining their hypersensitivity to various constant

stress. Thus, these basic macro neurophysiological biophysical mechanisms under constant exposure to stress have developed an automatic regulation of abnormal neuronal loop operation (ANLO).

Results

All articles presented by the description of the pathophysiology of Charles Bonnet syndrome did not explain in detail how and why visual hallucinations come out and how and why the syndrome is a transient homeostatic deregulated (THD) recurrence that can be treated positively with the macro neurophysiological biophysical neuro-psychotherapy. The latter in relatively short periods of months replaces THD with remission of transient homeostatic resynchronization (THR) to be trained on how to support it in the long term.

Discussion

ANLO is an external feed by macro physical stressors to interfere with external optical biosensors of the drawbacks of cones and rods of the retina. They adversely affect not only the pitfalls but the metabolism and the tiny vascular system of the retina. The drawbacks of cones and rods translate photons that come with small waves of macro data units reflected from objects, subjects and life event scenarios (LES). Here after the translation they get a physical-like structure as driving on attachment ionic flow optical information units through a unique line of ion channels using three sensory neuron chain into the visual center for identifying, analyzing and synthesizing. Each macro-parallel entity has been delivered through multiple lines to be in parallel functioning from disadvantages of cones and rods to run simultaneously using several lines of ion channels that we call neuronal electrical pathways (NEP's) into the center of the visual working cortical center. By analogy, individual lines of channels ions can be called a micro-wiring system of vision. Under healthy homeostatic conditions these kinds of parallel wirings process macro images of objects, biological subjects and LES. Stress, on the other hand, produces physical disturbances of size, volume, and configuration in a large number of ionic channels that cause an obstruction as the threshold level increases in electrical bio-impedance to ionic current waves in blocked NEP's lines. This immediately affects adjacent NEPs that drop the electrical bio-impedance level, thus ionic flow continues through non-specific NEP's deviations until reaching the indirect working memory centers with a final image deflection, thereby inflating data storage in such repositories. Therefore, one must always remember that in healthy situations the transmitted visual images at storage become inert (completely inhibiting), but under abnormal conditions such storages may be open and the information units automatically leap out into the working visual center. Such leaks from the storage memory repositories may be from previous recordings and display 'real external images' that feed the visual hallucinations. Hence, visual hallucinations become the product of automatic leakage of real visual information from the past stored in a storage warehouse and is now open. They may have different strengths in memory storage, and they compete for patients' attention to the inner imagination of hallucinations that torture subjects with the Charles Bonnet syndrome. At this stage of the syndrome it is important to also explain the macro neuro-pathophysiological input kinetics inputs during such morbidity.

Body Operational Ranges (BOR)

In normal conditions, BOR works with 4 quantitative steps at night sleep and 4 awake stages during the day at rest, with minimum, moderate and maximum effort. Keep in mind that the body acts according to the laws of physics like any technological devices built

on speeds in a unit of time. The body under metabolic energy also accelerates or monitors its activity according to the effort required and determined by the environment or individual. If the thing happens during wakefulness at the comfortable stage, the individual will find restlessness with extreme reactions, because a person who has lost control over 'internal brakes'. At nighttime during awakening at a maximal BOR speed a subject will experience a panic attack. These basic bio-physical rules are of great practical importance. When such biophysical rules are impaired due to deregulated neuro-pathophysiological mechanisms they are continually added automatically associated with higher speed or more observable levels than the alert state. Such patients borrow the maximum or minimum BOR rate related to the speed of environmental requirements or by personal decision. In the case of a maximum rate, the patient responds indiscriminately to normal pressures. The maximal rate blocks voluntary regulation and the patient is found on the BOR auto responder while looking like a 'no brakes' operation and when the BOR automatically lower at the daytime stage feels like a "powerless" person suffering from tiredness or exhaustion. Knowledge of the biophysical neurophysiological kinetics of daily functioning of BOR is extremely important as well as the pathological nightly BOR stages in Charles Bonnet syndrome cases that are in the condition of transient homeostatic deregulated (THD) recurrence with many symptoms that are expressed. So how can a neuro-psychotherapist to light a spark of hope? By presenting his or her facts to illustrate that the destructive syndrome of Charles Bonnet is fleeting. And this means that the worsening situation can be replaced by the innovative method with transient homeostatic synchronization (THR) that must be sustained during a long-term. So what are the most critical steps to take care of in the first place? Ask the patient what kind of quality of life he wants to achieve. This enables, among other things, to reveal real obstacles to the desire for a positive daily quality of life, at the level of expectations. So how to bring the patient closer to reaching such a personal anticipation from his first meeting? By building a stimulating approach that will attract his will through the following neuro-psychotherapy steps:

