Rochelle Caplan · Julia Doss
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Pediatric Psychogenic Non-Epileptic Seizures

A Treatment Guide

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I dedicate this treatment guide to the professionals who will use what they learn from it to bridge the treatment gap and address the unmet mental health-care needs of children and adolescents with psychogenic non-epileptic seizures (PNES) and their families. This treatment guide represents what the children with PNES who I have treated, their parents, and my coauthors have taught me about the illness. My thanks go to my pediatric neurology, psychiatry, and other multidisciplinary colleagues for referring me all these children.

Rochelle Caplan

I dedicate this book to my sweet Henry my own personal miracle, my family for the encouragement to follow my dreams, JSD my muse, and the Minnesota Epilepsy Group for providing an environment that honors the struggle of our patients and strives with me to support their healing. I also dedicate this treatment guide to my coauthors who are brilliant clinicians and have strengthened my work with these patients.

Julia Doss

I dedicate this book to my mentor Rochelle Caplan, M.D., who has been a rock and a star in my professional journey, and to my colleagues in psychiatry and neurology who have helped take care of PNES patients.

Sigita Plioplys

I dedicate this book to my mentor Rochelle Caplan, M.D., who was my guide as I began my journey working with individuals with PNES, and to my colleagues in neuropsychology who support my work.

Jana E. Jones

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Contents

Abbreviations

+	Positive
(−) or −	Negative
ADHD	Attention deficit hyperactivity disorder
AED	Antiepileptic drug(s)
CBT	Cognitive behavior therapy
MDD	Major depressive disorder
NES	Non-epileptic seizures
PNES	Psychogenic non-epileptic seizures
PTSD	Post-traumatic stress disorder
SSRI	Selective serotonin reuptake inhibitor
vEEG	Video electroencephalography

Introduction and Overview

1

Why Is There a Need for a Pediatric Psychogenic Non-epileptic Seizures (PNES) Treatment Guide?

Children and adolescents (the terms, child and children, refer to this wide age range throughout the manual) with conversion disorder involuntarily displace tension associated with negative emotions, such as anxiety, anger, fear, frustration, and demoralization onto physical symptoms. Pediatric PNES typically involves a conversion disorder whose clinical manifestations resemble seizures due to epilepsy. Even though pediatric PNES is a psychiatric disorder, mental health professionals (child psychiatrists, psychologists, neuropsychologists, and social workers) are reluctant to treat youth with this disorder. The main reason for their reticence is a lack of training. Most mental health training programs do not teach about the clinical manifestations of epilepsy, the psychosocial aspects of epilepsy, and how to treat children with conversion disorders, such as PNES. Thus, many mental health professionals do not have the knowledge and skill set needed to work with these children and their families.

Nonmental health clinicians (pediatric neurologists, epileptologists, pediatricians, family physicians, nurse practitioners, and clinical nurse specialists) who treat children with epilepsy are the first to see children with PNES. Since they frequently have little, if any, training in child psychiatry or psychology, they too feel ill equipped to work with children with PNES and their parents after this diagnosis is confirmed. They resist stopping the children's antiepileptic drugs (AEDs) if mental health professionals are not treating the children even though AEDs do not treat PNES symptoms [1].

Although pediatric PNES is a relatively rare disorder, it carries a high morbidity with numerous visits to doctors and the emergency room, use of ambulances, treatment with high doses of multiple AEDs, parents' lost days of work, as well as disruptions during school and school absences. Untreated, these children continue to suffer from their underlying conversion disorder and develop additional physical symptoms, and their comorbid anxiety disorders and depression become evident or

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worsen. They do not or inconsistently attend school and lead dysfunctional lives. Your willingness to work with these children and their parents will fill an important treatment gap for a highly morbid disorder.

To encourage professionals to treat children with this disorder, this treatment guide provides child mental health professionals, like you, with the hands-on clinical knowledge needed to diagnose and treat this condition. Due to space limitations and focus on the practical aspects of treatment, the manual does not include detailed information on the epidemiology, clinical presentation, etiology, course, and outcome of the illness. Interested readers can access this information in reviews by Reilly et al. [2] and Plioplys et al. [3].

What Will This Guide Teach You?

The treatment team minimally includes a mental health professional like you (child psychiatrist, psychologist, neuropsychologist, social worker, and/or psychiatric nurse), medical clinician(s) (pediatric neurologist/epileptologist, pediatrician, or nurse practitioner), and school staff (teacher, administrator, and/or school nurse). The first section of the guide describes how to recognize and diagnose PNES in children and adolescents, design a treatment plan, and provide feedback to the child and parents on the diagnosis and treatment. The subsequent sections present guidelines on how to administer psychoeducation about the disorder to the parents, child, medical, and school team; ensure continued involvement of the multidisciplinary treatment team in the care of these children and their parents; and what short-term and long-term therapeutic approaches and techniques to use with the child and the parents to stop the seizures and treat the child's underlying psychopathology.

The goal of the guide is to provide you with the tools necessary to understand and treat these children and their parents. To help you consolidate the expertise needed to treat these children, the authors recommend individual supervision with local supervisors on your cases until you feel competent with your skill set. The authors will also hold workshops and webinars on the treatment of pediatric PNES.

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Diagnosis of Pediatric PNES

2

The Underlying Psychopathology, Triggers, and Risk Factors

As briefly mentioned in the overview to this treatment guide, the underlying psychopathology of children with PNES, conversion disorder, involves displacement of the tension associated with negative emotions, such as anxiety, anger, fear, frustration, and demoralization onto physical symptoms. Why certain children develop conversion disorder with epilepsy-like symptoms rather than other physical symptoms remains unclear [1, 2]. However, current psychodynamic theories on pediatric PNES and evidence for triggers (see review in [3]) and risk factors [4]) shed light on ways the disorder might develop.

From the research perspective, triggers for pediatric PNES include learning difficulties; social problems; parent marital discord; family dysfunction; unrealistic expectations by the child or the parents for the child to excel at school, sports, or extracurricular activities; bullying and other forms of psychological abuse; and rarely physical or sexual abuse [5–9]. But not every child who experiences these trigger factors develops PNES. Two independent risk factors differentiate children with PNES from their siblings, a somatopsychiatric factor and an adversity factor [10]. In other words, children with medical problems, excessive use of medical services, fearful response to physical sensations, and psychiatric diagnoses—the somatopsychiatric factors—are at risk for PNES. Bullying associated with emotional problems, psychiatric diagnoses, and treatment with psychiatric drugs—the adversity factors—also increase the vulnerability for PNES.

From the psychodynamic perspective, children who develop PNES and other conversion disorders [11] appear to use avoidance when faced with situations that trigger negative emotions (fear, anger, frustration, anxiety, or sadness). In addition to not confronting and/or problem-solving the situation that triggers these negative feelings, these children are often unaware of or deny experiencing negative emotions. Thus, they are avoidant on both the functional and emotional levels. In some cases, the children have language difficulties with impaired use and/or retrieval of words to describe their emotions (alexithymia) (see review in Reilly et al. [3]) and/or

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difficulty using sentences to formulate [12] their feelings and thoughts, particularly those involving abstract concepts. As a result, and given their use of avoidance, they do not tune into their negative emotions and/or verbally express or talk about their problems and the associated emotions.

In other cases, the children have intact language skills. However, when they verbalize and express their difficulties or problems to their parents and ask for their help, the parents pay no or little attention to the children's complaints. In some cases, parents misinterpret, scold, criticize, or verbally abuse the children for their difficulties and avoidant behavior. These responses cause the children to back off, not share their difficulties with their parents, and continue to avoid dealing with the problems at hand.

The children's unexpressed negative emotions accumulate when the problem situation(s) does(do) not go away and/or gets(get) worse due to the children's avoidance. Repeat exposure to the problem situation(s) and the lack of problem-solving triggers(s) the children's anxiety, as well as negative responses by others, which, in turn, make the children more fearful. Mounting of their unexpressed negative feelings on the one hand and the practical results of not problem-solving on the other hand result in these children feeling there is no way out. Taylor [13] used the term predicament to describe this situation, which leads to displacement of the growing tension and mounting unresolved problems into physical symptoms.

Because of the attention these children get due to the seizure-like episodes, they are excused from meeting demands in the school, home, and social environment and/or from dealing with other potential stressors or triggers of their condition. Increased attention by parents and others to the child's "seizures," together with continued avoidance of dealing with ongoing problems, difficulties, and/or challenges, is called secondary attention. This inevitable phenomenon reinforces recurrence of the episodes which then take on a life of their own. The more they recur, the more attention the child gets and the more difficult it is for the child to cope with the ongoing problems. Antiseizure medications, also known as antiepileptic drugs (AEDs), can have adverse effects, including fatigue and irritability that further impair the children's ability to problem-solve and reinforce this vicious cycle. In terms of family functioning, the child's symptoms might overwhelm the parents in their efforts to deal with the child's illness and their own ongoing life stressors, such as family discord.

From the behavioral perspective, how parents respond when their child reports physical symptoms acts as positive or negative emotional reinforcers. As such, they can influence how much their child complains about aches, pains, and not feeling well. The wide range of parental responses includes a lack of response, a neutral concerned response, or an excessive anxious response for the child to receive immediate medical attention. In some families, parents only pay attention to their children when they are sick or have physical complaints. Children whose parents are overly anxious when their children have somatic complaints and children of parents who pay attention to them only when they are ill are at high risk for somatization and conversion disorder [14, 15].

Table 2.1 DSM-5 diagnostic criteria for conversion disorder

Conversion disorder
One or more symptoms of altered voluntary motor or sensory function
Physical findings provide evidence of incompatibility between the symptom and recognized neurological or medical conditions
The symptom or deficit is not better explained by another medical or mental disorder
The symptom or deficit causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or warrants medical evaluation

The Gold Standard Diagnosis

Confirmation of PNES is based on two essential components. The first component is a prolonged video-EEG (vEEG) in which the child has seizure-like episodes without EEG evidence for ongoing epileptic activity. The second component is that the child meets criteria for a conversion disorder or, more rarely, a dissociation disorder, based on a comprehensive psychiatric evaluation. This treatment guide focuses on treatment of children with PNES who have a conversion disorder. Table 2.1 lists the DSM-5 diagnostic criteria for this disorder [16].

Why Is It Difficult to Diagnose PNES in Children?

Medical Reasons

PNES Mimics Epilepsy

In most cases, physicians confirm a diagnosis of seizures due to epilepsy based mainly on reports by parents, family members, or other observers of the seizure manifestations. An EEG finding of epileptic activity helps confirm the diagnosis. However, EEG electrodes on the scalp do not pick up epileptic activity from deeper regions in the brain. Therefore, the lack of epileptic activity during a routine EEG when a patient is not experiencing a seizure does not rule out a diagnosis of epilepsy. Most epilepsy patients usually do not have a seizure in the doctor's office. So, when a child first has a non-epileptic seizure, even if a routine EEG is normal, physicians do not usually consider the possibility of a non-epileptic seizure.

PNES Occurs in About One-Third of Children with Epilepsy

In children with epilepsy whose seizures were controlled, the parents and physicians assume that the child has had a breakthrough of seizures when NES symptoms occur. In children with new-onset seizures, when seizures continue despite a trial of at least two AEDs, physicians assume they are dealing with intractable or treatment-resistant epilepsy. They, therefore, increase the AED dose, add an AED, or change to another AED in their effort to control seizures.

AED Adverse Effects

Since these drugs do not control seizure-like symptoms unrelated to epilepsy, the child's episodes continue. High doses of multiple AEDs can cause adverse behavioral and cognitive effects (see review in Caplan [16]). Parents might interpret medication side effects, such as inattention, spacing out due to tiredness, and irritability, as ongoing seizures. This, in turn, can lead physicians to further increase AED doses and/or number of drugs to control the "seizures."

Parental Behavior

As previously described above in "The Underlying Psychopathology, Triggers, and Risk Factors", parents' behavior when their children let them know about problems they are experiencing influences if and how the children share their difficulties with the parents and do or do not problem-solve. Features of parent behavior, described below, can make it difficult for physicians to reach a PNES diagnosis.

Denial of Psychological Problems

Some parents of children with PNES have difficulty recognizing or accepting that their children have learning, social, or psychological difficulties. These parents typically deny that their children have any problems other than seizures when physicians ask about problems.

Misinterpretation of Children's Behavior

As mentioned in section "The Underlying Psychopathology, Triggers, and Risk Factors", parents might unwittingly misinterpret their children's call for help as evidence for laziness, attention seeking, shyness, and/or lack of assertiveness, depending on the nature of the domain in which the child is having a problem. So, when physicians ask these parents if their children have any problems, they might respond with one of the above features, which are typically regarded as normal behavior.

Attention to Physical Symptoms

Parents are unaware that the attention, they do or do not give to their children's episodes, can perpetuate these symptoms.

Child Behavior

Many children with PNES deny that they have problems other than seizures. Others might acknowledge feeling sad or mad but not about the stress, difficulties, and problems they actually face.

Red Flags for Pediatric PNES

Child's Medical History

The following information in the child's history should alert you to the possibility of PNES:

- A change in the typically stereotyped clinical manifestations of children who have confirmed epilepsy, with and without seizure control.
- Children with new-onset seizures who also have a history of multiple nonspecific physical symptoms.
- Every child with a history of intractable seizures.
- Traumatic brain injury can lead to the development of epilepsy particularly in children with moderate and severe head injury [18]. Most children who experience mild head trauma do not develop epilepsy [19]. If they present with seizures 6 or more months after their head injury, however, they are more likely to have PNES than posttraumatic epilepsy [20].

Clinical Manifestations

Although the symptoms below suggest possible pediatric PNES, they are not specific to this condition. The previously described gold standard diagnostic method is essential to confirm a PNES diagnosis:

- Children with PNES have an inconsistent or changing pattern of symptoms rather than the consistent and stereotypic symptom pattern found in seizures due to epilepsy.
- The episodes of PNES are typically prolonged and last for more than 5 min. The lack of tiredness and confusion following these events differentiate them from the prolonged seizures of status epilepticus.
- PNES episodes begin with a gradual buildup often associated with hyperventilation.
- Children with PNES have clear consciousness following an episode.
- The episodes typically do not occur when the children are alone.
- The children do not sustain injury during episodes.
- Incontinence for urine and feces are rare.

Epilepsy Model

A relative, neighbor, or friend with epilepsy might serve as a model for the displacement into seizure-like behaviors of the negative feelings involved in the child being in a "predicament."

"The Only Problem Is the Seizures"

During the diagnostic interviews, described below, if the child and/or the parents deny any problems other than seizures as well as the possibility of stressors, other than the episodes themselves, rule out the possibility of a PNES diagnosis.

Techniques for the Child Diagnostic Interview

Ideally, the psychiatric/psychological assessment to determine if the child has PNES should be done in parallel with the neurological evaluation and vEEG. The three main goals of the diagnostic interview are to rule in or out a diagnosis of conversion disorder (or dissociative disorder), identify the child's stressors, and determine if the child has comorbid anxiety disorders and/or depression. See Table 2.2 for the recommended content and order of the interview. Although these children often deny any problems other than their seizures, use the techniques in Fig. 2.1 to encourage them to talk.

Table 2.2 Pediatric PNES psychiatric diagnostic interview guidelines

Topic	How to
Interview goal	Tell the child that epilepsy is not an easy illness to have and that it can affect different things in a child's life
	To understand how seizures are affecting the child's life, you would like to first ask the child to tell you about the seizures and then find out about the child's home, school, friends, mood, and other things
	If you feel you have good enough rapport with the child, mention that you know from other children with epilepsy that when they are stressed their seizures get worse
NES episodes	Ask the child to describe the episodes. If the child refers you to the parents for this information, ask the child what the parents have told the child that happens during a seizure
	Find out how the episodes have impacted different parts of the child's life including school, extracurricular activities, home, and friends
	Express empathy for the episodes and the impact they have on the child's life. This helps establish rapport with the child
Stress	Find out what things seem to make the child's seizures worse and what seems to make them better
	If the child denies any stressors, and you do not feel that the rapport you have with the child is good enough, go on to another topic. Mention that you know from other children with epilepsy that when they are stressed their seizures get worse. You might learn about the child's stressors during the rest of your interview. If not, you can try to bring up this topic again at the end of the interview. The best way to do it would be to tell the child you just want to make sure you understood what the child had said about different things that are stressful
	How does the child cope or has coped with the stressors, problems, and difficulties that the child mentions? If it is difficult to get information on coping or problem-solving strategies, avoidance might be the child's main way of problem-solving.

Table 2.2 (continued)

Topic	How to
Comorbid psychiatric disorders	Inquire about symptoms of mood disorders, anxiety disorder, attention deficit hyperactivity disorder (ADHD), learning disorders, psychotic disorders, eating disorders, conduct disorder, oppositional defiant disorder, substance abuse, autism spectrum disorders, and trauma. For young children and those with language or intellectual difficulties, see [21] for guidelines on how to ask about these topics
Conversion disorder	When you inquire about stressors, problems, or difficulties, does the child say that the only problem is the seizures? If the child is able to share some difficulties with you, what negative feelings do they arouse in the child?
	When you ask about sadness, anger, anxiety, and fear, does the child deny them?
	Has the child been bothered in the past or currently by physical symptoms?

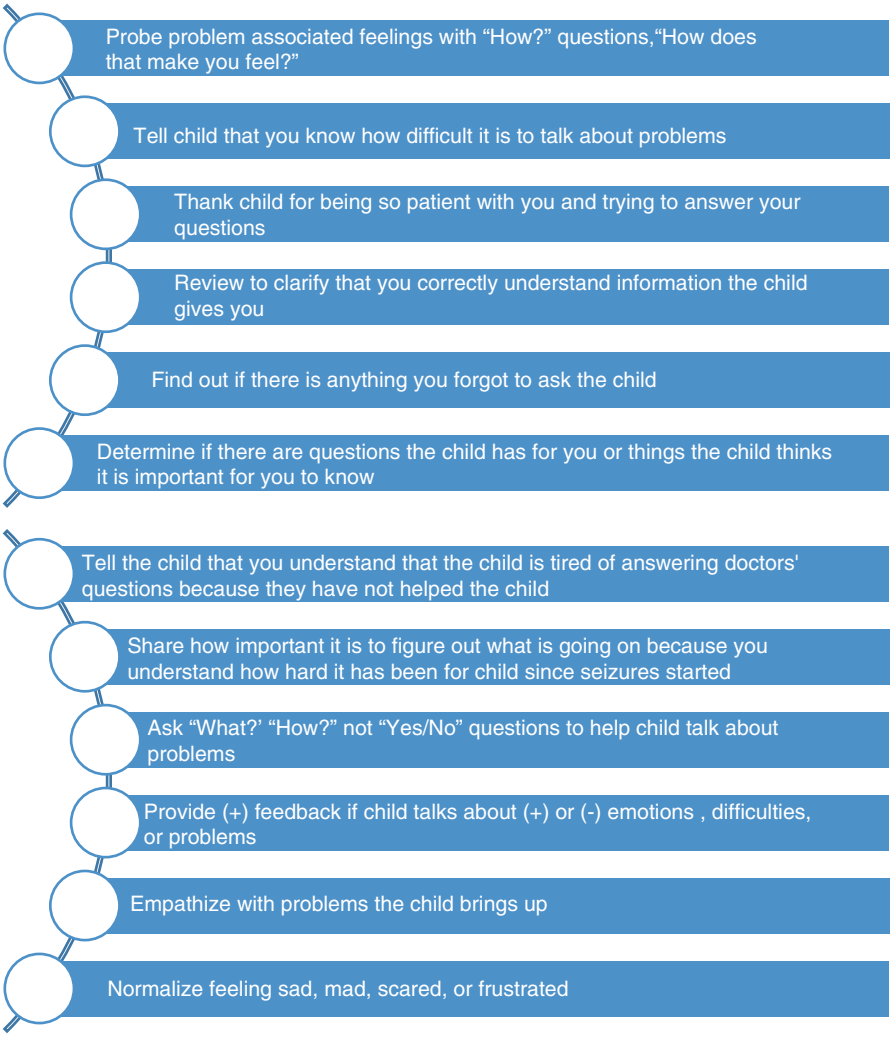

Fig. 2.1 Techniques to encourage children with PNES to talk about their problems

In terms of the interview format, interview the child without the parents to ensure that the child will be able to speak as freely as possible. If the patient is an adolescent, interview the adolescent before the parents. Always gage where the child is at developmentally both in terms of mental age and language skills and modify the language you use accordingly to ensure that the child understands you. This is particularly important because the child might have subtle receptive and expressive language difficulties [22]. Use concrete rather than abstract language for younger children and those with language difficulties.

Confidentiality, Diagnosis, and Treatment Plan

At the end of the interview, thank the child for being helpful and assure the child that what the child has told you is confidential. If the child has given you information that you think is important to share with the neurologist/epileptologist and/or the parents, particularly if it involves the child's safety, ask for the child's permission to do this.

Explain to the child that you need to talk with the parents and the neurologist/epileptologist to come up with a plan of how to help stop the seizures and the problems the child brought up in the interview. Most importantly, do not talk with the child or adolescent about the treatment plan until the parents have agreed to the plan.

Strategies to Use in the Parent Interview

The following topics in the interview of the parents will add to what you learned during your comprehensive assessment of the child. It will provide you with information needed to confirm the conversion disorder and comorbid psychiatric diagnoses. You will also get a sense of how open the parents are to acknowledging that the child has problems other than seizures and, more specifically, to the possibility of a psychiatric rather than an epilepsy diagnosis. Depending on how open the parents are, you will also learn about the impact of the child's illness on the family's functioning.

