



## Review

# Treating functional non-epileptic attacks – Should we consider acceptance and commitment therapy?



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## ABSTRACT

Patients who experience functional non-epileptic attacks (FNEA) are frequently seen in Neurology clinics. Diagnosis alone can result in cessation of attacks for some patients, but many patients require further treatment. There is evidence that certain psychological therapies, like cognitive-behavioral therapy (CBT) and psychodynamic interpersonal therapy (PIT) can be beneficial. Acceptance and commitment therapy (ACT) is a type of CBT that has been found to be effective at treating other somatic disorders, like epilepsy and chronic pain. In this paper, we explain what ACT is, the current evidence-base for its use, and the rationale for why it may be a beneficial treatment for patients who experience FNEA. We conclude that ACT is a potential treatment option for FNEA, and further research is required.

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## 1. Introduction

Functional non-epileptic attacks (FNEA), also referred to as dissociative non-epileptic seizures, psychogenic seizures or non-epileptic attack disorder, can look similar to epileptic seizures, but occur without an epileptic basis. FNEA and other functional neurological disorders can result in similar levels of disability, but more distress, when compared with patients who have neurological disease [1]. A study carried out in the US examined healthcare utilization 12 months before and after receiving a FNEA diagnosis in an Epilepsy Centre. They found that post-diagnosis, a mean cost reduction of \$1800 per patient was achieved, with an average decrease in hospital admissions and emergency room visits [2]. In Ireland, undiagnosed and untreated FNEA have been estimated to annually cost around €20,995 per patient (approximately \$22,000). An estimate of the cost of diagnosis (including inpatient vEEG monitoring, post-diagnosis neurology and neuropsychiatry appointments) was €6319 (approximately \$6700) per patient. The cost of 10 h of an individual CBT intervention provided by a psychologist and a follow-up neurology consultation was estimated to cost €2409 (approximately \$2500) per person [3]. Therefore, there is clear financial benefit for efficient assessment and treatment of FNEA.

The causes of FNEA are not clear, but certain factors have been found to be associated with experiencing them, and several psychological theories of their development and maintenance have been proposed. Associations between factors such as trauma, dissociative tendencies, emotion regulation difficulties, somatization, depression, anxiety disorders, stressful life events and experiencing epilepsy or having a family member with epilepsy have been identified [4–7]. Dissociation is considered by many to be a key mechanism in FNEA, and often people who experience FNEA have a range of dissociative symptoms [8]. The term dissociation is used to describe many psychological phenomena and it is not always evident what is being referred to when the term dissociation is used [9]. In the DSM-V, dissociation is defined as “a disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behavior” [10] (p. 291). Dissociation has been proposed to be a unitary construct that falls on a continuum, and as an occurrence that has two distinct forms: detachment and compartmentalization [9]. Others have suggested it is a multidimensional construct involving six distinct phenomena – depersonalization, derealization, identity dissociation, disengagement, emotional constriction and memory disturbance [11].

FNEA are frequently grouped within the broader group of functional neurological disorder (FND). This makes intuitive sense as FNEA often co-occur with other functional neurological symptoms, but examining FND as a whole may disguise differing paths to development and contribute to lack of clarity in terms of treatment. The two largest groups of patients within the wider group of FND are FNEA and functional

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motor symptoms, and there is current debate in the literature around whether these conditions should be examined and treated collectively or separately. Hopp et al. (2012) report similar psychological profiles between the two groups on measures of somatization, depression and anxiety [12], but Dermatini et al. (2016) report significant differences between the groups on a measure of dissociation, although both groups had significantly higher scores on an alexithymia measure compared to healthy controls [13]. A recent review concluded that these conditions should be considered as separate groups [14]. Although even examining FNEA as a single group is problematic, with some researchers arguing there are separate sub-types of FNEA [15,16].

It is as yet unclear what the most effective treatment for FNEA is. Provision of a clear and coherent explanation of the diagnosis is an essential component of treatment that can result in cessation or reduced attack frequency for some people [17]. Hall-Patch et al. (2010) found that a standardized communication strategy, delivered by neurologists, could result in cessation of FNEA (14% of sample) or a greater than 50% reduction in FNEA (63%) [18]. Psycho-education has also been evaluated with some promising results [19,20]. In terms of psychological therapy, cognitive-behavioral therapy (CBT) currently has the strongest evidence base [21,22]. There is also evidence for psychodynamic interpersonal therapy [23], as well as group interventions [24,25]. However, a Cochrane review published in 2014 concluded there was insufficient robust evidence to support any treatment for FNEA [26]. A recent meta-analysis of psychological interventions for FNEA, examining 13 studies, reported that 47% of patients were FNEA-free post-psychological treatment, and 82% of people achieved a reduction of 50% in terms of frequency of FNEA. This demonstrates a clear benefit for offering psychological treatment to those with FNEA. Carlson & Perry (2017) found that no particular treatment was more advantageous than others, and suggest that as the FNEA population is heterogeneous, a variety of treatments should be researched [27].

