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Perspective

Multimodular psychotherapy intervention for nonepileptic attack disorder: An individualized pragmatic approach

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ABSTRACT

Nonepileptic attack disorder (NEAD) is a highly distressing and costly condition commonly seen in specialist epilepsy clinics. Consistently effective treatments for NEAD remain elusive, and findings from research indicate that there is no one form of psychological therapy that will be effective in such a heterogeneous group of patients. In this paper, we propose a multimodular approach to psychological therapy in NEAD, which allows the clinician to tailor an individualized management program for the patient appropriate to his/her needs.

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1. Introduction

Nonepileptic attack disorder (NEAD) is a common problem. Having an estimated prevalence of two to 33 per 100,000 persons, it is believed to represent 10–22% of patients with intractable seizures referred to specialist epilepsy clinics [1]. It is an incredibly disabling condition, with 56% of sufferers in the United States dependent on social security [2]. Nonepileptic attack disorder carries high economic cost in case of nontreatment, with an estimated 920 million US dollars per year spent on medical investigations and antiepileptic medication following incorrect diagnosis and treatment as epilepsy [3]. Incorrect diagnosis and subsequent pharmacological treatment are not only ineffective but also potentially fatal for this patient group [4]. As yet, however, there is no clear consensus as to the most effective form of treatment. A systematic review [5] shows that several different approaches have been found to be helpful but with variable degrees of success. More recently, the current evidence base for a range of treatments for patients with NEAD was summarized with consensus guidance, but this does not provide a clear clinical approach that a busy clinician could easily follow [6].

Depending upon the psychiatric condition, underlying or co-morbid with the attacks, NEAD subtypes my be classified. Patients commonly suffer from depression, anxiety disorders (including posttraumatic stress disorder, PTSD), or dissociation. The demarcation between these conditions, however, may not be so clear-cut, and comorbidity is not limited to these three conditions. In a patient sample studied by Bowman and Markand [7], the mean number of current axis 1 psychiatric diagnoses was 4.4. Not all patients with NEAD, however, show psychiatric comorbidity. Using the Structured Clinical Interview for DSM IIIR, Jawad et al. [8] found no psychiatric disorder in 32.6% of their population sample with NEAD. A recurrent theme in the NEAD literature is that the underlying or comorbid psychopathology should dictate the choice of therapeutic procedure [9]. Although the pharmacological treatment of comorbid axis I diagnoses represents an important stage, psychological therapies are still the mainstay of NEAD.

A wide variety of approaches have been used for NEAD, including cognitive, behavioral, psychodynamic, and systemic therapies, EMDR, biofeedback, hypnosis, and psychopharmacological treatments [10]. However, NEAD is often a condition complicated by comorbidity with other disorders, with an often polymorphic psychopathological background [11]. Because of this, patients with NEAD need a tailored therapeutic approach.

Numerous case studies in the literature report successful outcomes when treatment has been tailored, and studies of mixed modality treatments suggest that an eclectic approach can yield good results.

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However, there are a number of drawbacks to this approach. First of all, these approaches are hard to study or replicate. The second point concerns the training of clinicians: it is helpful if there is some structure which can guide practice. Such a structure may also facilitate communication between multidisciplinary team (MDT) members and other teams. Finally, there are certain common elements which should be included in every therapeutic program, and for these, there is no need to 'reinvent the wheel' every time.

In this paper, we propose a multimodular model for psychotherapeutic interventions in NEAD based on the clinical features of the individual patient. Such a multimodular approach could be followed easily in busy clinical settings, and it would be possible to replicate it reliably and study it in research settings. The individual components of the multimodular therapy have already been used and studied in patients with NEAD.

2. Current psychotherapeutic options in NEAD

La France identified a number of difficulties with studying populations with NEAD, meaning that the evidence base is not large for any particular therapy. Patients in his 2007 SSRI treatment trial were excluded, or dropped out after enrollment for various reasons: their inability to differentiate between seizure types (when they had comorbid epilepsy and NEAD), because they were already on various medications or chose not to take any, difficulties with transport due to seizure-related driving restrictions, and difficulty completing questionnaires due to comorbid right-hand weakness. Many patients needed significant prompting to attend follow-ups. LaFrance also points out that the Hawthorne effect (positive improvement due to increased medical care and attention received while in a study) is particularly relevant in NEAD where patients may have felt disappointed by previous difficulties with treatment or felt that their diagnosis and care plan were unclear or undecided [12].