NES Episodes

Ask the parents to describe the episodes in terms of:

- The clinical presentation.
- Where the seizures occur.
- Who is with the child during an episode.
- How long episodes last.
- The child's awareness and functioning once an episode ends.
- How parents handle the episodes.

If the child also has epilepsy, ask the parents to describe how the seizures present. Express empathy for the impact of the child's episodes and/or seizures due to epilepsy on the parents' lives and on the family. This helps build rapport with the parents.

Stress

As for the child, explain that stress might trigger seizures and then find out what stressors the child might have. If parents describe the child's stressors, empathize with how difficult this might be for the child and for them. If the parents deny stressors, gently ask if the family is experiencing any stressors. When parents state that seizures are the only stressor for the child and for the family, this increases the likelihood of a conversion disorder diagnosis. Then ask what events and child behaviors precede episodes. Most parents usually deny any antecedent factors.

The Child's Medical History

Ask about past and current medical illnesses and hospitalizations. Determine what the parents do now and have done in the past when the child has physical complaints. Do they seek medical help and/or let the child miss school?

Psychopathology

Help the parents understand that seizures due to epilepsy impact different aspects of the functioning of the child and family. To help reduce the frequency of the child's seizures, explain that you will ask them questions about the child's behavior, emotions, and functioning. Inquire about symptoms of mood disorders, anxiety disorder, ADHD, learning disorders, psychotic disorders, eating disorders, conduct disorder, oppositional defiant disorder, substance abuse, autism spectrum disorders, and trauma. Find out about conflicts/problems between the parents and child and express empathy accordingly. The parents might deny that the child has any emotional or behavioral symptoms and conflicts in the family. Explain that the above occur to some degree in most children and families and that they might act as potential stressors that induce seizures.

Discipline

Find out if parents have made any changes in how they discipline the child since the onset of seizures. Clarify how both parents approach this topic. If they have different approaches, ask them to share how they resolve their differences. Inquire how the child responds to their different approaches and attempts to manipulate their differences.

Burden of Illness and Childcare

Inquire if both parents or one parent deals with the child's illness. How does this affect the other children and family functioning?

Schedule the Feedback on the Diagnosis and Treatment Plan

Explain to the parents that the team (minimally involving you and the neurologist/epileptologist) will review the information collected during the vEEG, the child's psychiatric/psychological interview, and the parents' interview. Then schedule a feedback session with the team about the diagnosis and treatment plan for the parents and child.

Summary

Diagnosis of Pediatric PNES

The possibility of PNES should be considered in:
Every child with intractable seizures that do not respond to AEDs

This diagnosis is confirmed through:

A vEEG with no epileptic activity during "seizures"
A comprehensive psychiatric evaluation that reveals evidence for a conversion disorder

Triggers

Undiagnosed and untreated
- Learning difficulties
- Social problems

Domestic strife (parenting, marital relationships)
Unrealistic performance expectations (child, parents)
Psychological abuse, bullying, and other forms of trauma

Risk factors

Somatopsychiatric
- Past medical illnesses, hospitalizations, and ER visits
- Psychiatric diagnoses, past emotional problems
- Passive avoidant coping
- Fearful response to physical sensations (anxiety sensitivity)

Adversity
  Treatment with psychotropic medications
  Adversities
    Bullying
    Domestic or community violence
    Serious personal illness, surgery, or medical procedures

Red flags

Other than seizures, child has no problems
Inconsistent seizure pattern
Long duration of seizures
Seizures occur in presence of others

Diagnostic techniques

Separate child and parent interviews
Concrete language with "What?" and "How?" and follow-up validation questions and few "Yes/No" questions
Empathize
Provide positive feedback for information the child provides
Normalize stressors, problems, difficulties, and negative emotions

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Diagnostic Feedback and Treatment Plan

3

Who Gives the Feedback?

Ideally, the pediatric epileptologist/neurologist should conduct the diagnostic feedback because the parents bring their child with PNES to this physician assuming that their child has epilepsy. They regard the pediatric epileptologist/neurologist as the team leader. However, the psychological nature of the disorder and its treatment underscore the importance of both the pediatric epileptologist/neurologist and the mental health care professional who did the diagnostic evaluation, each providing the information relevant to their expertise. If schedules do not permit a joint meeting, the mental health professional should schedule a meeting with the parents and child as soon as possible after the pediatric epileptologist/neurologist gives the neurological feedback.

It is important to give separate feedback to the parents and to the child for the following reasons. First, from the developmental perspective, explanation of the diagnosis needs to be done at a level that is commensurate with the child's cognitive, linguistic, and emotional levels. Second, parents might misinterpret a PNES diagnosis as suggesting that the child is faking seizures and express anger toward the child and the treatment team. These responses can be emotionally harmful for the child, impair rapport with the treatment team, and make it even more difficult for the child to talk about the child's underlying emotional problems and difficulties. Third, during the diagnostic interview, the child might have shared with the diagnosing mental health professional information about stressors, difficulties, or problems that the child does not want to disclose to the parents. If these issues should be addressed early in the treatment, the mental health professional should obtain the child's permission to include this information in the parent feedback.

This chapter first describes how the pediatric neurologist/epileptologist and you (or the diagnosing mental health professional) should give feedback about the diagnosis and describe the treatment plan to the parents. It then presents how to do this with the child. A sensitive approach and awareness that the parents and child might be quite resistant to learning about the psychological nature of the disorder are

R. Caplan et al., *Pediatric Psychogenic Non-Epileptic Seizures*,
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essential. This will ensure that they accept the diagnosis and treatment plan and prevent them from seeking out doctors who will diagnose the child with epilepsy. If the process goes awry, doctor shopping will occur, and the child's condition will go untreated. The child will continue to have seizure-like episodes and develop other physical symptoms in lieu of learning how to cope and problem-solve in an adaptive manner.

How to Give the Feedback to the Parents

Most importantly, allow enough time so the parents and child can ask questions and share their concerns about the diagnosis and treatment plan.

Feedback on the Diagnosis

Neurologist/Epileptologist

The physician tells the parents that the team is well aware of how difficult the child's uncontrolled seizures have been for the child, the parents, and the family. The team has reached a diagnosis and designed a treatment plan for the child. The physician should inform the parents that the findings of the psychiatric/psychological evaluation indicate that the child's seizures are due to psychological causes and that the child has a disorder called psychogenic non-epileptic seizures or PNES. The clinician should help the parents understand that seizures in children can come from many causes including epilepsy, brain tumors, stroke, inflammatory disorders, and psychological causes. The clinician should add that the vEEG, psychiatric/psychological evaluations, and medical tests administered to the child confirm PNES and rule out these other causes of seizures. Before the mental health clinician explains what PNES is and how to treat it, the epileptologist/neurologist should emphasize the following for the parents:

- Seizures due to psychological causes do not mean that the child is faking.
- PNES is rare, and only few professionals have the expertise to make this diagnosis in children.
- PNES is a treatable disorder.

If the child also has epilepsy, the physician should clarify that the child's current seizures are due to psychological causes, not epilepsy or any other brain disorder. The clinician should describe for the parents what the child's seizures due to epilepsy look like and what the child's seizures due to PNES look like. The physician should explain that, whereas during seizures due to epilepsy, the vEEG showed epileptic activity that was not the case for the child's current seizures.

If during the diagnostic evaluation the mental health clinician picked up that the parents are resistant to a psychological explanation for the child's condition ("My child has only one problem, seizures"), he/she should communicate this to the

pediatric neurologist/epileptologist who should modify the feedback. As previously described, the pediatric neurologist/epileptologist tells the parents that the team is well aware of how difficult the child's uncontrolled seizures have been for the child, the parents, and the family. The team has reached a diagnosis and designed a treatment plan for the child. The physician should inform the parents that there is good evidence that stress can trigger seizures. For this reason, the mental health care provider is part of the epilepsy team and will explain the importance of stress and the child's stressors. The clinician should describe the negative results of the vEEG (no epileptic activity during seizures) and other diagnostic tests. He/she should also explain that these negative findings suggest that the child's seizures are not caused by brain disorders, such as a tumor, stroke, inflammation, or any other serious illness involving the brain.

Feedback by the Mental Health Professional

You or the mental health clinician who conducted the diagnostic evaluation (referred to as you from hereon) should explain to the parents that people's emotional experiences affect how their body feels. They probably know people who when stressed get headaches or their back, neck, or joints act up. There are those who get heartburn or stomachaches. Similarly, some children have physical symptoms when they are under stress or faced with difficulties and problems. Children with PNES have what is called a conversion disorder, which means that stress, difficulties, or problems are expressed through physical symptoms. When the stressors, difficulties, or problems go unsolved or continue, the increasing tension has nowhere to go and is channeled through the body into physical symptoms. In the case of their child, the physical symptoms are seizures.

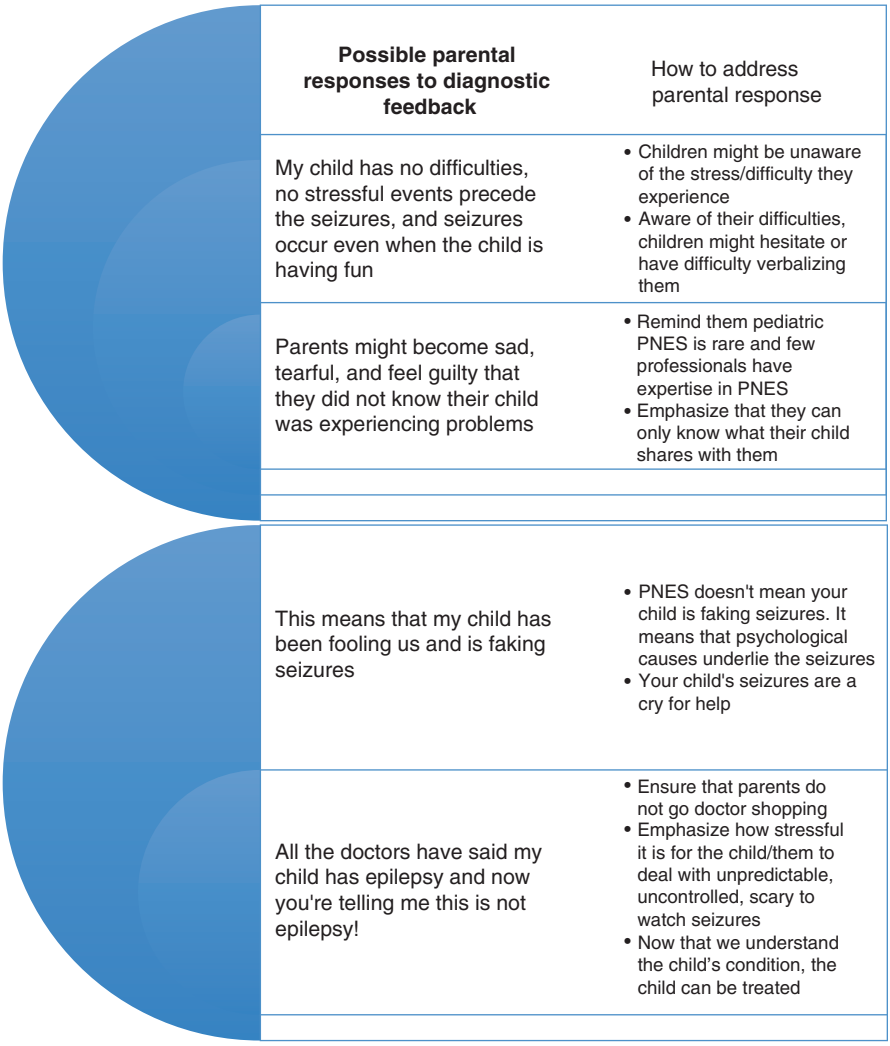
Talk about the stressors the parents mentioned during the assessment. With the child's permission, describe the stressors, difficulties, and problems the child reported. The parents might feel guilty because they were unaware their child has had these difficulties and did not help the child problem-solve. They might express anger toward the physicians who treated the child in the past because of all the wasted time during which the child continued to suffer due to uncontrolled episodes. Some parents vent about the school, the coach, or other individuals involved in triggering the child's stress.

For parents who are resistant to a psychological explanation for the child's condition, begin the feedback by talking about the impact of uncontrolled seizures on the child's life and on the life of the family. If the parents' resistance to a psychological explanation for their child's disorder becomes apparent only during the feedback, describe the mind-body connection in terms of stress and medical illness in general with possible examples of headache; back, neck, and joint pain; gastrointestinal symptoms; and other physical symptoms. You should continue to focus on how stress can trigger seizures using the examples of stressors the parents gave during their interview. Also, inform the parents that often the child is unaware of what is stressing the child. So, the next stage of treatment will involve figuring this out and providing the child with ways to deal with stress. However, in the interim, you will help the child manage the physical discomfort due to the NES symptoms. This

strengthens the child's rapport with you and lays the foundation for better exploring the child's stressors.

Sometimes, however, some parents, who previously denied any stress during the diagnostic interview, now open up and talk about possible stressors the child and family have faced. Encourage them to speak about the stressors, and provide positive feedback on the information you get. Fig. 3.1 describes some parents' responses and how to address them.

Regarding comorbid psychiatric diagnoses, if the child has anxiety disorder and/or depression, describe these disorders to the parents and how they might be a result



Possible parental responses to diagnostic feedback	How to address parental response
My child has no difficulties, no stressful events precede the seizures, and seizures occur even when the child is having fun	• Children might be unaware of the stress/difficulty they experience • Aware of their difficulties, children might hesitate or have difficulty verbalizing them
Parents might become sad, tearful, and feel guilty that they did not know their child was experiencing problems	• Remind them pediatric PNES is rare and few professionals have expertise in PNES • Emphasize that they can only know what their child shares with them
This means that my child has been fooling us and is faking seizures	• PNES doesn't mean your child is faking seizures. It means that psychological causes underlie the seizures • Your child's seizures are a cry for help
All the doctors have said my child has epilepsy and now you're telling me this is not epilepsy!	• Ensure that parents do not go doctor shopping • Emphasize how stressful it is for the child/them to deal with unpredictable, uncontrolled, scary to watch seizures • Now that we understand the child's condition, the child can be treated

Fig. 3.1 How to deal with possible parental responses to diagnostic feedback

of the recurrent uncontrolled seizures, missed schoolwork, other extracurricular activities, or lack of treatment for the child's underlying conversion disorder. If the child has attention deficit hyperactivity disorder (ADHD), explain how this disorder might contribute to or reflect the child's undiagnosed and untreated learning problems and their possible role in the conversion disorder.

The physician and you should ask the parents if they have any questions on what has been explained thus far about the neurological and psychiatric/psychological aspects of the disorder. If the parents have accepted the PNES diagnosis, the team should describe the treatment plan and use the term episodes instead of seizures.

The Treatment Plan for Parents Who Accept the Diagnosis of PNES

First outline the main treatment goals:

- Short-term goals
  - Stop the episodes.
  - Gradually stop antiepileptic drugs (AEDs) if the child does not also have epilepsy.
  - Return to school.
- Long-term goals
  - Treat the conversion disorder.
    - Help the child learn to recognize and adaptively cope with stressors, difficulties, and problems.
  - Treat comorbid psychiatric and learning disorders if present.

You will achieve these goals through individual therapy with the child and work with the parents. Explain to the parents that they play an important role as the therapist's co-therapists for two reasons. First, if the child's behavior is going to change, they need to be aware of and understand the changes so that they can help optimize the child's functioning. Second, because they live with the child, they can provide you or the treating therapist with information needed to understand the child's functioning.

In terms of the time frame (duration, frequency), inform the parents that it is important to begin the child's therapy and your work with the parents as soon as possible. In this early phase, the treatment focus will be the short-term goals of stopping the episodes and school reentry. During the first month, this will involve minimally weekly sessions with the child and parents and ideally biweekly sessions with the child.

Providing the parents with information on how long it takes to stop the episodes helps them have realistic expectations. It also gives them a sense that you know what you are doing and have had experience treating children with PNES. Help them understand that reduction of NES frequency occurs early in the treatment if the parents and child follow the treatment guidelines. Some episodes, however, might still occur during the first 3 months after diagnosis and occasionally more in a long term.

The pediatric neurologist/epileptologist will manage the decrease of AEDs, and, if indicated, a child and adolescent psychiatrist will monitor psychotropic medications.

The parents need to understand the importance of school reentry, which should ideally occur as soon as possible after diagnosis.

Emphasize that it takes time to achieve the long-term treatment goal of the child becoming a functional and adaptive problem-solver when faced with stressors, difficulties, and conflicts. This depends on how long the child has had untreated PNES, the nature of the child's underlying problems, the presence of comorbid psychiatric diagnoses, and the cooperation of the parents. You or the treating therapist will be able to predict how long treatment will take only with a better understanding of the child after about the first 3 months of therapy.

Additional educational testing is indicated if the diagnostic evaluation findings point to a possible learning disorder. The test results will determine what remedial and/or special education resources the child will need at school. If the initial comprehensive diagnostic evaluation suggested that the child has impaired social skills, the relevant testing should be done as these deficits, like those related to learning, might play an importance in the frequency of episodes and school reintegration.

Explain to the parents that the following treatment approaches (see details in Chap. 4) will be used to achieve the short-term goals:

- A behavioral approach for resolution of the episodes involves active parent participation and should be implemented from today.
- Ensure that the parents report episodes to you and not to the pediatric neurologist/epileptologist with whom you will actively collaborate.
- You and the parents will work with the school staff to ensure the child's reintegration into school.

What to say to other family members and friends? Parents often ask what they and their child should tell family members and their friends about their child's diagnosis. If they do not ask this question, find out how they will deal with this. Some parents feel comfortable saying that their child has PNES and will be treated by a mental health professional. Others prefer to say that the doctors have finally figured out how best to treat their child's condition or seizures and that this will take some time until the child will get better.

Follow-up feedback meeting: The parents should meet minimally with the pediatric neurologist/epileptologist and you to go over how they have processed the information they received during the feedback. They might have questions, concerns, and doubts about the diagnosis and treatment plan. It is important to encourage them to discuss these so as to ensure that they will agree to the proposed treatment for the child.

The Treatment Plan for Parents Who Do Not Accept the Diagnosis of PNES

Outline the following main treatment goals:

- Identify stressors that might exacerbate or trigger the child's seizures.
- Apply relaxation techniques to deal with stress.
- Reduce seizure frequency.
- Return to school.

These goals can be achieved through working with the child and the parents, the pediatric neurologist/epileptologist, and the school. To do this, you will meet once a week with the child and the parents to identify possible seizure-related stressors over the next month. During the next 3 months, you will help the child learn ways to reduce stress and apply them to deal with potential stressors. The child and parents should continue their regular appointments with the pediatric neurologist/epileptologist to monitor the child's seizures and AEDs. The parents need to understand the importance of school reentry, which should ideally occur as soon as possible.

Regarding the short-term treatment approaches, briefly summarize techniques you will use to help the child tune into bodily sensations, become aware of pending seizures, and use a variety of stress reduction techniques (see Chap. 4 and Appendices C–E, H–K). Through this treatment approach, you hope to reduce the frequency of the child's seizures. Achieving some seizure control will establish the parents' trust in you. This, in turn, might also help you penetrate the barrier that the child has no problems other than seizures. If that occurs, you might be able to apply the long-term goals using the techniques described in Chaps. 5–7.

Parent Feedback Summary

Team = neurologist/epileptologist + mental health professional
Allow enough time for the feedback and parents' questions and concerns

Modify feedback by parent type

Psychologically minded or unaware of child's difficulties
- PNES = psychiatric/psychological disorder
- Stressors, problems, difficulties <--> PNES
- **Preempt statement** by parents that child is faking seizures.
- Emphasize that **PNES is rare and requires special expertise**
  - **If child has epilepsy**, differentiate NES from seizures due to epilepsy
    - **Rename** seizures as episodes or events

Parents invested in epilepsy diagnosis
- Stress ← → seizures due to epilepsy

Treatment plan

Psychologically minded or unaware of child's difficulties
- *Short-term goal*: Stop episodes and AEDs, school reentry
- *Long-term*: Adaptive coping and problem-solving
- Type of intervention
- Individual child therapy
  - Parent counseling and support
  - Psychotropic medications
  - Ancillary testing/intervention: Educational, language, social skills

Parents invested in epilepsy diagnosis
- *Goals*:
  - Identify stressors
  - Apply relaxation techniques and reduce seizure frequency
  - Return to school

Feedback to the Child

If the feedback with the parents took a long time and the parents came out looking sad or angry, apologize to the child for having to wait so long, and thank the child for being so patient. During the feedback, modify the language you use based on child's developmental level.

Feedback on the Diagnosis

Neurologist/Epileptologist

The physician tells the child that the team is well aware of how difficult this illness has been for the child. The team now knows what the child has and how to treat it. Sometimes children are stressed or have problems and difficulties that they might or might not be aware of. This can cause their bodies to react with headaches, stomachaches, and, as in the child's case, seizures. Doctors treat these as if it is epilepsy, but the medicines for epilepsy are not good for this condition. And the seizures just happen again and again. The physician should explain that all the tests show that there is nothing bad going on in the child's brain. For a child who also has epilepsy, the clinician should explain that the medicine that the child took before controlled the seizures due to epilepsy. The seizures the child has now are different and need a different type of treatment.