CBT for the treatment of traditional mental health difficulties like depression and anxiety has continued to develop, incorporating elements from different treatment modalities. These so-called “third-wave” approaches include acceptance and commitment therapy (ACT). This paper explores whether ACT could have a role in the care of patients with FNEA.

## 2. Mindfulness-based therapies and FNEA

ACT is considered to be part of the “third wave” of cognitive-behavioral therapy (CBT): the first being traditional behavior therapy; the second being traditional CBT; and the third including dialectical behavior therapy, originally designed to treat suicidal behavior in those diagnosed with borderline personality disorder (DBT: [28]), mindfulness-based cognitive therapy, developed to reduce relapse for patients who experience recurrent depression (MBCT: [29]), and meta-cognitive therapy, developed for the treatment of anxiety disorders and depression (MCT: [30]). The main difference between traditional CBT (“second wave”) and third wave CBT is that traditional CBT aims to challenge and change thoughts and beliefs, whereas third-wave CBT approaches focus on altering the person's relationship to their thoughts, feelings and physical experiences. All these third-wave CBT approaches include mindfulness as part of treatment [31,32]. There is controversy over whether these newer approaches represent a distinctive “third wave” or are merely an extension of CBT [33].

The term mindfulness-based therapies (MBTs) includes not only these mindfulness-based CBT approaches, but also Mindfulness-Based Stress Reduction (MBSR), a group training program in meditation originally designed for patients not responding to conventional medical treatments [34]. This means that most MBTs are likely to include some traditional CBT theory and practices, but in the case of MBSR, it does not. MBTs can also be considered acceptance-based interventions, and ACT is also both a mindfulness and acceptance-based intervention [35].

Therefore, the evidence base for all MBTs is relevant when assessing the applicability of ACT for treating FNEA.

MBTs have been used effectively in the treatment of common mental health problems, such as depressive and anxiety disorders (MBCT [29,36]; ACT [37]; MCT [30,38]), psychosis (ACT [39]), and borderline personality disorder (DBT [28,40]). Mindfulness meditation is thought to benefit attentional control, improve body awareness, and facilitate emotional regulation. These components have been linked to associated changes in the brain [41].

Baslet and Hill (2011) propose that MBTs could be beneficial in treating FNEA. They argue that as more traditional CBT approaches are effective at treating FNEA [21,22,42], it is likely that similar interventions will also be helpful. CBT can reduce the frequency of FNEA, as well as comorbid psychiatric symptoms [22], therefore if MBTs can reduce psychiatric symptoms, they may also reduce functional neurological symptoms. MBTs have been used in the treatment of functional disorders, including FNEA (case reports only [43,44]) and functional motor symptoms [45], chronic pain [46], and irritable bowel syndrome [47], and a recent systematic review of MBTs for somatization has been published [48]. There have been many RCTs evaluating the efficacy of ACT for chronic pain, and the use of ACT to treat chronic pain is well-established, and is part of many pain management programs across the UK. Hann & McCracken (2014) carried out a systematic review on the use of ACT for chronic pain populations. They identified RCTs evaluated ACT in group, individual and self-help formats, and concluded that ACT is effective at enhancing general functioning and reducing distress, compared to inactive treatment comparisons [46].

## 3. Acceptance and commitment therapy (ACT)

ACT is a psychological therapy that has been shown to be beneficial in the management of many conditions, including depression [37], psychosis [39], chronic pain [46] and epilepsy [49]. ACT is based on behavioral principles. A key theory is the Relational Frame Theory, which, put extremely simply, is a behavioral view of language that suggests that human language and thought is something we have learnt to understand and produce, based on the responses within our environment [31]. According to the theory, people experience their lives through the medium of language, as if the verbal construction is the same as the events themselves. And as people experience their daily lives through the language they use to describe it (which may include negative predictions of the future or regrets about the past), they have less contact with the actual present moment as it is occurring. They may then respond to their verbal constructions of events, rather than their actual experience, and this may be unhelpful [50]. ACT is also linked to functional contextualism, where behaviors are seen as serving a function in a particular context [31]. ACT views psychological inflexibility as the driving force behind emotional distress, and aims to reduce distress and improve functioning through increasing psychological flexibility.

### 3.1. Psychological inflexibility and distress

Psychological inflexibility refers to behaviour being excessively controlled by internal experiences, rather than by chosen values or contingencies. This leads to “experiential avoidance” whereby a person seeks to avoid unwanted internal experiences (such as difficult thoughts or feelings), and their behavior is guided by this avoidance rather than what is really important to them. This has been identified as a process that is common across psychological disorders [51]. For example, a person with FNEA may stop going to work as they fear having an attack at work. This may be an area in their life that had given them a great sense of achievement and enjoyment. The loss of that activity may result in low mood, and impact negatively on their frequency of FNEA. Their attempts to not have FNEA are counterproductive, as they structure their life around avoidance, rather than what is important to them. It could be argued that patients' avoidance can even be demonstrated in the

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