- i. By getting patients' attention to the willingness to know that the proposed method cannot be undone, this explains the pathophysiology of the syndrome and the high probability of its elimination.
- ii. Evidence that stressful life event scenarios (LES) in daily life create generalized distress (GD) with neurophysiological biophysical mechanisms.
- iii. Training that LES leads to GD affect genes inborne or acquired to be sensitized and eventually generate abnormal neuronal loop operation (ANLO) under automatic performance to generate sick symptoms.
- iv. ANLO consistently emphasizes that BOR recruits four night sleeps and four stages during the day, which cause a person to experience metabolic energy exhaustion and sensitivity to normal stress.
- v. ANLO automatically opens a number of memory stores (repositories). The information units leak uncontrollably at the strength of the BOR that encodes them. Thus, all axes under BOR data are different from each other and the BOR accompanies the current activity, thus dynamically distorting the BOR operation and intrusive thoughts that are the result of leakage of information units in a kind of day restlessness and overnight panic attack performance.

- vi. ANLO in the circadian cycle occurs during a stress session and turns BOR into a maximum level that immediately blocks voluntary control and automatically activates kinetic and biochemical control at a level that destroys the 'internal brakes' and excessive metabolism takes place in the formation of metabolic energy that is perceived as intense internal discomfort with restlessness.
- vii. There is no point in explaining other pathophysiological mechanisms simply because the more we touch these excitatory signals, the ANLO gets stronger at a higher BOR rate, which is subjectively felt like another stressful effect. Therefore, these automatically ANLO one can call as 'transient homeostatic deregulated (THD) relapse.

Can one treat and prevent Charles Bonnet syndrome?

Is it possible to treat and prevent Charles Bonnet syndrome? From this point of view, patients should learn from the neuropsychiatrist and clinical neuropsychologist that ANLO automatically steers the THD state, and therefore they have to learn to control their self-dependence. This fact enables us to understand that a THR mode of remission releases the Will by a biophysical neurophysiological mechanism that is the backbone of the maintenance of vitality. Under these assumptions operates an innovative macro neurophysiological biophysical neuro-psychotherapy method. Hence, it is not just a re-educative scientific practice, but by training how to replace THD symptoms with signs of transient homeostatic resynchronizing (THR) remission in a relatively short period of time per months and maintain it voluntarily controlled by the following points:

- a. It is highly likely that the treatment of group therapy may stimulate and increase reciprocal effects during therapy sessions.
- b. To ensure that for this purpose a neuro-psychotherapist must perform all participants alike must obtain awareness to avoid a discussion on the pathophysiology of one symptomatology.
- c. To draw the person's attention to identify the causes of stress in order to prepare the patients for the "why and how" to protect their self-sensitivity to such encounters.
- d. Training "why and how" to avoid attention from self-conquest with obsessive thoughts and never initiate discussions in a family or social environment about unpleasant events.
- e. Training and patients to pay particular attention to the current scenarios of life event scenarios (LES) to prevent them primarily aspire to participate in neutral and positive encounters.
- f. Training and encouragement when they are alone they can retrieve from their memory pool past positive events that will reassure their overall organism is essential so for their recovery.
- g. There is guidance for patients how to cover daily life events scenarios (LES) by shifting attention to neutral or positive subjects
- h. Treating them with no substitute for life, health and quality of life. For this reason, they are encouraged to maintain a regular schedule of daily life: keeping three meals a day, drinking fluids for seasonal changes, performing walking exercises, light sports, rest, participating in positive social gatherings and maintaining continuous nighttime sleep.
- i. Training them to acquire interactive assertive skills that provide equality in any communication environment and prevents new stress encounters.
- j. Discouraging patients to participate in quarrels, arguments, and conflicts in order to win victories over others. It is important to remember that by such an approach, the individual can win an argument and lose a kilogram of health, which is dangerous to health.
- k. Training them not to impose their opinion on others with force that may pressure them and repel you
- l. Training them for mutual tolerance for any other opinion on a issue discussed from different angles of views. It is a design for many opinions in a social friendly setting
- m. Training patients to always keep pace with all the activities that ensure the body in daily tranquility.
- n. Training patients to use anti-stress strategies and for them self-management techniques.
- o. Training patients to find solutions to a current problem with concrete techniques.
- p. Training patients not to blame each other for current mistakes because they can be corrected later in the day, week, or by telephone or on next session.
- q. Training patients that there is no value in dealing with distant past mistakes. This produces additional stress. It is possible to learn not to repeat such mistakes, and to know definitively that the past has disappeared forever.
- r. Training patients to identify an own body tranquility that creates a pleasant feeling and a nice inner sensation of well-being.
- s. Training patients' that such states must be maintained from morning to late evening hours and day by day, week after week and year after year to find out that one's body wins an healthy state of transient homeostatic resynchronized (THR) long-lasting remission.
- t. Knowing by personal experience that an essential improvement is as much as you keep it in such a situation as you learn self-adjustable neuropsychological protective tools and live skills that provide more personalized quality of daily life.
- u. Achieving this goal will secure one with a tangible practical help of directing one's daily attention efforts to find and use one's tooling techniques to keep one's body tranquility that at this stage generates pleasant balanced emotion and is the better inner marker of cognitive well-being that is an internal healthy state.
- v. Reaching an optimized insight level about internal health that executes a nocturnal automatic homeostatic resynchronization under the overall physiological biophysical defense mechanisms and at daytime is under a voluntarily protected mechanism to become the best medical assistant in remodeling the new and true health.

Conclusion

The innovative neuro-psychotherapeutic method declares the new way in understanding and treating the neuro-psychosomatic diseases

that also include somatoform ones, which actively inhibit the automatic abnormal neuronal loop operation (ANLO) by gradually suppressing its operational condition called transient homeostatic deregulated (THD) relapse. The given method recommends simultaneously to voluntarily stimulate the body operational ranges (BOR) guiding its progress to achieve a stable transient homeostatic resynchronizing (THR) condition of remission in order to create a healthy new neuronal loop for its sustenance. During many years the author tried to understand how to turn off the ANLO that automatically regulated the macro biophysical pathophysiological mechanisms and at the same time gradually ignite a healthy neuronal loop by actively using protecting means of voluntary control over maintenance over long-lasting terms. The Macro biophysical physiological neuro-psychotherapy is the best practical system of tools and means soundly heralding fundamental hallmarks how and in which way a person unintentionally was exposed to physical stress and developed pathophysiological distress due to her or his inner inborn or acquired abnormal mutated genes. As a result, they develop current dynamics in which one gets into transient homeostatic deregulated (THD) relapses. These conditions have been mistakenly named as 'somatoform and psychosomatic disorders' and treated as a 'non-physical disorder.' Such a faulty approach entirely disarmed neurologists, psychiatrists and psychologists from a real medical (neuropsychological) treatment without drugs. However, the old psychotherapy motivated psychologists and psychotherapists to persistently staying stronger in realizing cognitive, behavior and positive 'here and now' dynamics rather than psychiatrists with drug biochemistry approach. The macro biophysical physiological neuro-psychotherapy offers a straightforward accurate neuropsychological (medical) system that will enrich conventional psychotherapists with neurologically rational meaningful actions and a full set of strategies, tools, techniques and skills used in real non-drug neuro-psychotherapy to replace THD with a transient homeostatic resynchronizing (THR) remission that is based on achieving body tranquility that rewards one with positive emotion and a cognitive sense of well-being.