The physician should tell the child that he/she wants the child to understand something very important:

- The child has an illness called psychogenic non-epileptic seizures or PNES.
- If stress, difficulties, or problems cause seizures, that does not mean that the child is faking.
- Only few doctors know how to recognize and treat PNES and make children well again.

Feedback by the Mental Health Professional

You should explain to the child that our brains and feelings affect how our body feels. For example, some children when they get nervous get a headache, and others get a tummy ache or feel like throwing up. Ask the child if the child knows any kids or adults like that. Then find out if that ever happens to the child.

Tell the child that children with PNES have a similar problem, but they have what looks like seizures, not headaches or tummy aches. So, what you want to figure out with the child is what is stressing the child, what worries the child has, and what difficulties the child might have. Explain to the child that all these can make the child's body feel cranky. Once you and the child understand what these problems and difficulties are, you can help the child teach his/her body not to have seizures.

If during the diagnostic evaluation the child shared difficulties or problems with you, remind the child of the things he/she told you about. Ask the child if the child would like some help to make those problems get better and to get rid of the seizures. See Fig. 3.2 for suggestions on how to respond to comments children make following the diagnostic feedback.

Regarding comorbid psychiatric diagnoses, if the child has an anxiety disorder, depression, ADHD, or a combination of these disorders, explain this to the child and how this can contribute to the learning, social, and/or family difficulties the child has shared with you. It is important that the child understand that all these conditions are treatable.

Once you feel the child is comfortable with the diagnosis of PNES, follow up the diagnostic feedback with, "Because these are not seizures caused by epilepsy we don't call them seizures. I use the name episodes but different kids call them different names. What would you like to call them?"

The Treatment Plan

In describing the treatment plan, be sensitive to the fact that the child might be quite tired and somewhat overwhelmed by the information the pediatric neurologist/epileptologist and you have given the child.

Individual therapy: Explain that you will work with the child to stop the episodes and help with the difficulties the child reported during the diagnostic evaluation. At first you will see the child twice a week, and once the child has fewer episodes, you will meet with the child once a week. Describe the behavioral approach that will be used to treat the episodes using the guidelines provided in Chap. 4. Tell the child that you have told the parents to implement the plan from today and would like the child to do the same. Help the child understand that you also need to work with the parents to ensure that they know how to help the child. Tell the child that the pediatric neurologist/epileptologist will decide how to slowly stop the medicines given for seizures.

If the child needs treatment with psychotropic medications, explain that a child psychiatrist can give medicine that will help the child with some of the child's problem behaviors/feelings. Find out how the child feels about what you have told the child, and encourage questions.

The child needs to understand that you, the parents, and the pediatric neurologist/epileptologist will work with the school to help the child catch up the missed work, get the necessary help for learning difficulties, and transition back to school. If during the diagnostic evaluation the child reported learning or social difficulties, help the child

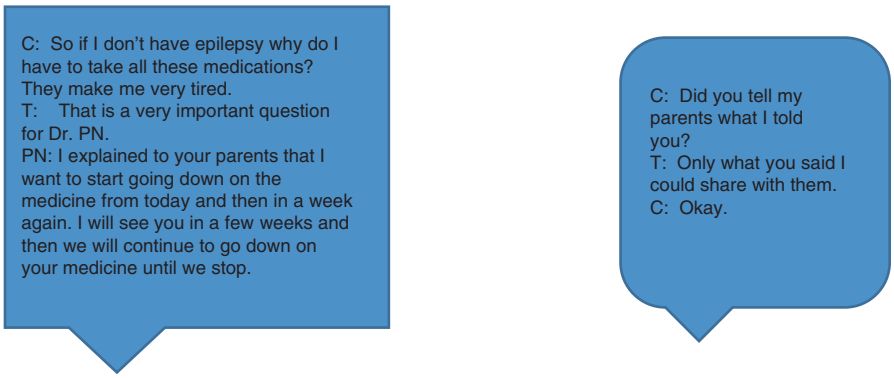


Fig. 3.2 Child's questions/comments during feedback [C = child, T = therapist, PN = pediatric neurologist]

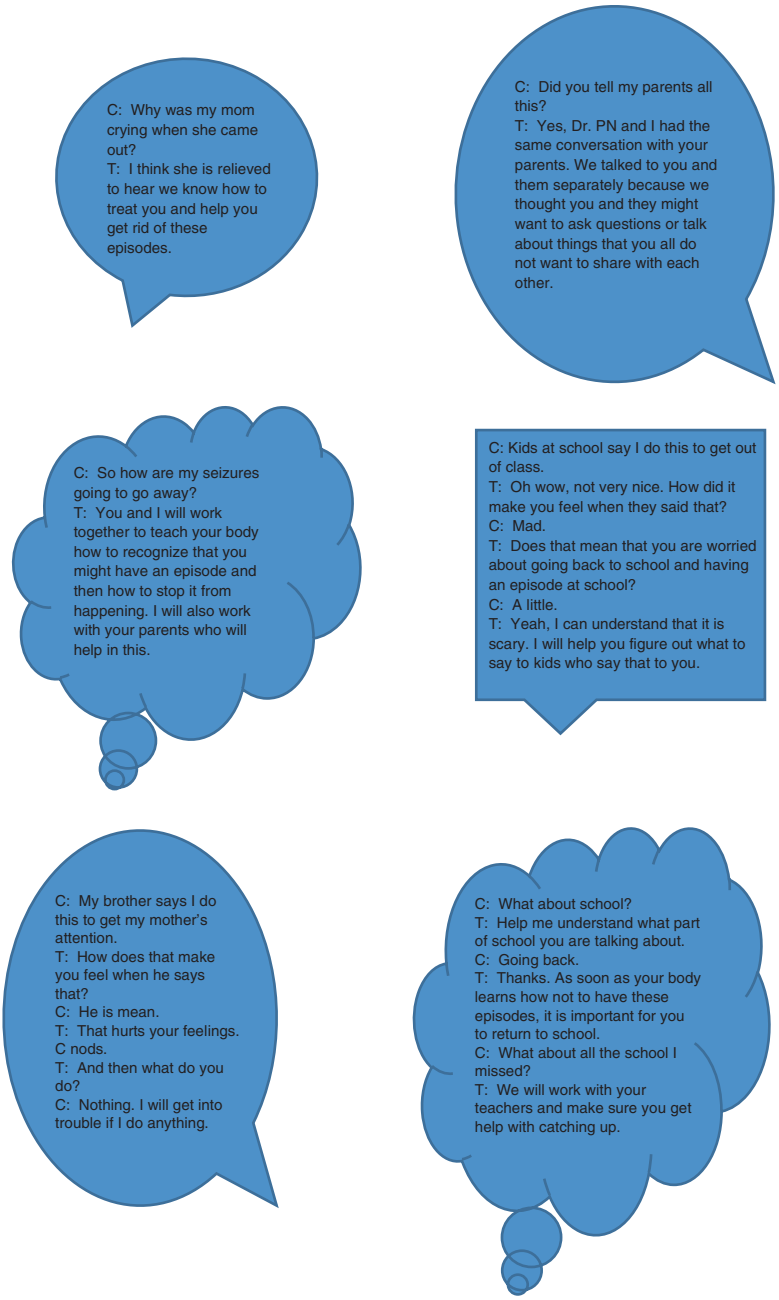


Fig. 3.2 (continued)

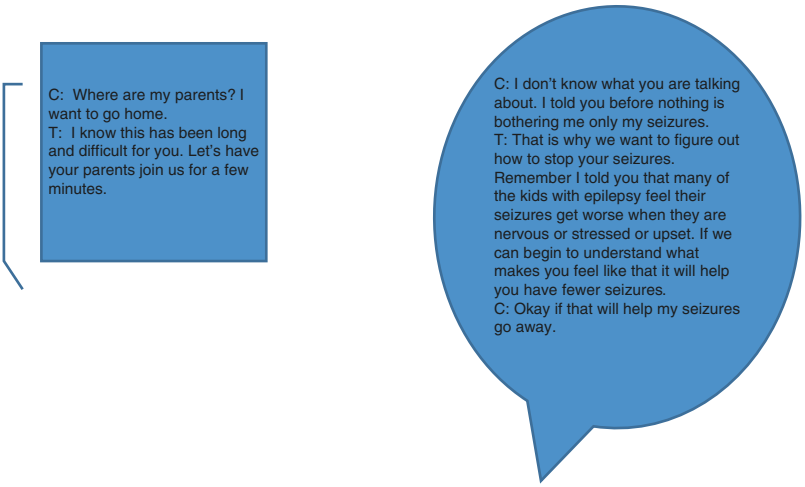


Fig. 3.2 (continued)

understand the need for testing. Explain that knowing exactly what are the child's difficulties and strengths in these domains will provide information needed to help the child.

It is most important to find out what fears the child has about going back to school. In addition, explore what the child would like to tell family members and friends about the diagnosis. Some children feel comfortable saying that they have PNES and will be treated by a mental health professional. Most children prefer to say that the doctors have finally figured out how best to treat their condition or seizures but that it will take some time until the child gets better.

Child Feedback Summary

Modify language based on child's developmental level
Team = neurologist/epileptologist + mental health professional
Seizures Conversion disorder
Discuss how **stress, difficulties, and problems** can cause physical responses including seizures
Explain that a PNES diagnosis does not mean "**faking**"
For child with epilepsy + NES, differentiate seizures due to epilepsy from NES
Stop using the term seizures for the NES, and **rename** them using a term the child chooses
Outline the **therapy plan** for the child and parents and how this will address the problems the child has shared with you
The pediatric neurologist/epileptologist will talk about the **change in AED drugs**
If needed, explain that a child psychiatrist will treat problems with **attention, worries, or sad mood** with medications

Describe the **behavioral approach** to treatment of episodes and what **you have instructed the parents to do** when the child has an episode
If indicated, also describe need for educational, language, social skills, and/or other **testing**
Find out about the child's **fears related to returning to school**, and emphasize that this is an important part of the treatment
Explore **what the child will tell friends and family** about the diagnosis and treatment
Encourage **questions, concerns, and comments** on the information you provided during the feedback

Combined Parent and Child Feedback Summary

Invite the parents to join you with the child, and tell them that with the treatment plan in place, the child will have fewer and fewer episodes and slowly life will return to normal for the child and family. Confirm appointments with the pediatric neurologist/epileptologist, with you, and if necessary the need to set up an appointment with a child psychiatrist. If the primary care provider referred the child, tell the parents that you and the pediatric neurologist/epileptologist will provide the physician with information on the diagnosis and treatment plan.

If the child has any episodes before the next appointment with you, they should contact you. You will decide if it will be necessary to also let the pediatric neurologist/epileptologist know. Ask the parents to contact the school to sign a release so you and the pediatric neurologist/epileptologist can contact the school to set up a transition plan and how to manage episodes that might occur at school. Most importantly, let them know that if they have any questions once they leave, they can contact you.

Short- and Long-Term Implications of Diagnosis and Feedback Techniques

The importance of the detailed approach to the diagnosis and feedback cannot be overstated. It determines if the parents and child accept the diagnosis, understand the psychological/psychiatric nature of the disorder, trust the treatment team, and do not go doctor shopping for an epilepsy diagnosis. Most importantly, it lays the foundation for the treatment of the child.

However, it takes time for the parents to accept the diagnosis. Even if the parents appear to be in full agreement with the diagnosis and treatment plan during the feedback, they often change their mind and need additional education about PNES. For this reason, it is important to schedule a follow-up feedback meeting with them and to apply the psychoeducation guidelines presented in Chap. 4 of this treatment guide.

Short-Term Treatment

4

Overview of the Treatment of PNES

The ultimate treatment goal is to help the child stop dealing with stressors and conflictual situations by avoidance and learn to cope and problem-solve in an adaptive manner. For didactic purposes, the treatment guide separately addresses the goals and techniques used in the short- and long-term treatment phases. However, some of their treatment goals and therapeutic strategies may overlap.

Comprehensive therapeutic intervention for pediatric PNES includes several modalities, such as psychoeducation, therapy (e.g., insight-oriented individual therapy, cognitive behavioral therapy (CBT), group therapy, and family therapy), and psychopharmacological treatment. In some cases, special education services, educational therapy, and social skills training are also indicated. Of note, work with the parents is an integral part of the treatment even when there appears to be no obvious family dysfunction. It provides the parents with the skills and support they need to cope with and manage the child's episodes, conversion disorder, and comorbid psychopathology.

The choice of the type of therapy depends on the needs of the individual case and on the availability of a professional with the relevant expertise. We recommend an eclectic approach that uses different therapeutic modalities based on the severity of the conversion disorder, the presence of comorbid psychopathology, and the level of family function or dysfunction. To be successful, the treatment approach should be flexible, and its modalities can change over time to address emerging problems as the patient and family reveal new issues during the course of treatment. Most importantly, multimodal treatment of pediatric PNES involves a multidisciplinary team that minimally includes a mental health professional (psychiatrist, psychologist, social worker, therapist, or counselor), a pediatric neurologist or epileptologist, a primary care physician, and school staff.

The short-term treatment phase starts after the team confirms a PNES diagnosis and provides sensitive diagnostic feedback to the parents and child as described in Chaps. 2 and 3. Ideally, it begins while the patient is still in the hospital undergoing

R. Caplan et al., *Pediatric Psychogenic Non-Epileptic Seizures*,
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Table 4.1 Short-term treatment goals

Provide psychoeducation about PNES
Develop rapport with the child and parents
Start individual therapy with the child and work with the parents to achieve symptom control and resolution
Reestablish the child's regular life routines including return to school
Treat comorbid psychopathology

the diagnostic assessment. But it might only occur after the child's discharge from hospital in the outpatient setting. You, the mental health clinician, then assume the role of the primary treating clinician and case coordinator. You will guide each of the multidisciplinary team members (pediatric neurologist/epileptologist, primary care providers, and school staff) on their role in achieving the treatment goals and meeting the needs of the child and parents. Table 4.1 above presents the goals of this treatment phase.

Short-Term Treatment Goal 1: Psychoeducation About PNES

Effective psychoeducation about PNES is the first step in the initial treatment phase. It begins during the feedback and arms the parents and children with the information necessary to understand that PNES is a psychiatric not a neurological illness. In addition to relieving their fear and anxiety about the effects of unpredictable PNES episodes, effective psychoeducation facilitates successful transition from medical care to psychiatric care. By providing information about PNES in a developmentally sensitive and empathic way, you will develop the rapport needed for the child and parents to collaborate with the treatment plan.

Provide separate psychoeducation to the child and parents to ensure that information the child shared with the treatment team will remain confidential until the child is ready to reveal it to the parents. In addition, it provides a safe milieu for the child in case the parents express negative feelings involving the child, such as difficulty accepting the child's psychological problems, anger because they think the child may be faking seizures and other physical symptoms, as well as guilt for not realizing that the child was experiencing the emotional difficulties that triggered the illness.

You should also regularly update the child's neurologist/epileptologist about the treatment progress. This helps the child's neurologist/epileptologist feel supported in their care of the PNES patient. Furthermore, it ensures that the neurologist/epileptologist will discontinue unnecessary antiepileptic drugs (AEDs) [1].

Delivery of psychoeducation to the child's school staff is a prerequisite to decreasing their anxiety about the student's episodes at school and ensuring their cooperation with your recommended plan for the child's return to school. The sections below outline how to deliver psychoeducation to the parents, the child, the child's clinicians, and the school staff.

Psychoeducation for the Parents

Remind the parents that PNES is a rare disorder and usually due to a conversion disorder in which emotional problems are converted to or channeled into physical symptoms. Find out what the parents understood about the treatment goals and approaches described during the diagnostic feedback. If the parents' concerns indicate that they have difficulty accepting that their child's seizures are not due to epilepsy, ask them to share their doubts with you. Acknowledge their fears about misdiagnosis of their child using the following explanations and approaches:

- PNES episodes look very scary for people who do not have any medical background or experience dealing with seizures due to epilepsy.
- Seizures due to epilepsy can have complex presentations. Whereas the standard approach to rule out epilepsy is based on the clinical presentation of the event, this is not the case for PNES. Only a prolonged vEEG can capture the events in question.
- For parents who are convinced that their child's episodes look like "real seizures," review the vEEG recording together with the pediatric neurologist/epileptologist and the parents to show them the negative findings (no epileptic activity on the EEG tracing when the child has seizure-like symptoms).
- If a vEEG recording is not available, tell the parents that although the child's episodes may look very much like "real seizures" due to epilepsy, some of the child's symptoms are not typically seen during seizures due to epilepsy. Then explain which features are uncharacteristic of the seizures of epilepsy but commonly seen in PNES. These include extended duration of the event without subsequent cognitive and behavioral changes, tightly closed eyes, erratic movements of the extremities and the entire body, as well as dramatic vocalizations and/or crying during the event. In addition, the presentation of symptoms often changes over time.
- If parents still have difficulty accepting the PNES diagnosis, recommend an additional follow-up visit with the treating pediatric neurologist/epileptologist or primary care provider.
- To ensure that the parents have a good understanding of PNES and why their child was diagnosed with a conversion disorder, direct them to the few online resources about pediatric PNES (see Appendix A) to increase their knowledge about the disorder.

Repeat the description of the short- and long-term course of the illness that parents have already heard during the diagnostic feedback. It is important for the parents to understand that the frequency of PNES episodes will decrease with time. But they should also be aware that these events might recur or present as other types of somatic symptoms (i.e., headaches, abdominal pain, dizziness, pain, muscle

weakness, or other abnormal movements) even during the more advanced stages of treatment when the child develops more effective communication, coping, and problem-solving skills.

Help them understand the need to gradually stop the AEDs if the child does not also have epilepsy and/or need these drugs as mood stabilizers. Encourage the parents to set up a follow-up appointment with the pediatric neurologist/epileptologist or primary care physician for the AED taper. If the child has a comorbid psychiatric diagnosis treated with an AED for mood stabilization, the parents should also schedule an appointment with the prescribing child psychiatrist to determine if the drug is indicated given the child's newly confirmed conversion disorder diagnosis.

Make sure that the parents understand that you, the mental health clinician, will be the primary clinician involved in the child's care and the contact person for when the parents have any concerns such as recurrent episodes or any other problems. Also, tell them that you will be in touch with the multidisciplinary team members including the pediatric neurologist/epileptologist, the primary care provider, and the school staff as needed.

Advise the parents how best to explain PNES to their other children, the extended family members, and their friends using the following script: "Suzy has a rare type of seizure-like episode (use the term that the child and the parents feel comfortable with), but they are not medically dangerous to her. The doctors at … . Hospital are experts in diagnosing and treating this type of problem. It will take time for Suzy to get better with the new treatment."

Revisit the need for psychoeducation as often as needed, especially if the child continues to experience episodes and/or if the parents demonstrate any signs of resistance to treatment. The checklist below highlights the main points of the parent psychoeducation (Fig. 4.1).

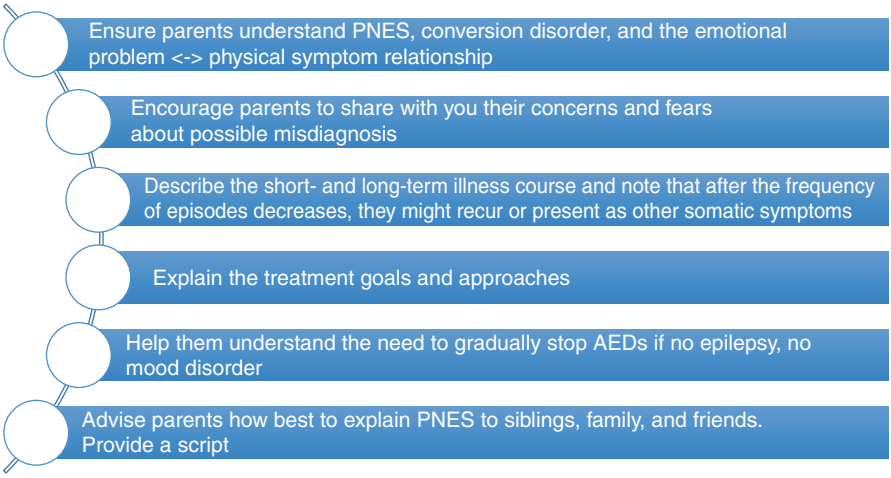


Fig. 4.1 Parent psychoeducation checklist

Psychoeducation for the Child (Fig. 4.2)

Clarify what the child understood about the PNES diagnosis from the feedback session. It is often necessary to go over the explanation several times using developmentally appropriate language. If the child does not appear to understand what the illness is, talk about the mind-body connection and its role in PNES. Remind the child about the stressors and difficulties the child mentioned during the psychiatric/psychological evaluation. Encourage the child to ask questions and let you know if your explanation is not clear enough. Let the child know that, if he/she is interested, you can provide the child with the few online resources designed for youth with PNES (see Appendix A).

Use the name the child chose to refer to his/her PNES episodes. Describe the short-term and long-term treatment goals and how they will be achieved in developmentally appropriate language. Inform the child that you will be the child's therapist and that you will also see the parents to help them learn how to help the child. Assure the child that you will work with the school to facilitate the child's reintegration to school and resolution of school-related problems that are stressful for the child.

Also, explain to the child that the pediatric neurologist/epileptologist will gradually reduce the AEDs added for the episodes but not those given for seizures due to epilepsy. If the child is on an AED for mood stabilization, the prescribing child psychiatrist will decide if there still is a need for AEDs to stabilize the child's mood.