There is one randomized controlled trial (RCT) of paradoxical therapy (a behavioral intervention which involves suggesting that the patient intentionally engages in the unwanted behavior such as wanting a dissociative seizure). This showed improvement in symptoms compared to diazepam [13]. Goldstein's pilot cognitive behavioral therapy (CBT) study showed that the CBT group was more likely to have 3 months of seizure freedom compared to those in standard medical care in a neuropsychiatry clinic, and a larger multisite randomized controlled trial is currently taking place [14]. Cognitive behavioral therapy modules for NEAD are often designed to address specific issues, such as seizure symptom control [14,15], to identify and control reactions to triggers for dissociative attacks or treat depressive or anxiety symptoms. Behavioral interventions such as operant conditioning have been used for patients with PTSD and dissociation [16].

Psychodynamic approaches may be helpful with symptoms thought to arise from interpersonal difficulties and/or unresolved emotional conflicts, such as those pertaining to early abuse or other childhood traumas [17]. Such interventions may be used to explore the meaning that patients attach to stressful relationships and events, which are often seen to be instrumental in the development of NEAD as a coping strategy. Family or relationship difficulties are also frequently seen as precipitating or perpetuating factors in NEAD. Findings by Moore et al. [18] and Turgay [19] suggest that there is a role for systemic therapy in the treatment of these attacks. Moreover, relatives are often as anxious as the patients and may be angry about the diagnosis [20]. Psychoeducation and reassurance of family members should help to lower their stress levels, producing secondary benefits for the patient. This should reinforce the primary benefits of the intervention.

Despite anecdotal and case study evidence that a tailored approach is needed for NEAD, most studies have focused on the application of a single treatment modality to all patients. For example, studies testing CBT (for instance) have applied CBT to all patients in the sample (minus controls, if any are used) rather than testing the use of specific CBT-based interventions devised for patients presenting with specific CBT-appropriate profiles. Results of such an approach have been mixed: some patients respond but others do not. Applying a treatment such as CBT rigidly across the board with all patients with NEAD without individualization does not work because, as stated by LaFrance in 2007, 'one size does not fit all' [21]. Different patients, whose attacks have different etiologies and different psychological functions, need individualized treatments and a range of different treatments based upon these factors.

3. A multimodular model for psychotherapeutic intervention

The model that we suggest combines multidisciplinary assessment, and initial basic psychoeducation with a secondary tailored approach to future psychological therapies depending on comorbidity, symptoms, and psychosocial factors (Fig. 1).

3.1. Phase I — basic intervention

3.1.1. Multidisciplinary team (MDT) diagnosis in a specialist clinic

Firstly, all patients with NEAD need thorough neurology and neuropsychiatry assessment, including establishing whether there is any psychiatric comorbidity such as PTSD, personality disorder, other dissociative symptoms, depression, or anxiety. This initial interaction with medical services is a crucial moment, and promoting transition is essential; anecdotally, an adverse experience with practitioners inexperienced in functional neurological symptoms, for example in an emergency department setting, can unnecessarily prolong the illness. Some patients who see neurologists might then not attend their neuropsychiatric or psychology appointments and look for another neurological opinion. Using a multidisciplinary approach from the first assessment seems likely to promote smoother transition between services and a brighter outcome.

Presenting the diagnosis is one of the most thoroughly researched interventions for NEAD, largely thanks to the early availability of a detailed protocol [22]. A number of strategies about optimal and effective communication of diagnosis to patients have since been described [23,24]. However, outside of specialist epilepsy clinics, many neurologists may need training in delivery of this type of intervention. Diagnosis of NEAD is most commonly done by neurologists and is a generally accepted part of their role [25]. Doing this in a specialist clinic with a multidisciplinary team and without the time pressure of a general neurology or epilepsy clinic may mean that neurologists are more at ease and patients receive better information and may facilitate transition to a neuropsychiatric clinic and other psychological interventions.

Ideally, when presenting the diagnosis, the neurologist should give the patient the opportunity to ask questions and to discuss their feelings about and understanding of NEAD. Videoelectroencephalographic (vEEG) data could be shown and discussed. In practice, however, this ideal can be difficult to achieve because it must be squeezed into a 15- to 30-minute session. It is important to be realistic about what may be achieved and to acknowledge that most of the patient's psychoeducation needs will not be met in this short time span. There may be several reasons for this:

- Neurologists may need more training to feel comfortable saying what needs to be said;
- Patients may be overwhelmed by the information;
- Patients may be overwhelmed by their emotional reaction to the diagnosis.

Presenting the diagnosis is the important first step and, in some cases, may be sufficient to resolve the attacks [26–29]. However, given the time constraints and possible need to adjust emotionally and psychologically to the diagnosis (especially in the case of a rediagnosis following an incorrect diagnosis of epilepsy), this session may not be the best time to give all of the necessary information and, for this reason, group psychoeducation may naturally follow this preliminary stage. In

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