Acknowledgments

None.

Conflicts of interest

The author declares that there is no conflicts of interest.

References

1. Teunisse RJ, Cruvsberg JR, Hoenagels WH, et al. Visual hallucinations in psychologically normal people: Charles Bonnet's syndrome. *Lancet*. 1996;347(9004):794–797.
2. Tan CS, Sabel BA. Dynamic changes in visual acuity as the pathophysiologic mechanism in Charles Bonnet syndrome (visual hallucinations). *Eur Arch Psychiatry Clin Neurosci*. 2006;256:62–63.
3. Plummer C, Kleinitz A, Vroomen P, et al. Of Roman chariots and goats in overcoats: The syndrome of Charles Bonnet. *J Clin Neurosci*. 2007;14(8):709–714.
4. Brucki SMD, Takada LD, Nitrini R. Charles Bonnet Syndrome: Case series. *Dementia & Neuropsychologia*. 2009;3(1).
5. Nair AG, Nair AG, Shah BR, et al. Seeing the unseen: Charles Bonnet syndrome revisited. *Psychogeriatrics*. 2015;15(3):204–208.
6. Cammaroto S, D'Aleo G, Smorto C, et al. Charles Bonnet syndrome. *Funct Neurol*. 2008;23(3):123–127.
7. Cox TM, Ffytche DH. Negative outcome Charles Bonnet syndrome. *Br J Ophthalmol*. 2014;98(9):1236–1239.
8. Schadlu AP, Schadlu R, Shepherd JB. Charles Bonnet syndrome: a review. *Curr Opin Ophthalmol*. 2009;20(3):219–222.
9. Gold K, Rabins PV. Isolated visual hallucinations and the Charles Bonnet syndrome: a review of the literature and presentation of six cases. *Compr Psychiatry*. 1989;30(1):90–98.
10. Abbott EJ, Connor GB, Artes PH, et al. Visual loss and visual hallucinations in patients with age-related macular degeneration (Charles Bonnet syndrome). *Invest Ophthalmol Vis Sci*. 2007;48:1416.
11. Adachi N, Watanabe T, Matsuda H, et al. Hyperperfusion in the lateral temporal cortex, the striatum and the thalamus during complex visual hallucinations: single photon emission computed tomography findings in patients with Charles Bonnet syndrome. *Psychiatry Clin Neurosci*. 2000;54(2):157–162.
12. Baier B, de Haan B, Mueller N, et al. Anatomical correlate of positive spontaneous visual phenomena: a voxelwise lesion study. *Neurology*. 2010;74:218–222.
13. Brown GC, Murphy RP. Visual symptoms associated with choroidal neovascularization. Photopsias and the Charles Bonnet syndrome. *Arch Ophthalmol*. 1992;110:1251.
14. Flint AC, Loh JP, Brust JC. Vivid visual hallucinations from occipital lobe infarction. *Neurology*. 2005;65:756.
15. Choi EJ, Lee JK, Kang JK, et al. Complex visual hallucinations after occipital cortical resection in a patient with epilepsy due to cortical dysplasia. *Arch Neurol*. 2005;62:481.
16. Chen CS, Lin SF, Chong MY. Charles Bonnet syndrome and multiple sclerosis. *Am J Psychiatry*. 2001;158:1158.
17. Naisberg Y, Aynon M, Weizman A, et al. Estimating brain homeostatic derangement by bioimpedance technology. In conference Proceedings. *The 26th Israeli Conference on Mechanical Engineering, Technion City, Haifa*. 1996;76–86.