Ask the child what she/he wants to tell peers about the condition. Suggest that the child use a script similar to the one you discussed with the parents: "I have a type of seizures (use the term that the child chose) that are not dangerous. The doctors at … Hospital are real experts in these types of problems, and they said it will take time for me to get better."

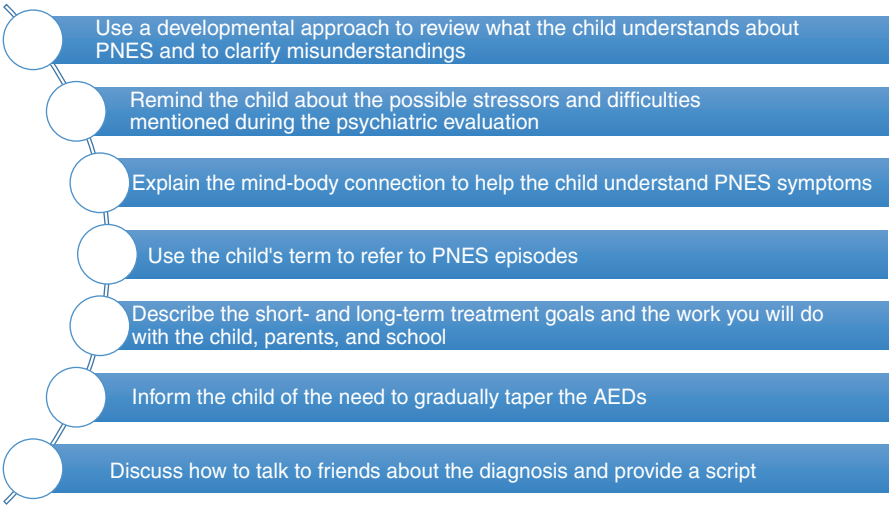


Fig. 4.2 Child psychoeducation checklist

Psychoeducation for the Child's Clinicians

Inform the clinicians about the few websites with information about PNES (see Appendix A). If the physicians were not involved in the diagnostic work-up, describe the child's symptoms and illness course to date. Discuss the difficulties the parents might have accepting this diagnosis and/or their fear that "something might have been missed" in the diagnostic work-up. This will help the medical professionals understand why the parents might call them rather than you about recurrent episodes. Suggest that they redirect the parents back to you for the ongoing management of the child's episodes if the parents call them to report additional episodes.

Recommend discontinuation of AEDs, unless the child has epilepsy and/or is taking these medications for mood stabilization. But emphasize that after the changes in AEDs, the involvement of the pediatric neurologist/epileptologist (or primary care provider) is essential for your work with the family and school staff. In fact, there should be at least one or two follow-up appointments with these clinicians to support the family in the initial phase of treatment, remind them about the medically benign nature of PNES episodes even if they recur, and assure successful transition from medical to psychiatric treatment. The prescribing child psychiatrist should manage AEDs prescribed as mood stabilizers.

Continue to update the clinicians on the child's progress and parents' acceptance of PNES diagnosis. Encourage them to work with you on advocating for the child to resume a regular routine and return to school first on a part-time and then on a full-time basis. Together with you, they should assure the parents that the child's condition is treatable.

Psychoeducation for the School Staff

Before the child returns to school, obtain the appropriate consents from the child (12 years and older) and the parents for release of the medical, psychiatric, and personal information required to communicate with the school staff. Provide the school staff (principal, nurse, and child's teachers) with links to the few websites about PNES (see Appendix A). Write a letter to the school (see Appendix B) describing the child's PNES episodes, treatment plan, and how to manage the episodes at school. The letter should also include information about the child's psychiatric, cognitive, and social-functional deficits that require school-based assessment and intervention. Discuss the need for regular contact between a school representative

Short-Term Treatment Goal 1 Summary: Psychoeducation

- **Psychoeducation, the first step in the initial treatment phase:**
  - Helps the parents and the child understand that PNES is a psychiatric and not a medical illness
  - Facilitates the transition from medical to psychiatric care
  - Strengthens your rapport with the child and parents and encourages their engagement in treatment

- **Provide psychoeducation separately to the child and parents** to ensure the child's confidentiality and provide a safe milieu if the parents express negative feelings
- **Psychoeducation should include** information on:
  - The diagnosis of conversion disorder and the relationship between emotional and physical symptoms
  - Short- and long-term treatment goals and how they will be achieved
  - Your role as the therapist in the treatment
  - How to discuss the condition with others
- **Encourage the child and parents to discuss their concerns** with you, and provide additional psychoeducation as often as needed
- **Psychoeducation for the other clinicians** ensures their involvement in the treatment and should include information about and resources for PNES, the current status of the child's PNES episodes and parental acceptance of the diagnosis, the treatment plan, and the need for an ongoing collaboration
- **Psychoeducation for the school** supports the child's return to regular routines and should include information about and resources for PNES, a letter to the school describing the child's condition, the treatment plan, and how to manage the episodes at school.

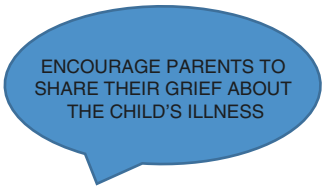
and you to ensure two-way exchange of information about the child's episodes and functioning at school.

Short-Term Treatment Goal 2: Development of Rapport

In order to establish your therapeutic relationship with the child and the parents, conduct their initial sessions separately. Rapport with the parents helps them be open to your support during the difficult initial treatment stage. It also ensures that they will use the behavioral approach needed to control the child's episodes and begin to share with you family and other stressors that might play a role in the child's PNES and in their relationship with the child. The rapport you establish with the child helps the child trust you and be receptive to the behavioral treatment approach to reduce the frequency of the episodes. It is also essential for the child to agree to be in therapy.

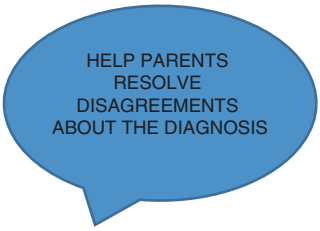
Techniques for Building Rapport with the Parents

Ask the parents to describe the episodes from their own perspective, even if you have already heard this. This will help you understand how they experience the child's illness and their level of acceptance of the PNES diagnosis. Sharing your concern and empathizing with them about



the episodes and what they are going through assures them that you are sincerely interested in what is happening to their child and to them. Your empathic and non-judgmental approach also allows them to begin to explore what stressors and negative feelings might impact their child's functioning.

If the parents disagree among themselves about the PNES diagnosis and its management, clarify the reasons for this, and help them mediate and resolve their disagreements. In doing so, you model practical "therapeutic" skills that they can use for discussing disagreements between themselves and with their children. Reassure the parents that they will find it easier to accept the PNES diagnosis as the behavioral techniques for management of the episodes begin to work and the child's episodes become more infrequent.



Assuage parental guilt by clearly stating that they are not to blame that the doctors took so long to figure out the PNES diagnosis. This is a rare disorder, and most MDs do not have the expertise to make this diagnosis. Explore the parents' cultural, religious, and social background, and use culturally sensitive language when providing psychoeducation and during the therapy sessions.

Emphasize that the parents are part of the "treatment team" and that you need them to be your co-therapists. This approach empowers them so that they can effectively help the child manage his/her episodes using your behavioral instructions. The parents should also understand that you need them as your co-therapists for the long-term therapy of the child. Schedule weekly appointments, but if necessary, work with the parents as often as twice per week until they are more comfortable managing the episodes. By providing continuous support during this difficult period, you establish your role as the primary provider for the child's treatment. This will encourage the parents to call you first rather than the neurologist and primary care physician when an episode occurs. Your frequent appointments with the parents also provide you with information about possible stressors that might have triggered ongoing episodes.

Encourage the parents to call you between therapy visits, when the episodes seem out of control, and/or when they feel angry, anxious, or overwhelmed about difficulties they experience with the behavioral treatment plan. Provide reassurance that recurrence of episodes does not represent treatment failure and is common at the beginning of treatment. Restore the parents' confidence about their ability to

help their child during an episode using your recommended behavioral techniques (described in Short-term Treatment Goal 3 below). As the parents feel less anxious about the episodes, their child will notice the change and may be more willing to model their parent's calm and confident approach.

Techniques for Building Rapport with the Child

Ask the child to describe his/her own perspective on the PNES episodes and what the child thinks about the PNES diagnosis even if you have already heard this. This will help you better recognize the child's level of understanding and acceptance of the diagnosis and demonstrate to the child that you are sincerely interested in the child's experiences and opinions. Then use the techniques, described in the child's long-term therapy section in Chaps. 5–9, to consolidate and maintain your rapport with the child.

Resistance to Treatment

Both conscious and unconscious factors play a role in the development of resistance. During the initial phase of PNES treatment, the parents and child might experience resistance to treatment, particularly if you were not involved in the diagnostic feedback and/or psychoeducation, and the feedback was not effectively provided. The parents might still have difficulty accepting the psychological basis of the child's episodes. The child might become resistant to treatment if you make her/him identify and express negative feelings before being ready to deal with the emotional pain these feelings cause. If unaddressed, resistance will lead to discontinuation of therapy. Therefore, it is important to recognize early signs of resistance and use the therapeutic strategies described below to undo it. Most importantly, be mindful of trying to prevent resistance.

Resistance in the Parents

In addition to poor diagnostic feedback and psychoeducation about PNES, several reasons might underlie parents' resistance:

- Personal factors, such as emotional or personality problems, marital or family dysfunction, and cultural beliefs, may contribute to the parents' difficulties in understanding and accepting that medical symptoms might arise from emotional/psychological problems.
- The parents might think that their child's PNES diagnosis means that they are incompetent parents.
- Overwhelming anxiety and guilt about the extent and implications of the child's psychological, educational, or social problems and dysfunction can make it difficult for parents to accept the diagnosis and type of treatment indicated.
- Relatives and family friends might offer opinions that make parents doubt the validity of the child's diagnosis.

It is most important that you recognize signs of resistance in the parents:

- They cancel appointments or say that the child does not want to see or speak with you.
- They are not comfortable that you see the child without them.
- They repeatedly call the medical team members (pediatric neurologist/epileptologist, primary care provider) rather than you when the child has episodes.
- They do not follow the treatment plan for episodes, described below in section "Short-Term Treatment Goal 3: PNES Symptom Control". More specifically, during an episode, they pay attention to and talk with the child, do not physically separate from the child, take the child to the ER, and do not discontinue the child's AEDs despite the recommendations of the pediatric neurologist/epileptologist.

Resistance in the Child

A resistant parent is the most common cause for the child to be resistant. The child's emotional and cognitive immaturity and/or difficulties might limit the child's ability to understand the abstract body-mind connection and that medical symptoms can arise from emotional problems. If you introduce this interpretation of the child's episodes too early in therapy, the child will become resistant. As described in detail in the long-term therapy section (see Chaps. 5–7, Child Long-term Treatment Goals 1–3), you gradually help the child tune into, recognize, and verbalize negative emotion, stressors and difficulties and only connect them with physical manifestations (see Chap. 8, Child Long-term Treatment Goal 4) when the child is emotionally able to comprehend and accept this connection. Although you begin to work on these goals from the beginning of therapy, keep in mind that this takes time. Therapy that progresses too quickly might induce the child's fears about revealing family conflict and/or traumatic experiences before he/she is ready to do so.

In addition, continued secondary gain due to parental attention and privileges and no demands for chores, absence from school, as well as withdrawal from sports and extracurricular activities reinforce the child's episodes. Recurrent episodes then make the child (and parents) feel that the therapy is not working.

As for the parents, early recognition of signs suggestive of the child's resistance is essential. These include refusal to come to appointments because they "do not fit in with our schedule," increase in the number and severity of episodes on therapy days, use of the term "seizures," and the appearance of new physical symptoms.

Techniques to Prevent Resistance

From the beginning of your relationship with the parents and the child be sensitive to any possible signs of disagreement with and resistance to the treatment plan and your suggestions. Develop a good understanding of the underlying anxiety, apprehension, feelings of guilt, as well as personal and cultural obstacles that the child and/or parents might have before engaging in interpretations about behavior and emotions. Rethink what in your prior session(s) with the child and/or parents might have obstructed the therapeutic progress. Reevaluate your own countertransference and its effect on the child and parents.

If you moved too quickly in the child's therapy, reestablish rapport and address this with the child. Model how to talk about miscommunications or misinterpretations you

might have made because you did not understand what the child was trying to tell you. For example:

- I have been thinking about what you said and I might not have understood what you were trying to say about ….
- I didn't realize that you were trying to tell me something very important.
- Since we last met, I was thinking about it and recognized that I need your help to better understand how you were feeling.
- I need your help so together we can better figure out how to take care of this problem.

Use similar techniques with the parents in order to reestablish and/or improve your therapeutic relationship with them. You can best achieve this during separate sessions with the parents.

Short-Term Treatment Goal 2 Summary: Development of Rapport

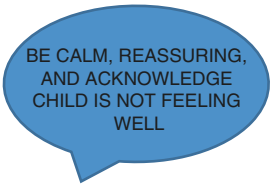
- **Establish rapport early on** in the therapeutic process:
  - Parents will be open to sharing information with you and following the treatment plan
  - The child will trust you, agree to the treatment plan, and begin to identify stressors and difficulties
- **Techniques to establish rapport:**
  - Listen to the parents' concerns, be culturally sensitive, develop an understanding of their stressors, express empathy, assuage their guilt, and provide them with support
  - Hear the child's perspective, fears, and concerns, empathize, and provide hope that he/she will get better
  - **Parents might experience resistance to treatment** due to ineffective diagnostic feedback or psychoeducation, lack of rapport, personal/cultural factors, parental guilt, overwhelming anxiety, and conflicting information from family and friends. **Address** this by checking for:
    - Cancellation of appointments
    - Opposition to you seeing child and parents separately
    - Reaching out to neurologist/epileptologist or primary care provider when episodes occur
    - Not following treatment recommendations for handling episodes
  - **The child experiences resistance** if parents are resistant**,** therapist makes premature interpretations during the child's therapy, and the secondary gain continues. **Address** this by checking for:
    - Appointments don't fit "our" schedule
    - Increase in episodes on the day of therapy
    - Use of term seizures to describe episodes
    - Development of new physical symptoms
- **Attend to signs of resistance and address them as soon as possible,** develop an understanding of treatment obstacles, reevaluate your countertransference, and work to reestablish rapport

Short-Term Treatment Goal 3: PNES Symptom Control

PNES symptom control is essential, promotes the child's return to a regular life schedule, and relieves the family's anxiety about the disorder. It can be achieved only if the child and parents understand the psychological basis of the disorder and the need for behavioral management of the episodes. PNES symptom reduction and complete resolution may take approximately 1–6 months, depending on the individual child, comorbid psychopathology, underlying and ongoing stressors, and family functioning.

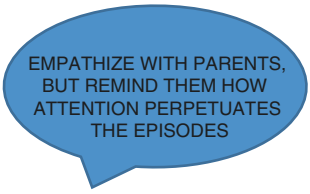
Behavioral Management of PNES: The Parents' Role

As previously described in Chaps. 2–3, at the onset of PNES, parents are often unaware that the episodes are due to emotional difficulties. If they minimize the attention given to the symptoms, the parents reduce the potential for the secondary gain that perpetuates the episodes. The following strategies help parents manage the episodes both for their child and themselves.



Instruct the parents on the importance of being calm and reassuring the child during an episode. A reminder that the episodes do not harm the child's brain helps them feel less anxious. Ask the parents to tell the child that they understand that the child is not feeling well. For example, "I see you are not feeling so good right now."

During the event, remind the parents to avoid touching and talking to the child. If possible, they should leave the room after informing the child that they are following your instructions. "As recommended by Dr. …, we will be in the next room. When you are feeling better, come and let us know." If the child requests that they remain in the room, the parents should remind the child that "I'm doing what the doctor told me to do." However, if the child gets upset, the parents can remain in the room but should not interact with the child.



Remind the parents that you understand how difficult it is for them to withdraw from the child during an episode. Emphasize that not paying attention to the child during an episode is an important step in stopping the episodes. The more attention the child gets, the longer the episodes will last and the more frequently they will occur.

If an episode occurs in a nonpublic setting with other people present, the parents should ask everyone to leave the room until the end of the episode. The parents should provide clear instructions to other caregivers and family members on how to manage the episodes in the parents' absence. If an episode takes place in a public setting, the parents should ask the people around to stay calm and reassure them that the episode will subside if they back away. The parents should sit by the child without interacting with her/him until after the episode.

Parent training techniques: In the initial phase of therapy and continuing throughout, it is necessary to help the parents develop an understanding of their own emotional and behavioral responses to their child's physical symptoms and behavior during the episodes. These emotions, in particular if they involve significant distress, must be understood in order to help the parents develop responses that will be most appropriate for the management of the child's symptoms.

So, inquire as to which strategies the parents have tried, what has worked, and what has not. When an episode occurs, the parents should acknowledge it as described above and then refocus or distract themselves from these symptoms. If parents feel anxious during the child's episodes, suggest that they use relaxation exercises including deep breathing, muscle relaxation, and visual imagery (see Appendix C). For parents who feel the need to log each episode, help them understand that a PNES Event Calendar will validate the importance of the child's seizure-like and physical symptoms and will reinforce them.

Most importantly, support the parents when setbacks occur (see Dialogue, How to Recognize Child's Stressors in Chap. 12: Parent Long-term Goal 3). Encourage open dialogue with you if the parents continue to express concerns about the validity of the PNES diagnosis and the effectiveness of the therapy. Empathize with them about their concerns, and indicate that you understand how difficult it is for them to see the child yet again have episodes. Revisit the need for additional psychoeducation about the course of PNES and its triggers.

Behavioral Management of PNES: The Child

The child should understand that symptom control can only be accomplished with the child's cooperation. However, successful resolution of the episodes is dependent on your therapeutic relationship with the child and attaining the long-term therapy goals (Table 4.2 below) in your work with the child and with the parents as described in Chaps. 5–9 and Chaps. 10–14, respectively.

The most difficult aspect of the behavioral treatment of NES symptoms for the child is to be left alone with little or no attention from the parents or others during an episode. To ensure that the child does not feel rejected by the parents, explain to the child that you have instructed the parents and caregivers to leave the child alone until the episode ends. Do not provide the same explanation to the child that you

Table 4.2 Long-term treatment goals

Child therapy	Work with parents
Recognize, monitor, and express negative emotions	Revisit how parents manage stress during child's NES episodes
Identify stressors	Understand and facilitate family communication
Verbalize emotions associated with stressors	Recognize the child's stressors
Connect negative emotions with NES symptoms	Identify family stressors
Problem-solve adaptively	Help the child problem-solve

have given to the parents regarding the role of limited attention during the episodes. Show the child how to use simple relaxation techniques, including deep breathing (see Appendix D), muscle relaxation, and visual imagery. When the child is ready to return to school, inform the child that the teachers will use the same approach as the parents during an episode.

Let the child know that you understand how difficult the proposed behavioral plan sounds at the beginning. But assure the child that it will become easier over time as the episodes subside. Remind the child that the relaxation techniques will help his/her body to learn how to stop and, in the future, prevent the episodes.

At the next session, ask the child to describe to you what she/he was experiencing physically and emotionally just prior to the episode and what some of the physical and/or emotional triggers were (see Appendix E). Since children often forget what they felt, encourage the child to write, text, or e-mail you this information.

Short-Term Treatment Goal 3 Summary: PNES Symptom Control

- **A behavioral approach** in which parents pay **no attention** to the child during an episode:
  - Reduces the **secondary gain** that prolongs recurrence of episodes
  - Promotes return to a **regular life schedule**
  - Relieves the **family's anxiety**
- Help parents deal with the **emotions** they experience during an episode
- Tell child that parents and teachers are following **your instructions** during an episode
- **Reassure the** child and encourage use of **relaxation strategies**
- Therapist with parent and child consent will explain the behavioral management plan and need for a consistent approach to the **school**
- **Resolution** may take **1–6 months** based on the individual child, comorbid psychopathology, stressors, and family functioning

Short-Term Treatment Goal 4: Reestablishment of Regular Life Routines

As previously mentioned, after the PNES diagnosis is confirmed, it is important to guide and support the family in their transition back to a regular life schedule as soon as possible. The longer it takes, the more secondary gain is involved, and the more difficult it is for the child to "catch up" with school work, social relationships, and extracurricular activities, as well as to relinquish the "sick role." Ultimately, successful resumption of regular activities provides the child and family with a sense of control and "normality."

Returning to school is an essential part of the child's reintegration to normal life routines. For this to be successful, you need to understand the child's difficulties that might hinder the reintegration and provide accommodations needed for learning (including a plan to catch up on missed work), social, or athletic problems. In fact, the challenges during the transition to school make this goal the most difficult to accomplish due to fear that the child will have an episode at school.

The reactions of the child's fellow students and school staff to episodes in the past and that occur once the child returns to school are additional obstacles. The school staff is often quite resistant to modifying established school protocols to deal with the child's episodes. This is further complicated if the child also has learning problems. Nevertheless, the child needs to resume regular school and after-school activities as soon as possible after PNES is diagnosed.

Therefore, the transition should be gradual based on the child's progress in treatment; the type and severity of the child's academic problems, social difficulties, and underlying psychopathology; as well as how well the family has accepted and adjusted to the child's condition. Ideally, the child should return to school on a part-time basis several days after discharge from the hospital. However, if the child has been out of school for an extended period and has undiagnosed learning difficulties that need to be assessed, the transition may take much longer. The transition is easier if the child knows that the school will provide the resources needed to help the child catch up with missed work and/or to address the child's learning deficits.

This goal can be more easily accomplished if you and the entire treatment team of teachers, school nurse, school administrators, primary care physician, and neurologist/epileptologist all work together. Most importantly, during the reintegration to school, you should be available to support the child and the parents through frequent sessions. Your availability for the school team is essential and involves consulting them on the phone, e-mail, or through meetings to prevent PNES symptom exacerbation due to the child's emotional and behavioral regression.

Recommendations for the Parents

Advise the parents to return to their previous work schedules and daily family routines as soon as some control of the episodes is achieved, and the child can return to school. The child might experience more physical complaints, particularly in the morning before school or when faced with daily responsibilities, such as homework that taps into the child's learning problems. The parents should not give the child special privileges or accept his/her reasons for avoiding resumption of regular activities, responsibilities, and chores. They should use the same parenting and discipline strategies for all the children in the family.

Instruct the parents to contact the school and request a 504 plan or an Individualized Education Plan (IEP) to determine what school accommodations will be necessary. If indicated, they should request educational testing through the IEP to evaluate the child's cognitive functioning, to rule out learning difficulties, and to identify the necessary accommodations. If the school resists developing a formal IEP, the parents should request a transitional Health Management Plan.

It is important that the child's neurologist and primary care provider write letters (see Appendix B) to the school supporting implementation of the Health Management Plan that the treatment team and parents develop. The parents will present the school staff with a Behavioral PNES Management Plan (see section below) that you develop with the parents. It should include written instructions on how to manage the child's episodes at school and in the classroom (see Appendix F).

Homebound schooling is indicated only if the child continues to have frequent episodes; the transition was started, but not successfully implemented; the school refuses to accept the child "until the episodes stop;" and/or the school is unable to follow the Behavioral PNES Management Plan in the classroom. Children with chronic poor control of their episodes may require transfer to an inpatient psychiatric unit or to a therapeutic school until resolution of the episodes is achieved (see section "Short-Term Treatment Settings" below).

Recommendations for the Child

If the child's learning difficulties have contributed to the school avoidance, help the child understand that having learning problems does not mean that the child is "dumb." This helps alleviate some of the anxiety the child has about going back to school. Also, provide examples from what you know about the child to support this statement. Explain to the child that educational testing will help identify the learning deficits, and provide the school with the information needed to determine how best to help the child deal with these difficulties. In most cases, however, the need to catch up on missed work is a significant stressor and deterrent to returning to school. Inform the child that you and the rest of the team are in touch with the school staff and have a plan to help the child catch up with the work.

If the problem underlying school avoidance is social, you should focus the therapy on trying to understand what the child sees as the main social problem and how

the child initiates and responds to interactions with peers. It is difficult for children to talk about their social difficulties, so it might take a while to determine the extent of the problem. Therefore, it is important to be patient and not pressure the child to reveal information he/she is not yet ready to reveal to prevent an increase in episodes and no shows for therapy due to resistance. For children in elementary school, you might benefit from the teacher's observations of the child's social behavior.

Even though the child is now having fewer episodes, let the child know the plan that you and the parents have implemented if the child has an episode at school. Encourage the child to be sure to use relaxation, deep breathing, and other techniques you teach the child to help abort an episode if it occurs at school.

Also, discuss with the child how to respond to remarks made by fellow students in the event that the child has an episode at school. First find out how the child would like to respond to comments, such as those described below. Compliment the child if he/she comes up with responses, and help improve on them through role-play. If the child does not come up with any responses, talk about how scary it is to have to answer the kids when they say mean stuff. Invite the child to join you in role-play in which you model possible responses. For example:

Peer: What's wrong with you?
Child: The doctors at … Hospital are helping me with my episodes, but it will take a while for this to stop.
Peer: Are you faking this to get out of doing the work?
Child: When I have one of these in class, it means that I have to make up the work I miss. Why would I want to fake one and make myself have more work?
Peer: You just want everyone's attention!
Child: Actually, right now, you are really doing everything to get everyone's attention!
Peer: Yuck, seizure brain, disgusting!
Child: You're right; it is scary to watch.

Let the child know that you will see the child frequently during the transition. Also, mention that it would be helpful if the child writes a reminder on paper, a cell phone, or e-mail about what happens at school that makes the child feel good or bad. You can then both go over this at the next session. This information will help you understand the child more and be in a better position to help the child feel comfortable back at school. Also, remind the child that if the child feels the need to speak with you about school or other things even though it is between appointments, you can be easily contacted.

Recommendations for the School Staff

After you and the parents come up with a mutual agreement on the child's plan for return to school, give it to the school staff together with information about the child's psychiatric, cognitive, and social difficulties. This will help the school staff

Table 4.3 Transitional plan for school return

Instruction	Details
Week 1	Attend school for 1 h/day
Weeks 2 + 3	If successful and no evidence for increased anxiety and episodes,[a] increase by 1–2 h/day each week
Week 4	Attend school full time only with appropriate 504 or IEP plan educational accommodations
Ensure a relaxation period	10–15 min per day
Designate an aid or point person	To help when child is distressed and/or has an episode
Appoint a buddy support system	To normalize experience and decrease child's distress at recess and between classes
Apply the behavioral approach to episodes[a] Class staff move child to a quiet, designated area, ideally, to the back of the classroom Monitor the child until the end of the episode Teacher instructs the class to resume activities School staff representative calls parents to inform them about the episode	Treating clinician provides school with written PNES behavioral management protocol Remind child that school staff uses same approach as at home Avoid using wheelchairs and helmets and calling 911

[a]*Episode* episode of seizure-like events

better understand and determine how to best help the child deal with his/her difficulties at school. It will also facilitate their willingness to cooperate with the parents and the treatment team on the proposed transition to school plan. School staff members are often resistant to modifying established school protocols in order to deal with the child's PNES episodes. Table 4.3 presents an example of a transitional plan for the child's return to school.

Recommendations for Pediatric Epileptologist/Neurologist, Primary Care Provider, and Psychiatrist

Provide the medical professionals with regular updates on the treatment progress. This is particularly important if:

(a) The child or parents are resistant to accepting the psychological nature of PNES and seek out additional medical evaluations and treatments.
(b) The parents have difficulty following the instructions for behavioral management of the episodes.

(c) The child develops other unexplained medical or neurological symptoms that prompt the parents to "doctor shop."
(d) The school resists collaborating with the treatment team's proposed management plan for episodes that occur at school and for the child's transition back to school plan.

Short-Term Treatment Goal 4 Summary: Reestablishment of Regular Life Routines

- **Child**
  - **Resumes regular school and after-school activities as soon as possible** once symptom resolution begins:
    The longer the transition to a regular life schedule
    The greater the **secondary gain + difficulty** to "catch up" and relinquish "sick role"
  - Therapy should address the **specific reasons for school avoidance**
  - Help the child with a **plan for catching up** with missed schoolwork
  - Inform child about the **management of an episode at school**
  - Ask the child to note possible **triggers** at school
  - **Physical complaints** might occur, particularly before school, before/during homework, or when faced with daily responsibilities
  - **Recurrence of frequent episodes may require transfer** to an inpatient psychiatric unit or to a therapeutic school until episodes resolve
- **Parents**
  - Resume their **previous work schedules and daily family routines**
  - **Do not** accept child's reasons for avoiding resumption of regular activities and responsibilities
  - Request a **504 plan, an Individualized Education Plan (IEP), or a transitional Health Management Plan** if the school will not develop an IEP
  - **Ask** the medical providers to write letters of support
  - Present the school staff with the **Behavioral PNES Management Plan** you develop with the parents
  - **Homebound schooling is indicated if:**
    The child continues to have frequent episodes
    The transition was not successfully implemented
    The school refuses to accept the child until the episodes stop
    The school does not follow the Behavioral PNES Management Plan
- **A transitional plan** for a gradual return to school is essential (Table 4.3)
- **The entire treatment team** should work together
- During school reintegration, **be available** to support the child, parents, and school staff

Short-Term Treatment Goal 5: Comorbid Psychopathology

Treat the comorbid psychopathology concurrently with the conversion disorder as needed during the initial and long-term phases of treatment. Together with the child's psychiatrist, you should develop a comprehensive treatment plan using the standard psychopharmacological and therapeutic interventions indicated for the child's additional psychiatric diagnoses. See Chap. 15 for cognitive behavioral therapy (CBT) of anxiety disorders and depression in youth with PNES. It is important to clearly communicate to the parents that treatment of the child's comorbid psychiatric diagnoses, other than conversion disorder, in the initial treatment phase does not stop the episodes. Therefore, they should follow the instructions on how to manage the episodes, as described under Short-Term Treatment Goal 4.

If the child needs psychopharmacological intervention and you, the therapist, are not a psychiatrist, the child should see a psychiatrist. To assure successful collaboration, the mental health clinicians in the team need to clarify each of their roles and communicate about the child's response to treatment.

Short-Term Treatment Settings

Outpatient Mental Health Clinic

Most children with PNES with and without comorbid psychopathology will receive psychiatric treatment in this setting.

Inpatient Psychiatric Treatment

Care in this setting may be indicated under the following conditions:

- The child has uncontrolled PNES episodes at school and at home.
- The child has had PNES episodes for a year or longer and/or school absence of 3 or more months together with:
  - Severe post-traumatic stress disorder (PTSD), mood disorder, or psychosis
  - Suicidal thoughts, plans, or attempts
- A new report of child abuse that requires a Department of Children and Family Services (DCFS) or Department of Child Services (DCS) investigation and removal from the home.
- The parents do not implement the behavior management program for the episodes.
- The home environment is unsupportive and/or hostile.

Partial Psychiatric Hospitalization

Partial psychiatric hospital program is indicated under the following conditions: reintegration to school is unsuccessful; the child does not respond adequately to the outpatient treatment for his/her comorbid psychopathology; the parents poorly manage the child's episodes; the child's episodes have continued for a year or longer; and the child has missed school for 3 or more months. Intensive outpatient day treatment programs are beneficial for PNES patients whose chronic comorbid psychopathology interferes with PNES treatment, such as school avoidance, mood disorders, PTSD, substance abuse, non-suicidal self-injurious behaviors, and eating disorders. These programs provide intensive group and individual therapy using a broad variety of treatment approaches, including CBT (see Chap. 15), motivational, dialectical behavior therapy, and mindfulness-based programs.

Medical Rehabilitation

Medical/rehabilitation treatments, such as physical therapy for comorbid gait abnormalities, abnormal movements, or muscle weakness, can be included in the initial phases of treatment in parallel with psychotherapy and other interventions. Admission to a medical rehabilitation facility helps the child and parents learn more about the stress-mind-body associations in medical illness. They also become more amenable to the behavioral intervention techniques indicated for the child's episodes and the need for long-term therapy. This approach should be considered for cases in which the child and the parents continue to have difficulty accepting that PNES is a psychological disorder and/or if the child experiences multiple neurological and medical symptoms in addition to the episodes.

Treatment Setting Summary

Outpatient treatment is indicated for most children with PNES with/without comorbid psychopathology

Inpatient psychiatric treatment should be considered when:

- The child has uncontrolled PNES episodes
- The child has a chronic PNES course with episodes for a year or longer and/or school absence of 3 or more months, along with severe PTSD, mood disorder, psychosis, suicidal thoughts, plans or attempts, or a newly revealed history of abuse
- The parents do not cooperate with the behavior management program for the episodes

Partial psychiatric hospital program is indicated when:

- Reintegration to school is unsuccessful
- There is a lack of response to outpatient psychiatric treatment
- Parents exhibit poor management of the child's episodes
- The child requires specialized individual or group treatment programs for chronic comorbid psychopathology that interferes with the treatment of PNES

Medical/rehabilitation facility treatments should be considered when:

- The child and the parents still have difficulty accepting that PNES is a psychological disorder
- The child may have multiple neurological and medical symptoms in addition to the episodes

Reference

1. Plioplys S, Doss J, Siddarth P, et al. A multisite controlled study of risk factors in pediatric psychogenic nonepileptic seizures. Epilepsia 2014;55:1739–1747.

Long-Term Treatment

5

Table 5.1 presents the five long-term treatment goals. Similar to peeling back the layers of an onion, all the problems and difficulties these children have usually might not be apparent in the early stages of treatment. Therefore, pacing during each phase of treatment is most important and cannot be overstated. Moving too quickly or working on a goal before the child is ready can result in termination of treatment.

During the long-term treatment phase, it is essential that you continue to work with the child's parents separately. Ideally see them on different days so that the child is not in the waiting room thinking about what you and the parents are saying about the child. Maintain your rapport with the parents, continue to engage them as your co-therapists, and be sensitive to early signs of resistance. The long-term parent goals (Table 5.1) help the parents understand and facilitate family communication, become sensitive to the different ways their child expresses difficulties and stressors, identify family stressors, and support the child's problem-solving efforts. It is important that you schedule family sessions with the child only when the child is able to acknowledge and verbalize the need to meet with the parents to address issues that arise during the child's therapy. Figure 5.1 presents useful road map suggestions for your long-term work with PNES children and their parents.

Table 5.1 Long-term child and parent treatment goals

Child goals	Parent goals
Recognize, monitor, and verbalize emotions	Revisit how parents manage stress during NES episodes
Identify stressors	Understand and facilitate family communication
Verbalize emotions associated with stressors	Recognize the child's stressors
Connect negative emotions with NES symptoms	Identify family stressors
Problem-solve adaptively	Help child problem-solve

R. Caplan et al., *Pediatric Psychogenic Non-Epileptic Seizures*,
DOI 10.1007/978-3-319-55122-7_5

Fig. 5.1 Road map tips for treating PNES children and their parents

Child Long-Term Treatment Goal 1: Recognize, Monitor, and Verbalize Emotions

Children with PNES often are not in touch with the emotions associated with their experiences and thoughts particularly if these are negative and involve anger, hurt feelings, sadness, fear, and tension. This difficulty can stem from a variety of reasons including trouble connecting with and/or verbalizing emotions (alexithymia), a subtle language disorder, and fear of a negative angry response by others. Addressing this goal is essential from the beginning of the therapy because the episodes represent maladaptive physical expressions of these negative emotions. Helping the child recognize, verbalize, and monitor emotions using the techniques below should be part of the treatment plan for each session.

Probe for and Acknowledge Child's Expression of Emotions

Throughout treatment, when the child shares information or describes a situation, ask: "And how did that make you feel?" This simple technique draws the child's attention to the fact that most situations involve some emotion(s). It also encourages the child to first reflect, "Do I feel something?," and then to verbalize the emotion. You should both empathize with the child about the emotion the child expresses and provide positive feedback every time the child talks about an emotion or emotional experience.

- Wow.
- When that happened, did you feel sad, mad, scared, or…?
- And that made you feel…?
- You are doing such a good job talking about….

Identify and Monitor Emotions

Help the child tune in and track positive and negative feelings that arise during the child's daily activities. In doing so, be attuned to the child's subtle expressions of emotion. The techniques in Table 5.2 guide you on how to encourage the child to talk about feelings.

Table 5.2 Techniques that encourage talking about feelings

Technique	Response
Let's talk about feelings[a]	
"Some kids know what they are feeling but sometimes it gets all jumbled. Let's talk about some of the feelings you know that you have and how you can tell you are feeling that way."	"Nothing," "I don't know," or a shoulder shrug are highly likely in the early treatment stages. Although less likely, they occur even in the later stages. The extent of the verbal response also varies by age. An older child may come up with a paragraph whereas a younger child may give only a one-word answer
Identify emotions in others[b]	
Practice by using pictures and/or scenarios you make up that might be of relevance to the child. Then gradually encourage the child to talk about the emotions of people close to the child. • What does mom (dad, brother, or sister) do when angry? Always follow up with: • How does that make you feel? And/or • What do you do when that happens?	Most children find this easy to do Eliciting actions in those close to the child help the child describe situations that might induce the child's negative feelings Early in treatment, child might avoid responding These follow-up questions help provide some insight on how the child feels

(continued)

Table 5.2 (continued)

Technique	Response
Use technology to normalize feelings	Some children/teens respond well to technical information
• Show the child a brain scan that demonstrates involvement of different brain parts when people experience positive and negative emotions • Use cell phones and/or social media to see what emotions peers express, what they might mean, and how to filter this information	This helps normalize that everyone experiences emotions that are controlled by the brain even if they are negative
Direct probes of the child's feelings	
Journal Suggest that the child use a cell phone or pocket notebook to remind the child about experiences that did not feel good	Teens are more responsive than younger children
Checklist Provide the child with a problem and stressor checklist, ask the child to create a problem list or, if necessary, do it with the child	Helpful for all ages
Severity ranking Encourage the child to rank the child's emotions from the most bothersome to the least	Helpful for all ages
Indirect probes of the child's feelings	
Ask the child to write (dictate in the case of learning problems) a letter to the doctor about what does not feel good	Good for all ages
Let the child draw, use clay, paint, or other art forms while talking. This might calm and help the child verbalize ongoing thoughts and feelings	Helpful for younger children
Create a play with the child in which the different actors experience physical feelings, difficult or stressful situations, or emotions	Positive response in younger children

To apply [a] and [b], see feelings checklist in Appendix G

Attend to the Child's Nonverbal and Verbal Cues of Discomfort

Children with PNES become overwhelmed easily when exploring experiences that evoke negative emotions. Early in treatment, this might trigger an episode. As treatment continues, the child becomes better at controlling the episodes. It is important to pay attention to the nonverbal (more frequent) and verbal cues that suggest the child is uncomfortable or struggling when asked to describe feelings. These cues should guide you on whether you should or should not continue the ongoing topic of conversation. Nonverbal cues include:

- Withdrawal of eye contact.
- Change in the volume, prosody, and/or speed of speech.
- Inattentiveness.

- Fidgeting and finger tapping.
- Blink rate change.
- No show for appointment.

Also, pay attention to common verbal cues including abrupt digression from the topic of conversation, slow or no response to a question you ask, as well as child questions, such as "When are we done?" and "How many more questions?"

When these nonverbal and verbal "shutdown" cues occur, acknowledge the child's distress. If you thank the child for letting you know how he/she feels, this shows that you pay attention to everything about the child, pick up when something bothers the child, and have respect for the child. Even if you understand the therapeutic importance of the feelings involved, do not push your treatment agenda unless the child is emotionally ready for it. Acknowledge if you prematurely pressured the child to talk about something the child does not want to talk about or you overwhelmed the child with an interpretation of the child's symptoms/behavior. Let the child know that you would like to figure out how to make it easier for the child. Make maintaining rapport with the child your main priority!

Model Expression of Negative Emotions

From early on in the therapy, model how to verbalize emotions by providing examples of how you feel in commonly occurring nonpersonal situations that induce negative emotions. This normalizes for the child the fact that adults, including you, the therapist, experience negative emotions.

Connect Emotions with Body Awareness

Making the child aware of and tracking the association between emotions and bodily manifestations is an important part of the therapy (see drawing of stress and our bodies in Appendix H). It helps the child understand that the child's negative emotions and/or stressors can induce the child's episodes. However, do not make this connection before the child is emotionally able to actually experience it (see Chap. 8) as it will induce resistance.

Explore the link between bodily sensations and emotions by describing common experiences that make people sad, mad, happy, and excited and how these feelings might be accompanied by physical sensations. For example, find out what the child feels when the child has to give a speech in class (nervous, scared, and/or shy) and then ask how the child's body feels (sweaty palms and/or heart racing).

Share how you and children you have worked with feel (mind, body) in situations that induce negative feelings. This normalizes that, when we experience negative emotions, our bodies sometimes respond, particularly when we do not or are unable to express our negative feelings. Then try to find out similar experiences the child has had and if they are associated with any physical sensations. This will help you better understand what emotions are hard for the child to express.

For younger children, it can be helpful to have visuals of the body so the child can point to them. Alternatively, ask the child to draw how the child's body feels when experiencing different emotions. On a full body or a face drawing, ask the child to use different colors to identify different emotions and how or where a person's body experiences them (see body and face drawings in Appendices I and J, respectively).

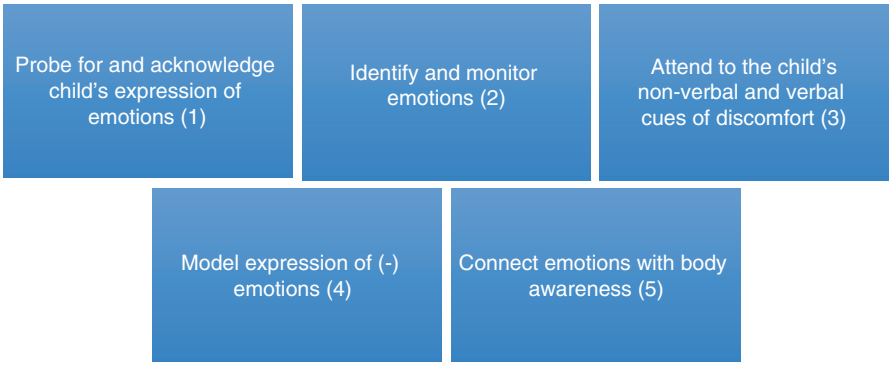
Consider discussing what the body feels like when emotions cannot come out. But do this only once the child is able to recognize and talk about his/her own negative feelings in commonly occurring situations. Discuss the importance of expressing how one feels, even if it is unpleasant, because otherwise bad feelings do not go away. To help the child understand, describe what happens to a stuffed plastic bag or to a balloon with too much air.

Explain how the body feels when one cannot get an emotion out and the ways in which the body speaks up. For example, when stressed some people get headaches, stomachaches, or backaches. But emphasize that we all need to express our negative feeling(s) in an emotionally accepted way. Then we and the person who is upsetting us can tolerate the expression of this emotion.

Dialogue: How to Probe for and Help Child Express Negative Emotions

This demonstrates how to encourage the child to recognize, monitor, and verbalize emotions. The comments in the yellow bubbles address the therapist's use of the previously described techniques which are summarized and numbered from (1) to (5) in the checklist below. The blue bubbles provide remarks on the child's response to the therapist's techniques.

Checklist of Goal 1 Therapy Techniques



Child: My mom dropped me off at school all last week because Kristen (best friend) and I got into a fight on the bus. I just didn't want to talk to her, and I think she's still mad at me.

Therapist: So you and Kristen had a pretty big fight, and she made you mad.

Child nods.

ACKNOWLEDGES – FEELINGS (1)

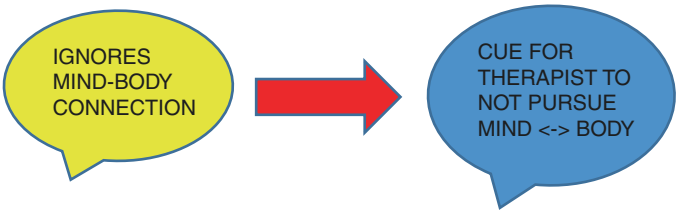
Therapist: What happened?

Child: She was just being really rude, and she always has an attitude and thinks she knows everything. And now I think she told our other friends about it and they are mad too. Well and I haven't talked to any of them either, but I also didn't go to school yesterday because I felt a little shaky.

Therapist: So you think that Kristen also told your other friends about the fight? And you felt mad and a little shaky.

Child: Well I don't know for sure, but I think she did because she's really rude like that.

PREMATURE MIND <-> BODY (5)



Therapist: What was your fight with Kristen about?

Child: She was just being rude.

IDENTIFIES – FEELINGS (2), AVOIDS TO PROBLEM SOLVE

Therapist: How did you feel about her being rude?

Child: Mad. I don't think I'm going to talk to her anymore.

PROBES – FEELINGS (1)

QUIETLY = DISCOMFORT CUE (3)

Therapist: What did she say that hurt your feelings?

Child: Well, yea… (quietly). She told me that my thighs looked fat in my skirt. And I don't think you should say something like that to your best friend.

TRIES TO UNDERSTAND – FEELINGS (2)

IDENTIFIES SADNESS (2)

Therapist: What she said sounds very hurtful. And that could for sure make someone feel mad. Do you think that there were any other unpleasant feelings then or that you feel now when you talk about it?

Child: Sad too I guess.

EXPRESSES (1), NORMALIZES (4) – FEELINGS, PROBES FOR MORE – FEELINGS

EXPRESSES REASON AND – FEELINGS

Therapist: What makes you feel sad?

Child: She's supposed to be my best friend, and that is just a really mean thing to say. I would never say that to her.

TRIES TO UNDERSTAND – FEELINGS (2)

Therapist: So you've had a rough week, not only did your best friend say all that stuff that was hurtful and made you mad and sad, but you also felt shaky?

CHANGES TOPIC = DISCOMFORT

Child: Yeah, I just woke up yesterday morning, and I felt shaky and thought that maybe I might have an episode. So, I did some of the things we talked about and felt better, but by the time I felt better, I couldn't go to school.

EMPATHIZES (1), NORMALIZES–FEELINGS (4), BUT REPEATS LINK BAD WEEK–SHAKINESS

Therapist: So it didn't last all day? Just a little shaky when you woke up?

Child: No, actually, just a little bit and then I felt better, but I still stayed home.

Therapist: Oh, you'd already missed the time to go to school, so decided to stay home?

Child: Well, my mom couldn't bring me to school, and I would have taken the bus, but I had missed the bus, and I didn't want to go on the bus anyway because of Kristen….

Therapist: Sounds like you were able to control the shaky feeling through using the techniques we talked about? That's great. Remember before when we were trying to get your episodes under control, we talked about how sometimes things in our lives stress us out, and we might not even really know it? And we also talked about that our bodies can react in different ways when we are stressed. Now that you feel better today, do you think that the shaky feeling had anything to do with what's been happening?

Child: I did think of that yesterday. I thought maybe all of the things that Kristen has been doing has been really stressful and maybe that's why I felt shaky. But when I first started to feel shaky I didn't think about that….

Therapist: You are really doing a great job at trying to figure this all out. It is not easy.

Child: Thanks.

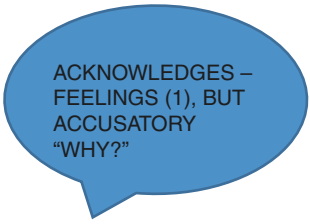
Comment: In this dialogue, the therapist helped the child recognize and express her negative feelings by gently probing for these feelings. The therapist expressed empathy for the girl's hurt feelings, normalized them, and gave the girl positive feedback for talking about this difficult topic. The therapist captiously and gently helped the child make the connection between her negative feelings and being shaky. Now read the following dialogue and notice approaches that can prevent a child with PNES from verbalizing emotions. The comments in the blue bubbles address the therapist's use of the previously described techniques which are summarized and numbered from (1) to (5) in the checklist above. The blue bubbles also provide remarks on the child's responses (yellow bubbles) to the therapist's techniques.

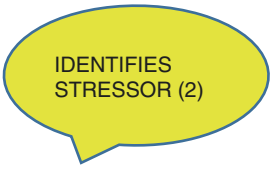
Dialogue: How to Not Probe for and Help Child Express Negative Emotions

Child: …My mom dropped me off at school all last week because Kristen (best friend) and I got into a fight on the bus. I just didn't want to talk to her, and I think she's still mad at me.

Therapist: Oh so you were in a fight and Kristen got mad at you? Why don't you want to talk to her?

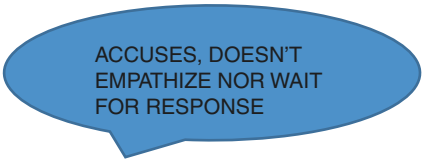
Child: I don't know.





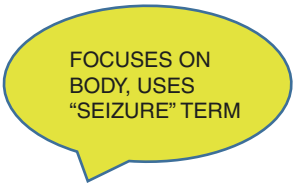
Therapist: So when you get mad, you don't talk to people? What was the fight about?

Child: She was just being really rude, and she always has an attitude and thinks she knows everything. And now I think she told our other friends about it, and they are mad too. Well and I haven't talked to any of them either, but I also didn't go to school yesterday because I felt a little shaky.



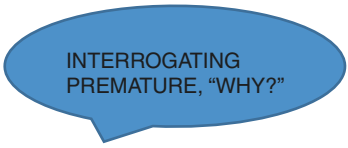
Therapist: So, you didn't talk with Kristen and you didn't go to school because she and your other friends are mad at you?

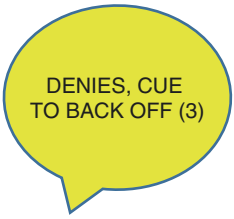
Child: I didn't go to school because my legs were shaky.



Therapist: Why do you think your legs started to shake?

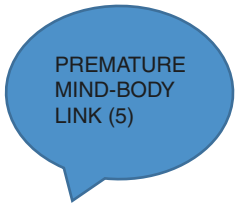
Child: I started to have a seizure.





Therapist: But I am hearing that you were pretty mad and then you felt shaky.

Child: Well I am not sure that I was shaky, and maybe they are not mad at me.

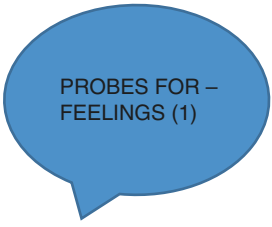


Therapist: I am confused. You said you were shaky and that you were mad, Kirsten was mad, and then that your other friends were mad?

Child: It really was no big deal.

Therapist: But you didn't go to school for 1 day and then had your mom drop you off every day. So, something was bothering you.

Child: Yes, but now I am fine. I was scared I might have another seizure.



NON-VERBAL DISCOMFORT CUE

Therapist: So, you stayed home because you were scared of having an episode at school. But didn't the fight have something to do with it?

Child: Not really… (quietly). She told me that my thighs looked fat in my skirt. And I don't think you should say something like that to your best friend.

LINKS MIND-BODY (5) DOESN'T TUNE INTO FEELINGS (2)

"SEIZURE" + DEFENSIVE RESPONSE = RESISTANCE TO MIND-BODY LINK (3)

Therapist: Can you speak up? It is hard for me to hear. Is that comment about you looking fat what made you start having a fight with her?

Child: She's supposed to be my best friend.

IGNORES SOFT VOICE CUE, ACKNOWLEDGES – FEELING (2) WITH NON-EMPATHIC TONE

RELUCTANTLY CONFIRMS – FEELINGS (2)

Therapist: So, what she said hurt your feelings?

Child: I guess.

CLARIFIES – FEELINGS (2)

"SEIZURE" + DEFENSIVE RESPONSE = RESISTANCE TO MIND-BODY LINK (3)

Therapist: That makes sense. So, tell me about the episode you had when you were mad.

Child: It was almost like a beginning seizure, and I already told you I wasn't really mad.

EXPRESSES LOGIC NOT EMPATHY, PREMATURELY LINKS MIND-BODY (5)

Therapist: Oh, I thought maybe that was your body telling you how mad you are or that your feelings were hurt.

Child: (Legs start shaking) Well, it was like I was beginning to have a seizure, but it went away.

Therapist: Looks like you are getting mad with me right now.

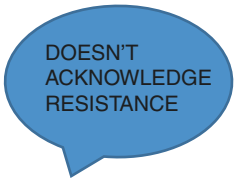
Child: No I am not. It's just that my legs are shaking, and maybe my seizure is starting.

Therapist: I would like you to relax, breathe deeply, and think of nice things.

Child: That helps with my legs. Maybe I won't have a seizure. Next week I can't come because my grandmother will be visiting.

Therapist: Oh, that's too bad. Can she come with you? I would like to meet her.

Child: I'll ask her but I don't think we can come.



Comment: In this dialogue the therapist focused on causes and reasons for what occurred to the child rather than helping the girl express her negative feelings. The therapist also did not provide positive feedback for negative emotions the child expressed nor did she empathize with the girl's negative feelings and experiences. The therapist's "Why?" questions had an interrogative, critical tone. Premature presentation of the mind-body connection together with lack of attention to the child's nonverbal and verbal cues of increasing discomfort led to the girl's resistance and refusal to come to the next session.

Summary: Checklist of Techniques

Use the checklist below to help you remember the techniques that encourage children with PNES to recognize, identify, and talk about their negative emotions.

Child Long-Term Treatment Goal 1: Checklist of Techniques

Probe for and acknowledge emotions
And how did that make you feel?
Wow…hm
When that happened, did you feel sad, mad, scared, or …?
So … made you feel…?
Identify and monitor emotions
Some kids tell me ….
What does mom (other close people) do when sad, angry, worried…?
How do you know that mom (other close people) is sad, angry, worried…?
How does that make you feel?
What do you do when that happens?
Check out this picture of what your brain does when happy, sad, etc.
Journal of events/feelings
Choose from problem list of stressors and feelings and rank emotions
Letter to the doctor
Create a play
Pick up nonverbal cues of discomfort
Withdraw eye contact
Distracted, fidgets
Blink rate change
No show
Note verbal cues of discomfort
Speech volume, prosody, speed, and topic of conversation change
No response to your questions
Slow answers
"When are we done?" "How many more questions?" "My mom is in a hurry."
Late cancellation
Model expression of negative emotions
Common, nonpersonal experiences
Enhance emotion and body awareness
Stuffed balloon
Examples using what other children tell you
Visual aids to identify what body parts respond
Common physical complaints associated with stress
Model common experiences

Child Long-Term Treatment Goal 2: Identify Stressors

6

How to Help the Child Identify Stressors

As for Goal 1, identification of the child's stressors involves a gradual process that starts with the more easily identifiable problems that were apparent during the diagnostic evaluation. It continues as you and the child explore problems that are harder for the child to acknowledge, label, and talk about. The 4 C tips in Fig. 6.1 and the techniques in Sections "Mapping Potential Stressors", "Storytelling", "Revisit", "Provide Positive Feedback and Empathize", and "Bridge to Coping and Problem-Solving" will assist you in helping the child to identify stressors.

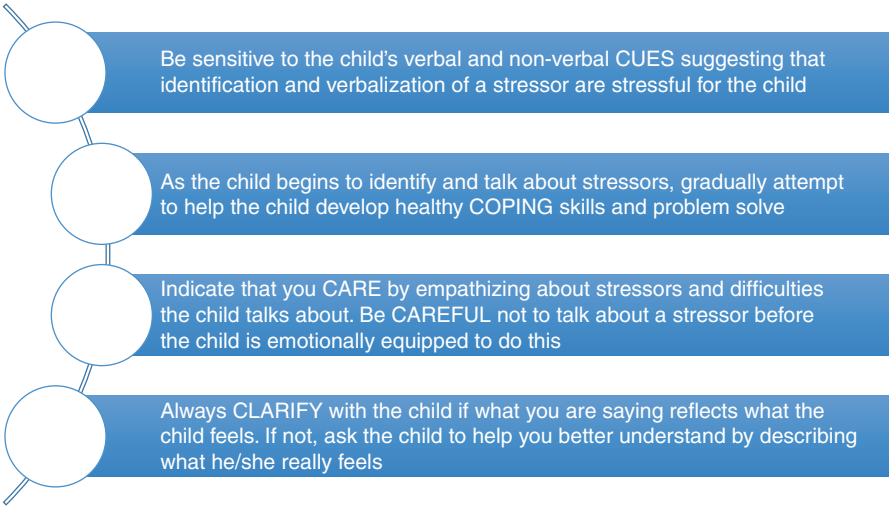


Fig. 6.1 The 4 C tips for identifying stressors

R. Caplan et al., *Pediatric Psychogenic Non-Epileptic Seizures*,
DOI 10.1007/978-3-319-55122-7_6

Mapping Potential Stressors

For stressors at home and in the family, ask questions, such as "Who in your family is the funniest?," "Who in your family is the quietest?," and "With who in your family would you like to spend more one-on-one time?" Explore the child's experiences at school and with friends using similar questions to identify possible stressors. The child's answers to these questions give information about family relationships, communication, and possible stressors. But, identification of potential stressors early in treatment does not mean that you should label them as such. As emphasized in Goal 1, proceed cautiously and only address a stressor when the child becomes aware of its impact on the child's emotions and functioning. See Appendix K for a worksheet to help child identify stressors.

Storytelling

Suggest that the child play a story game with you. You each take turns to tell different parts of a story. Ask the child who should begin the story. Each storyteller decides when it is the turn of the other individual to continue the story. If the child decides to start the story (which is preferable), pay attention to what the child's story might actually be telling you. When the child wants you to continue the story, introduce elements that might be of relevance to the child (e.g., one of the child's stressors), what the protagonist feels, and how the protagonist problem-solves. If the child wants you to start the story, choose a topic related to the child's potentially stressful experiences or difficulties.

For the game to be less personal, however, describe the protagonist as being a person from very far away in a different land. With younger children, you could begin: "Once upon a time, far away in …, there was a girl named …" ("Now it is your turn …"). "Every day, … would…." ("It's your turn again"). If the child enjoys this game and enthusiastically speaks during his/her turns, move to more challenging story game topics (involving stressors the child is experiencing) during subsequent sessions. You might also start by saying: "I want to tell you a little about someone that I used to work with who had similar difficulties. This child described things getting harder (difficulties with) when …".

Revisit

Consider talking about worries the child might have told you about and find out if there are additional ones. Another approach is to ask the child about things the child does not like and that "bug" the child.

Provide Positive Feedback and Empathize

Since these children usually get negative feedback at home and school, they really appreciate and thrive on any affirmation they receive. So, acknowledge and give positive feedback every time the child describes a stressor, negative emotion, and unpleasant experience no matter how minute a detail it might be. Then empathize with how the child felt in these situations.

Bridge to Coping and Problem-Solving

If the child provides you with information about a stressor or a difficult situation, always ask the child "How does that make you feel?" and "When you experience …, what helps make it better?" and then follow-up with "And what doesn't help when … happens?"

Dialogue: How to Identify Stressors

The child in the dialogue below is 10 years old and has had several therapy sessions for her PNES. Her episodes have ceased, and she has begun to focus on stressors. The therapist is trying to elicit information about the child's life and family to understand what the child experiences at home and her difficulties. As you read the dialogue, think about the previously described 4 Cs and therapy techniques presented below in Fig. 6.2. The blue bubbles include comments about the therapist's approach, and the yellow bubbles present comments about the child's responses.

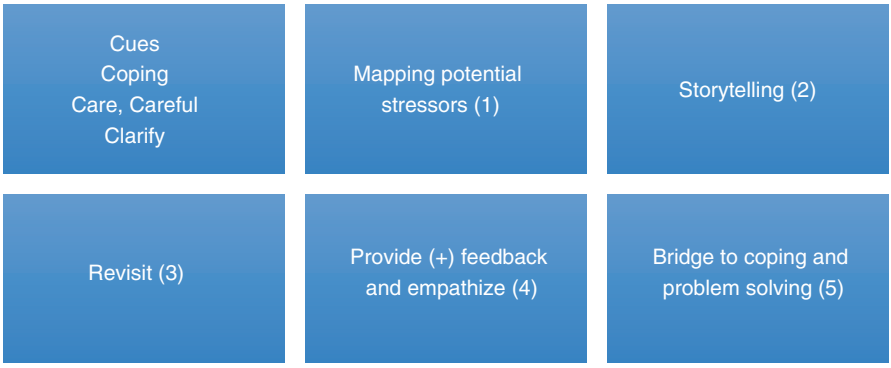


Fig. 6.2 Summary of Cs and Goal 2 Techniques

Therapist: We've spent a lot of time talking about your episodes, and you've done a great job getting them under good control! I was thinking that maybe I could get to know you a little better, know who the important people are in your life, and what they are like.

Child: Okay.

Therapist: Let's start with who you live with. Can you remind me again who's at your house?

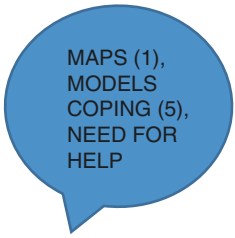
Child: Well, I've got two houses.

Therapist: That's right, so you've got two sets of people at two different places, right?

Child: Yep. At my Mom's it's me and my brother, my mom, and her boyfriend. And at my dad's it's him and my step-mom and my step-sister, but my brother doesn't go over there all the time.

Therapist: Okay, so you've got your brother with you at your mom's house and at your dad's it's just you and your stepsister? Do you think we could draw this out so that I can keep track (gets out drawing things, sits on the floor with child, and starts creating a map)? Sometimes it's easier for me to remember if we put it on paper.

Child: That looks kind of like a family tree that I did in history.

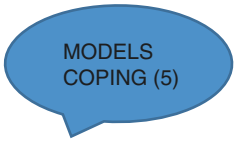


Therapist: That's right. We can make it look like that and maybe even add some other things in so that I can remember better. Like stuff about relationships. So, who in your family would you say is the funniest?

Child: Probably my dad. He always tells jokes.

Therapist: Let's make this line a red color, to remind me that he is funny. Does he tell silly jokes or play practical jokes?

Child: He teases me a lot. And everybody laughs; he does that with everyone and most people think it's really funny.



Therapist: So, he tells jokes, sometimes about you or things you do, and people think it's funny?

Child: Everybody does.

CLARIFIES

INDIRECT DISCOMFORT CUE

Therapist: Do you think it's funny too?

Child: Yeah, mostly funny. I mean everybody thinks he's funny.

PROBES – FEELINGS (GOAL 1) AND STRESSOR (GOAL 2)

EXPRESSES – EMOTION (GOAL 1)

Therapist: Mostly funny, but not always funny?

Child: [quiet] Sometimes I think I'm too sensitive.

CLARIFIES

Therapist: Do you feel like you are too sensitive because you don't always think it's funny?

Child: Yeah.

CLARIFIES

AVOIDANCE

Therapist: How does it make you feel sometimes when he teases you?

Child: I don't know.

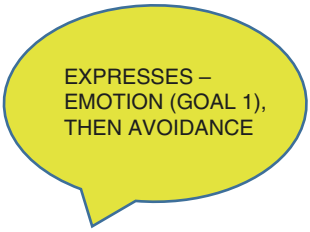
– FEELINGS PROBE (GOAL 1)

EXPRESSES – EMOTION (GOAL 1)

Therapist: But it's not always funny?

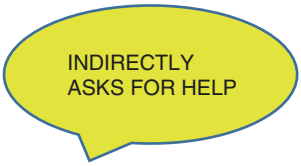
Child: Sometimes it's embarrassing.

CLARIFIES



Therapist: Sometimes the things he says are embarrassing?

Child: Well, sometimes I just feel embarrassed, but I always make a big deal out of nothing. Never mind, it's not a big deal.



Therapist: It sounds like sometimes you get upset but you think maybe you shouldn't? Like you are taking it too seriously?

Child: Everyone else just thinks it's funny. I don't know what my problem is.

Therapist: You seem to be blaming yourself for getting embarrassed about it?

Child: Well I should just be able to take a joke.

Therapist: Because everyone else does?

Child: Yeah.

Therapist: Do you think that everyone else that is around when your dad is teasing you finds it funny?

Child: Yeah.

Therapist: Do you think they think it's funny when he teases them?

Child: Yeah.

Therapist: They think it's funny all the time?

Child: Yeah…. Well maybe not all the time. Most of the time.

Therapist: Can you remember a time when it didn't seem like they thought it was funny?

Child: No.

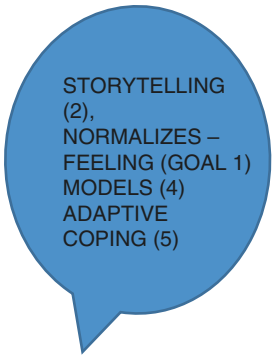
Therapist: Ok. Let me just make sure that I understand. You feel embarrassed when your dad teases you, but you think you should be able to take a joke better and that everyone else seems to think it's funny when he teases them most of the time—but there are times that they might not think it's funny, you just can't remember a time that happened?

Child: Yeah.

Therapist: Ok. Let me see if I can help you think about this situation a little differently. I'd like to tell you a story about another person that I worked with and see what you think of it.

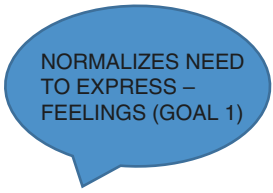
Child: Ok.

Therapist: So, there was this kid that I was working with who had a twin sister. And they had a lot in common, but there were some things that they were interested in that were different from each other. The person I worked with was really artistic, and her sister was really into sports. The sister used to always tease the kid that I worked with because she was clumsy, and this made it hard for her to play sports. So even though she didn't want to play sports and she could admit that she was kind of clumsy, she felt bad and embarrassed when her sister would tease her if she tripped on the sidewalk. And this got worse and worse and everyone else thought it was just funny and silly teasing, even her sister. But my patient did not see it that way at all. Can you understand how she might have felt?



Child: Yeah, I mean it makes sense that she would feel bad, and everyone should have known that.

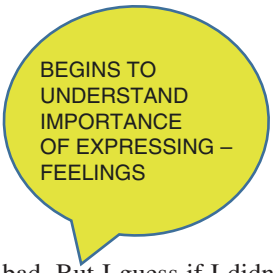
Therapist: Well, I agree, it makes sense that she felt bad because that was a sensitive area for her. But, no one really knew it made her feel so bad. She never told anyone.



Child: Maybe she was afraid they'd be mad if she told them she felt bad about it?

Therapist: I think that's true. She was worried they would be mad, and she was always worried that they would feel bad if she told them they hurt her feelings.

Child: Yeah, because maybe she was being too sensitive.

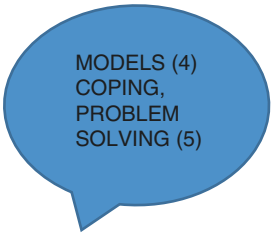


Therapist: Do you think she was being too sensitive, or do you think that it makes sense that she would feel that way and that other people just don't understand why she would feel badly about it?

Child: Well I can understand why she would feel bad. But I guess if I didn't know how she felt about it, I would think she was just being too sensitive.

Therapist: Do you know what I did to help her? We talked about how she could tell her sister that this hurt her feelings in a way that she wouldn't be as scared about her sister being mad or having hurt feelings.

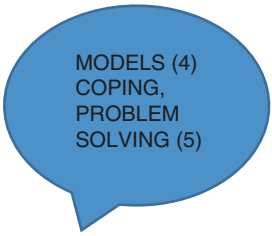
Child: Did it work?



Therapist: That she would tell her sister how she felt and the teasing changed?

Child: Yeah.

Therapist: It did work actually. We spent a lot of time talking about how to do it and even practicing what to say, and after she talked to her sister, it got a lot better.



Dialogue: Unsuccessful Identification of Stressors

The following dialogue of the same case demonstrates the child's responses (yellow bubbles) when a therapist (blue bubbles) uses (1)–(5) poorly, not at all, or neglects to use the 4 Cs when indicated.

Therapist: We've spent a lot of time talking about your episodes and you've done a great job getting them under good control! I was thinking that maybe I could get to know you a little better, know who the important people are in your life, and what they are like.

Child: Okay.

Therapist: Let's start with who you live with. Can you remind me again who's at your house?

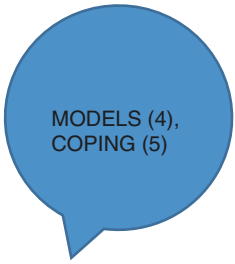
Child: Well, I've got two houses.

Therapist: That's right, so you've got two sets of people at two different places, right?

Child: Yep. At my Mom's it's me and my brother, my mom, and her boyfriend. And at my dad's it's him and my step-mom and my step-sister, but my brother doesn't go over there all the time.

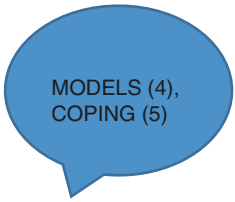
Therapist: Ok, so you've got your brother with you at your mom's house and at your dad's it's just you and your step-sister? Do you think we could draw this out so that I can keep track? Sometimes it's easier if we put it on paper for me to remember (therapist takes out drawing things, sits on the floor with child, and starts creating a map of the family).

Child: That looks kind of like a family tree that I did in history.



Therapist: That's right. We can make it look like that and maybe even add some other things in so that I can remember better. Like stuff about relationships. So, who in your family would you say is the funniest?

Child: Probably my dad. He always tells jokes.



Therapist: Let's make this line a red color, to remind me that he is funny. Does he tell silly jokes or play practical jokes?

Child: He teases me a lot. And everybody laughs, he does that with everyone, and most people think it's really funny.

MODELS (4)
COPING (5)

Therapist: So, he tells jokes, sometimes about you or things you do, and people think it's funny?

Child: Everybody does.

Therapist: Do you think it's funny too?

Child: Yeah, mostly funny. I mean everybody thinks he's funny.

CLARIFIES

NON-VERBAL DISCOMFORT CUE, EXPRESSES – FEELING (GOAL 1)

Therapist: What's does he say about you in his jokes and teasing?

Child: [quiet] Sometimes I think I'm too sensitive.

INDIRECT REQUEST HOW TO PROBLEM SOLVE

Therapist: Why do you say that?

Child: I don't know.

NO + FEEDBACK FOR EXPRESSING - FEELING, INTERROGATING "WHY?"

AVOIDANCE

Therapist: How does it make you feel sometimes when he teases you?

Child: I laugh.

PROBES – FEELINGS (GOAL 1)

AVOIDANCE

Therapist: But is that because you think it is funny?

Child: I just laugh.

CLARIFIES

EXPRESSES – FEELING, THEN MINIMIZES, DENIES

Therapist: You just laugh even though he is teasing you?

Child: Well, sometimes I just feel embarrassed, but I always make big deal out of nothing. Never mind, it's not a big deal.

CLARIFIES, CRITICAL TONE

Therapist: So you laugh even though you feel embarrassed? Wouldn't it be a good idea to tell your father how he makes you feel?

Child: Everyone else just thinks it is.

PREMATURE COPING SUGGESTION (5)

AVOIDANCE

Therapist: Why not just tell your father to stop because he embarrasses you?

Child: Well, I should just be able to take a joke.

PREMATURE PROBLEM SOLVING (5)

DENIAL

Therapist: It sound like you don't want to speak to your father about this.

Child: He's really very funny.

CLARIFIES

DENIAL

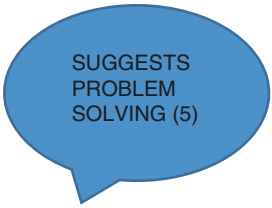
Therapist: So everyone else that is around when your dad teases finds it funny?

Child: Yeah.

CLARIFIES

Therapist: Do they ever tell him to stop?

Child: I am not sure.



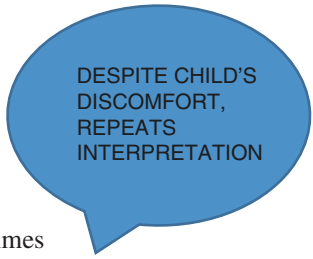
Therapist: What would happen if they did?

Child: He would probably stop teasing them.

Therapist: So why would that be different for you?

Child: I didn't say it would.

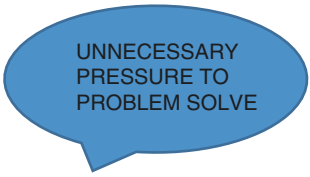
Therapist: But even though your dad teases and embarrasses you, you think you should be able to take a joke and not share how you feel with him?



Child: I really am okay with the jokes, just sometimes not so okay.

Therapist: Okay. So, what are you going to do about this?

Child (shrugs shoulders): Laugh when he teases I guess.



Therapist: And how will that make you feel inside?

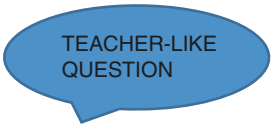
Child: It will make him happy.

Therapist: Is it scary to tell your father that you don't like what he does?

Child looks away.

Therapist: Did you hear what I asked you?

Child: How much more time will it be before my dad picks me up?



Therapist: You did a great job telling me that you get embarrassed when your dad teases you. I know it is not easy to talk about it.

Child (makes eye contact): I didn't really mean embarrassed. My dad is picking me up and taking me to buy new shoes when I leave your office.

Comment: The therapist started off the session well, but increased the child's stress level by prematurely trying to make her problem-solve about the stress her father's teasing invokes in her. The therapist should have first explored the child's feelings about the stress related to her father's behavior in a sensitive manner as demonstrated in the previous dialogue without pursuing problem-solving until clarification of all the child's emotions. But, the therapist prematurely and repeatedly tried to make the girl problem-solve and ignored the girl's nonverbal and verbal cues suggesting discomfort. This led to the child's denial of negative feelings, avoidance, and resistance. The positive feedback and empathy that the therapist provided in the end were ineffective because the child did not feel heard or understood throughout the session. This reinforced the child's continued denial of the problem.

Summary

Child Long-Term Treatment Goal 2 Summary: Techniques to Help Child Identify Stressors

Important Cs

Child

- Verbal and nonverbal **CUES**
- **COPING** when faced with stressors

Therapist

- **CARE** + **CAREFUL** approach to child's stressors
- ***C*LARIFICATION** of what child says

Techniques

- Map stressors at home, school, and with friends
- Storytelling
- Revisit the child's worries, dislikes, and difficulties
- Provide + feedback and empathy whenever child provides information on (−) emotions, stressors or problems
- Lay the building blocks for adaptive coping and problem-solving by asking:
  - "What helps to make … better?"
  - "And if that doesn't happen, then what?"

Child Long-Term Treatment Goal 3: Verbalize Emotions Associated with Stressors

7

Suggested Techniques

When the child describes a stressful situation, find out how that makes the child feel. These children often respond "Fine," "Okay," shrug their shoulders, or say, "I don't know." The toolboxes you acquired in Goals 1 and 2, together with the COMFORT techniques (Fig. 7.1), and the dialogues presented below will help you create an environment in which the child can comfortably explore and verbalize emotions associated with stressors.

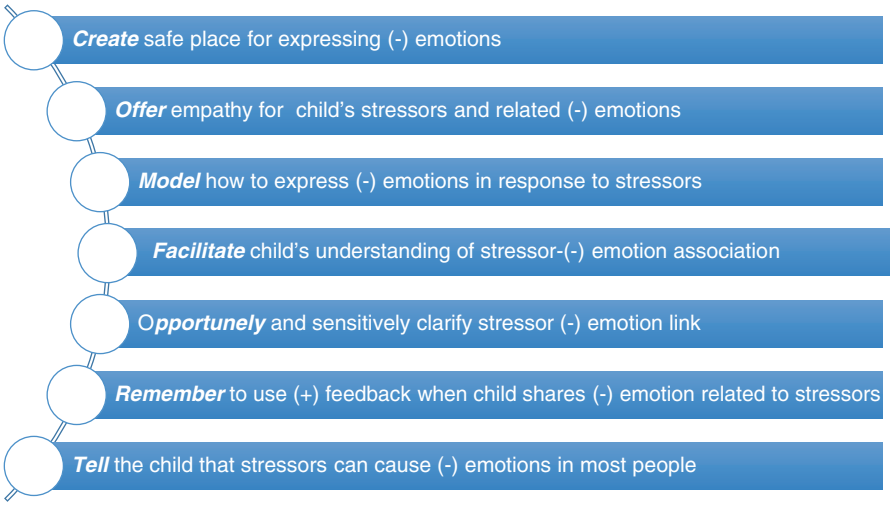


Fig. 7.1 Techniques to facilitate verbalization of stressor-related emotions (COMFORT)

R. Caplan et al., *Pediatric Psychogenic Non-Epileptic Seizures*,
DOI 10.1007/978-3-319-55122-7_7

Dialogue: How Not to Probe for Stress-Related Emotions

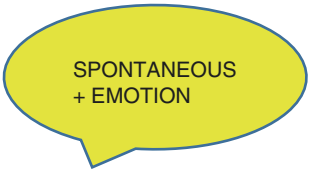
This 16-year-old adolescent [E] has been in therapy for approximately 9 months. At initial diagnosis, her PNES symptoms were occurring daily and involved full-body convulsions. Three different regional epilepsy centers misdiagnosed and treated E for epilepsy. The fourth epilepsy center diagnosed PNES, and her family accepted this diagnosis. Her episodes resolved after eight individual therapy sessions. Her stressors, identified at the onset of therapy, included advanced placement classes that required more work than the teen felt she could manage, a busy traveling hockey schedule, bullying by a group of girls in her class, and what was described as the "typical" frustration teens feel about their relationship with their mother.

E presented as an attractive, quiet, and rather unconcerned teen. She easily expressed irritation with her family members for being overly concerned about her symptoms. She also felt frustration because the bullies in her class were making her life "challenging." Although she showed little happiness or excitement about her academic and sports accomplishments, she spoke of them openly. E seemed to be comfortable and relatively confident at the outset of therapy. It became clear during the first several months of therapy that she was quite self-conscious and guarded about discussing her true feelings. It was difficult to help her express intensity in her emotions. When she described situations, everything was "fine" and "normal." Over time it became clear that this was not an accurate description of her life at home and at school. The therapist was aware of more than "typical" teenage difficulties between mother and daughter and the mother's very critical stance. The dialogue below demonstrates how not to probe for stress-related emotions. The blue bubbles comment on the therapist's techniques and the yellow bubbles on E's responses.

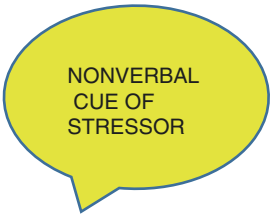
Therapist: How are you? How has your week been?

E [without much excitement]: Pretty good. Umm, I haven't had any episodes, so only 2 months until I can drive again.

Therapist: You must be really happy about that. You have enjoyed driving in the past, right?



E: Well, I guess I haven't been able to do much of it, because these episodes were always happening. It will be nice to be able to get away though.



Therapist: Yes, you mean to be able to go places that you'd like to go more on your own?

E [rolling her eyes]: Just to get out of my house.

Therapist: Getting out of the house and being with friends without needing to be driven around will be really nice.

E: And I'll get to go out with my boyfriend again without my parents needing to drive us everywhere.

CLARIFIES (GOAL 2) WITHOUT PROBE FOR – EMOTION NOR FOR STRESSOR!

SO, E DOESN'T ELABORATE ON HOME-RELATED STRESS

Therapist: That will probably feel very good.

E: Yeah.

PROBE FOR + RATHER THAN – EMOTIONS!!

VERBALIZES STRESSOR

Therapist: So, what kinds of things do you like to do when you get to be on your own?

E: I like to be with friends. I prefer being out of my house, so anything that gets me out of the house.

TOPIC CHANGE WITHOUT PROBE FOR – FEELINGS RELATED TO STRESSOR OF BEING HOME

AVOIDANCE

Therapist: Why don't you like being at your house?

E: I don't know, it's boring.

"WHY?" RATHER THAN "WHAT" QUESTION

AVOIDANCE' BUT EXPRESSES – FEELINGS FOR BROTHER

Therapist: Just not a lot to do there?

E: Not really. And my brother is really annoying.

NO PROBE FOR FEELINGS ABOUT HOME

Therapist: Yeah, little brothers can be pretty annoying.

E: He just won't leave me alone.

ACKNOWLEDGES COMMON FEELINGS FOR BROTHERS BUT DOESN'T ADDRESS AVOIDANCE

Therapist: So, getting out of the house would be nice and being with friends and your boyfriend. Now that your episodes are well controlled, are you planning on going back to the hockey team?

E: Probably.

CHANGES TOPIC AGAIN

Therapist: We talked last week about goals that you want to try to accomplish including managing your schedule a bit so that you did not feel like you couldn't have a social life. So, have you thought any more about how we can approach that goal? Which things that you are doing do you feel like you could put on hold?

CHANGES TOPIC, REINFORCES E'S AVOIDANCE

E: Well, since I'm not driving a lot of the stuff after school is already put on hold because my parents won't pick me up late, so I end up being stuck in my house all the time.

REPEATS BEING STUCK IN THE HOUSE

AVOIDANCE CONTINUES

Therapist: Oh, well, maybe that is a good thing. Because it's kind of forcing you to slow down a bit and have a little more free time and not be so overscheduled?

E: But it's boring and then I'm stuck at home all the time.

JUDGMENT!!! NO PROBE FOR E'S – FEELINGS

Therapist: Let's try to reframe this as an opportunity to start over and create your schedule and environment the way that you would like it to be and a way that would be healthier for you, instead of being involved in so many activities and then getting overtired and burnt out.

E: Ok.

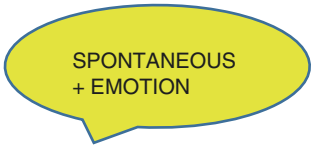
Comment: By focusing on activities rather than probing for the negative feelings this adolescent girl feels about being at home, the therapist did not access any information about what is happening at home. In effect, the therapist gives the patient a covert message that he does not want to hear what the patient is trying to express.

Dialogue: How to Probe for Stress-Related Emotions

In contrast to the previous dialogue, the following dialogue nicely shows how to probe for stress-related emotions.

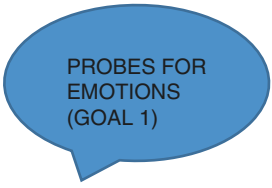
Therapist: How are you? How has your week been?

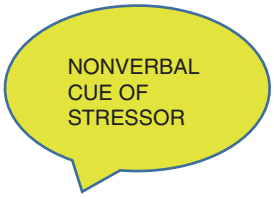
E [without much excitement]: Pretty good. Umm, I haven't had any episodes, so only 2 months until I can drive again.



Therapist: You must be really happy about that! You have enjoyed driving in the past, right?

E: Well, I guess I haven't been able to do much of it, because these episodes were always happening. It will be nice to be able to get away though.





Therapist: Yes, you mean to be able to go places that you'd like to go more on your own?

E [rolls her eyes]: Just to get out of my house.

Therapist: You seem a little annoyed or frustrated about home. What has happened that makes you feel that way?

E: I don't know.

Therapist: You just seemed to roll your eyes when you mentioned getting out of the house.

E: It's just kind of in general. It's annoying to be there.

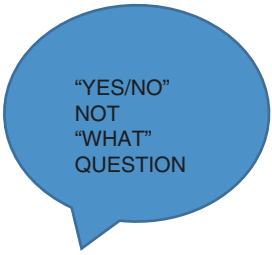
Therapist: Well, maybe we can talk a little about what feels annoying.

You've mentioned that before, feeling annoyed, but I realized after we talked last week that I don't know very much about your life at home or how you feel about things there. Do you feel comfortable talking a little more about that today?

E: Sure.

Therapist: Is there anything that you can think of that you would like to talk about your home life or your parents or brother?

E [makes quizzical facial expression]: Not really....



Therapist: Ok, well, if it's ok with you then maybe I'll just ask you about what I'm curious about?

E [with a big smile]: That sounds good.

Therapist: So you rolled your eyes when we talked about getting away and said it's annoying to be there. So, let's start there, what feels annoying about being there?

E: There are probably a lot of things.... I think the thing I was thinking about is my little brother and how he is just in your face and loud all of the time. I wish I could get away from him, but when I can't drive, I have to just be in my room.

Therapist: It feels a little like you are trapped?

E: Exactly! Yes, I'm trapped in my house. But I can't even lock my bedroom door because then I'm being rude and I get in trouble.

Therapist: Your parents think you are being rude by trying to stay in your room?

E: That and by locking the door. They have this thing about me locking my door, or actually kind of having anything locked away. It's like I have no privacy.

Therapist: Do you feel like they are constantly checking up on you when you are in your room?

E: They check up on everything. I have to give my mom my phone every night so she can read my text messages, or any time she asks for my phone actually. She looks in my school stuff and through my notebooks. She insists that I have to be friends with her on Facebook or I can't have an account. I snapchat my boyfriend because she can't read those.

Therapist: So, she's probably pretty aware of what is going on with you most of the time then, if she checks all of those things.

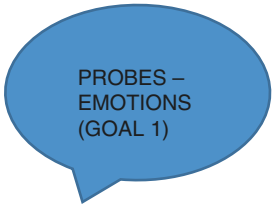
E: Even though I try to hide some of it. It's not like I'm doing anything bad, I just don't want her reading everything all the time. She thinks she is my friend, she even texts my friends sometimes, like she's just part of the group. It's so embarrassing.

Therapist: You describe that as embarrassing, and before you were talking about being annoyed with all of this. It sounds like it can be pretty frustrating?

E: She doesn't trust me, even though she has no reason not to.

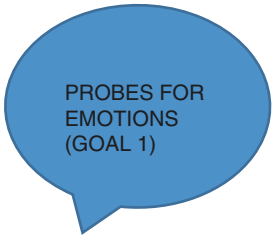
Therapist: How does that make you feel?

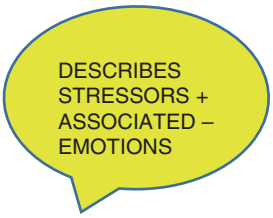
E: Frustrated, annoyed.



Therapist: Do you feel anything else about it, when you think about it or when you are in that situation?

E: I don't know... [thinking]. You mean does it make me feel sad?

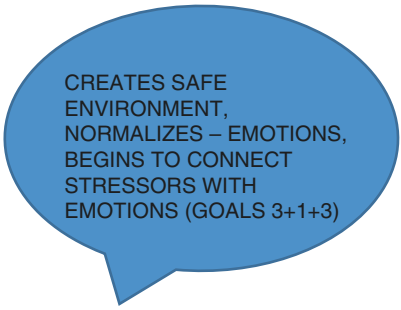




Therapist: Exactly that's very thoughtful of you. You could be feeling sadness. I can imagine you are feeling a lot of different things.

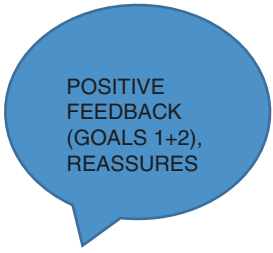
E: I guess I never thought about how I feel.

Therapist: That's not unusual. A lot of the time, people don't stop and think about how they feel about things, but how you feel about things can impact what you do in those situations and even sometimes what you do in future situations.



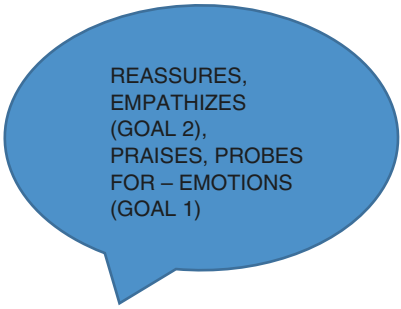
E: Sometimes lately, I've noticed that I feel sad or really angry, and I don't even know why, it's not like something has just happened.

Therapist: Well you are working really hard in therapy to understand your feelings. Once you start working on managing stressful things, like getting your episodes under control, sometimes that helps you notice how you feel and react to certain situations. But it might not always feel very normal or good when you first start to experience it.



E [laughs]: Yeah, I was wondering if I have bipolar now or something [laughs].

Therapist: I would say, no, you don't have bipolar. When people first start noticing and talking about their feelings, it can feel a little overwhelming sometimes. But maybe you're starting to be more aware of how you feel—which is a really healthy thing. Do you also notice things that make you feel sad or mad?



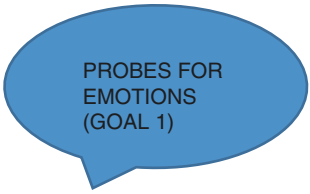
E: Yeah, like back to my mom. I walked in the other day and found her reading my journal after school. I had hidden it in my dresser, but I guess it wasn't hidden enough. And when I walked in, she was like acting all entitled, like it was totally fine. So, at first, I just started screaming at her. And then she started screaming back at me, and my stepdad had to come in. And then after they both left and said I was grounded, I just started sobbing.

Therapist: Walking in on her reading that after you'd hidden it and thought it was safe was probably a big shock, and then you were understandably pretty emotional.

E: Yeah.

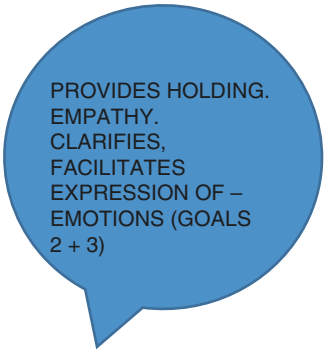
Therapist: When you were screaming at her, how were you feeling?

E: Mad.



Therapist: Really mad.

E: I hated her. I felt like I hated her, and I wanted to just rip the book right out of her hand, actually I did do that. And then she started screaming at me.



Therapist: You felt so angry at her that you felt like you hated her in that moment and then she reacted back to you in a really similar way huh?

E: My step-dad had to come get her out of my room.

CLARIFIES, FACILITATES (GOAL 2 + 3)

EXPRESSES – EMOTION

Therapist: And then you started to sob?

E: Yeah, after they left I just laid on my bed and texted my boyfriend and cried for like hours.

EXPRESSES – EMOTION

Therapist: Why do you think you felt so sad then?

E: I don't know, I just felt... and I don't know if I should say this, I mean I don't want you to freak out. But I just felt like I wanted to die, like I should just kill myself and then they won't have to bother with me anymore. But I don't want to do that, I mean I was just upset, I don't want you to freak out.

PROBES FOR CAUSE OF – EMOTION

DESCRIBES EXTENT OF – EMOTION

Therapist: I won't freak out. Thank you for telling me. That is a scary and overwhelming feeling to have. But let's talk about that feeling. It sounds like it felt really out of control?

E: Exactly, I did feel like that, like really out of control. Like I was so upset I just didn't know what to do with myself. And that was the first thing I thought of.

SAFE HOLDING, CLARIFIES (GOAL 2)

Comment: In this successful dialogue, E is able to discuss not only why she does not want to be at home, but also expresses her intense emotions associated with it. As in the prior dialogue, the therapist begins in a rather casual, conversational way. In contrast to the previous dialogue, the therapist responds to E's rolling of the eyes, a nonverbal gesture, as she said, "Just getting out the house." The therapist indicates

that she understands the nonverbal communication and wants to know more about what it meant. The therapist also conveys to E that it is safe to explore this emotion in the therapy session. Following a series of probes, clarifications, facilitations, positive feedback, empathy, and some interpretation, E is able to discuss what is hurting her about her relationships with her brother and mother. Most importantly, she also reveals the range of intense emotions that she experiences in response to these stressful situations at home.

Summary

Child Long-Term Treatment Goal 3:
Verbalize Emotions Associated with Stressors

To achieve this goal, apply Goal 1 and 2 techniques when child describes stressors:

Empathize when child expresses (−) emotions, stressors
Probe for, **acknowledge**, and **facilitate** expression of (−) emotions
Identify and respond to **nonverbal and verbal cues** of discomfort that suggest a stressor
Provide **(+) feedback** when child describes stressor and/or expresses (−) emotions
Clarify description of stressors and associated feelings to make sure you understand

To achieve the above, use the COMFORT elements:

Create a safe and holding environment for stressors and associated (−) emotions
Offer (+) feedback for verbalization of stressor and (−) emotions
Model how to express (−) emotions
Facilitate description of stressors and their (−) emotions
Use every **opportunity** of expression of emotions and stressors to begin to link them
Maintain **rapport** by being respectful of child's struggles to express (−) emotions/stressors
Tell child that most people have (−) emotions

Child Long-Term Treatment Goal 4: Connect Negative Emotions with NES Symptoms

8

Suggested Techniques

Whenever a child with PNES brings up any type of physical complaint, find out what the emotional triggers are using the techniques described in the following sections.

Link Between Bodily Sensations and Emotions

Gently revisit this link using the methods described in Child Long-Term Treatment Goal 3 in Chap. 7. In addition, you can describe how people might experience physical sensations when things occur that make them sad, mad, happy, or excited. Ask the child to talk about examples in the child's life that bring up these same emotions, and ask what physical sensations accompany them. It is also helpful to remind the child about negative incidents or events that the child has told you about. Find out what physical sensations the child might have experienced then and who the child told about them. Inquire if the child also expressed the negative feelings the child experienced in these situations. If not, find out what negative repercussions might have occurred if the child verbalized those feelings.

For younger children, it can be helpful to have visuals or to draw how the body feels when experiencing different emotions (see Appendix I for example drawings of the body). On a full body or face drawing, ask the child to use colors to identify different emotions and which body parts might experience them.

To normalize the mind-body connection, share how you and children you have worked with feel and think in situations that induce negative feelings. Talk about the emotions experienced when a child gives a speech in class, participates in a competitive sports game, or performs on stage. Then find out what your patient would feel (nervous, scared, shy) in a similar situation and how the child's body might react.

R. Caplan et al., *Pediatric Psychogenic Non-Epileptic Seizures*,
DOI 10.1007/978-3-319-55122-7_8

What Is Your Body Telling You?

As the child becomes more open to sharing negative emotions and experiences with you, suggest, "Was this your body letting you know that …?" Premature interpretation of the link among negative emotions, stressors, and episodes can cause the child's discomfort and resistance. To avoid this happening, be sure the child is ready emotionally for you to make these connections.

Story Game

Chapter 6, section "Storytelling" described when and how to implement storytelling. Ask the child how what happens in the story might make the protagonist (whether imaginary or the child) feel both emotionally and physically. Initially, this may be hard for the child. But as the child progresses in therapy, it becomes easier and more spontaneous.

The Exploding Balloon Phenomenon

To help the child understand what happens when one does not express negative emotions, describe how a stuffed plastic bag or a balloon with too much air eventually bursts. Also, discuss how the body feels when people cannot express an emotion and the ways in which their bodies react or speak up. When stressed, some people get headaches, stomachaches, or backaches. Talk about the importance of the child expressing feelings, even if it is unpleasant because otherwise bad feelings do not go away. Model this for the child from your own experience or that of other children.

After Understanding the Link Between NES and Emotions

Well into therapy, if a stressful situation occurs, the child might experience stress-related physical symptoms other than NES. Gradually work on making the link between stressors and these symptoms by clarifying the emotion the child experienced and the symptoms that developed. If, in earlier stages of therapy, you used an approach that helped the child express negative feelings or make the connection between physical sensations and negative emotions, revisit those tools.

Dialogue: How to Connect Among Stressors, Negative Emotions, and Episodes

This 14-year old high school freshman cheerleader was in her sixth month of therapy with infrequent episodes that occurred mainly at school. During the first 3 months of therapy, her therapist and cheerleader coach recommended that she

not resume her cheerleader activities until her episodes were controlled. Educational testing revealed language-based learning and reading difficulties. Although the patient had communicated to her parents about her learning difficulties already in third grade, they ignored her complaints and encouraged her to apply herself. The therapist worked frequently with the mother, but the father was "always too busy" to attend these sessions. The mother continued to have difficulty acknowledging her daughter's learning difficulties and felt they were emotional and subjective.

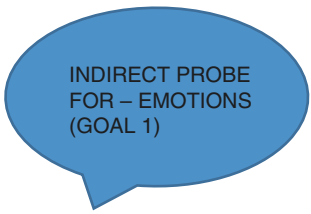
It took about 3 months of therapy before the patient started to talk about negative feelings. At first, she expressed anxiety related to her learning difficulties. Later, she reported feeling rejected by her peers at school. Several months into therapy, she said that she was bothered by her younger brother's intrusive behavior, particularly when her boyfriend visited her at home. The therapy focused on helping the girl gradually tune into and express negative feelings, as well as deal with her learning and social difficulties. Her episodes at school stopped. Although she was quite content not to resume her cheerleader activities, she was unable to share with the therapist what, if any difficulties she experienced during cheerleading. In fact, she repeatedly stated she loved cheerleading.

The patient was a third generation cheerleader, and her mother devoted a lot of her free time to her daughter's cheerleader activities. She arranged for her daughter to return to cheerleading without consulting with the therapist. For the first month (the fourth month of therapy), there were no untoward events, and the patient felt comfortable doing easier routines than she had been involved in prior to her illness. In meetings with the mother, the therapist emphasized the importance of a gradual return to cheerleading activities only when her daughter felt she was ready to do this. However, about 6 weeks after resuming cheerleading, the mother and coach encouraged the teen to do the challenging routines she had been involved before onset of her episodes. Without discussing how she felt about this with her therapist or anyone else, the patient agreed to do these challenging and daring routines. Within 3 weeks, she began to have episodes again at school.

As in previous dialogues, blue balloons are comments on the therapist's techniques and yellow balloons on the adolescents' responses.

Therapist: So I heard from your mom that you were not feeling so good at school.

Teen: Yes, I had to leave class on Monday and go to the nurse's office and then again on Wednesday, but today I was fine.

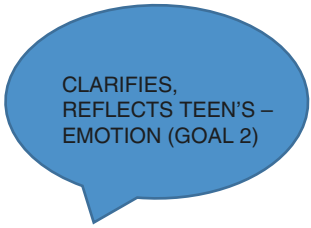


Therapist: That must have been tough for you.

Teen with tears in her eyes: Yes, the snobs all had something to say about this. They said that I am just trying to get everyone's attention and not do all the work.

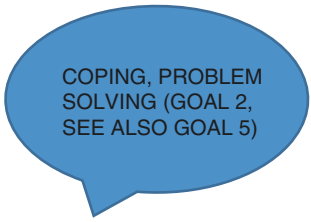
Therapist: I can see that really made you feel sad.

Teen starts to cry: The more episodes I have, the more work I miss. Why would I be doing this on purpose?



Therapist: You had come up with this great answer for them in our session when you were having episodes a few months ago. Were you able to say this to them?

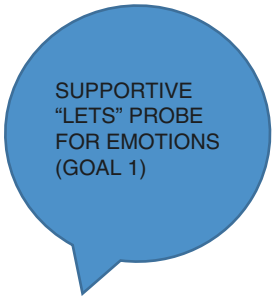
Teen: This time I did.



Therapist: Great that you let them know how they made you feel. I know that was not easy for you.

Therapist: So let's try and figure out together what has been going on that has been stressful for you since I saw you last.

Teen: I work with my tutor, and my teachers are happy with my progress.



Therapist: How are things going at home?

Teen: Fine.

IGNORES DENIAL, PROBES FOR STRESSORS (GOAL 2)

Therapist: What about your brother?

Teen: He has actually been behaving well and not bothering us.

PROBES FOR STRESSORS (GOAL 2)

Therapist: And with mom and dad?

Teen: My father has been away, and my mother has been very busy working on the next cheerleader camp.

PROBES FOR STRESSORS (GOAL 2)

Therapist: What's happening with cheerleading?

Teen: The games are starting and I have practice everyday. We will be having games also on Saturdays.

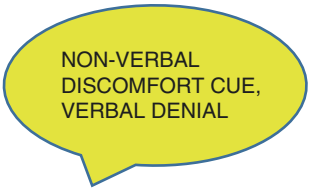
PROBES FOR STRESSORS (GOAL 2)

VERBAL CUE SUGGESTS DIFFICULTY

Therapist: Wow, that's a heavy schedule.

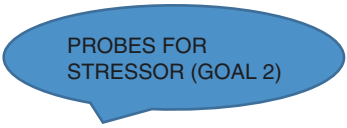
Teen: That's what happens when the season starts.

EMPATHIZES (GOALS 1 + 2)

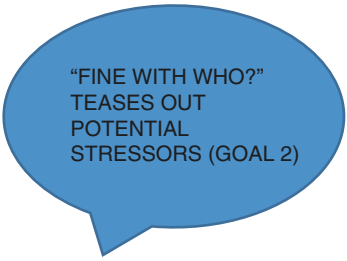


Therapist: How are you managing with this load?

Teen with a weak smile: Fine.



Therapist: Help me understand what fine means. Fine with the coaches? I know you were worried about the new junior coach. You thought she is very demanding.



Teen: I wasn't worried about her. I just thought she is very demanding and strict. But she had this long conversation with me, and it made me feel much better. She wants me to do what I can and not overdo it. She said that I am very young to be in the varsity team, and she is very aware of that.

Therapist: And the other coach?

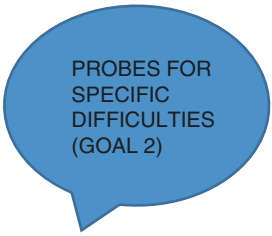
Teen: She is great.

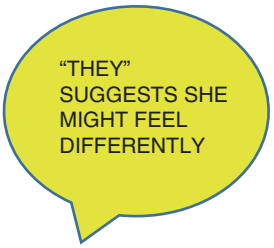
Therapist: What about your teammates?

Teen: They're good.

Therapist: And how do you feel doing the actual routines? If I remember correctly, you were okay the last 2 weeks not doing the complicated ones.

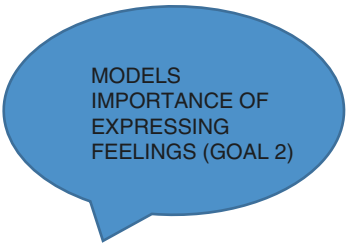
Teen: The coaches said they need me for the pyramid, and my mom said it would be good for me to get back into it.

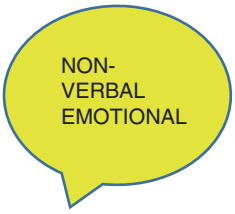




Therapist: Did they ask you how you feel about it?

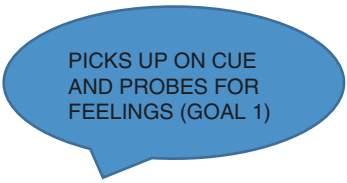
Teen: They all felt that I can do it.





Therapist: But how do you feel about it?

Child's eyes fill with tears, and she looks down.

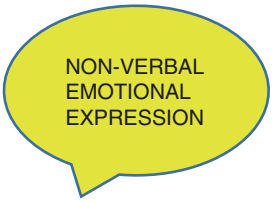


Therapist: Oh, you really look very unhappy about this.

Teen sobbing: They don't understand that someone will die because of me.

Therapist: Oh what a scary thought. How can that happen?

Teen sobbing and shouting: You don't understand. I am the one who is holding them up.



Therapist: Oh, now I get it. And you are scared that you are not strong enough. So, the people above you can fall. Oh, that is so scary.

Teen crying nods yes.

Therapist: Have you shared this with the coach?

Teen nods no.

SUGGESTS COPING PROBLEM SOLVING (GOALS 2, SEE ALSO GOAL 5)

Therapist: How about your mom?

Teen nods no.

SUGGESTS COPING PROBLEM SOLVING (GOALS 2, SEE ALSO GOAL 5)

Therapist: Would you like them to know?

Teen nods yes.

SUGGESTS PROBLEM SOLVING (GOALS 2, SEE ALSO GOAL 5)

INDIRECTLY SAYS MOTHER IS UNSUPPORTIVE

Therapist: How do you want to do this?

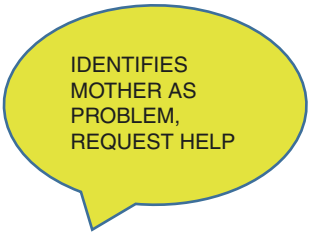
Teen: My mom thinks I am strong enough.

ENCOURAGES PROBLEM SOLVING (GOALS 2, SEE ALSO GOAL 5)

Therapist: And the coach?

Teen: She needs everyone to be safe.

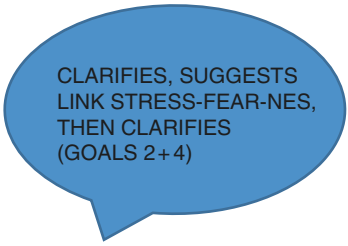
NEEDS TO KNOW COACH'S APPROACH BEFORE ADDRESSING MOTHER'S LACK OF SUPPORT



Therapist: That makes a lot of sense. So, you are saying that your mom does want to hear that you feel you cannot do it.

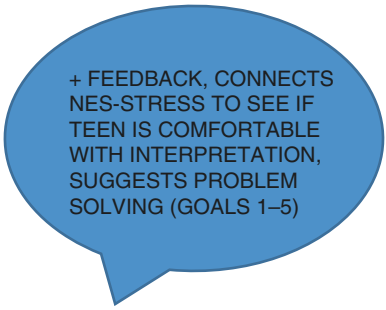
Teen nods: Maybe you should talk with my mom.

Therapist: So let me make sure that I understand. You were scared about dropping one of your teammates and felt you couldn't talk to anyone about it because you were worried what they would think about you. You had all those really unpleasant feeling inside you without a place to go, and then you had the episodes this week. Does it make sense to say that your body was talking for you?



Teen smiles and nods yes.

Therapist: Wow, you have really done an amazing job helping us figure out how when you are very stressed and cannot speak about it, it comes out in your episodes. So, what you want to try and remember is to know that when you have these yucky feelings, you need to talk about them rather than keep them locked inside.



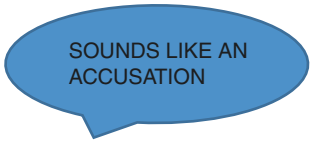
Teen: Thanks.

Comment: In this dialogue the therapist gradually connected the girl's episodes with the stress she experienced only after the therapist managed to clarify what the stressor might be. The girl understood this connection, the cathartic moment, and achieved insight on how her unexpressed fears of causing the death of one of her teammates caused her episode. The therapist repeated what she had understood from the patient's description to make sure that the patient's insight was, in fact, emotional rather than verbal acknowledgment of what the therapist had said. The girl's smile and nod were confirmatory. The following dialogue shows how this could all have gone awry.

Dialogue: How Not to Connect Stressors, Negative Emotions, and Episodes

Therapist: So I heard from your mom that you are having episodes again.

Teen: Yes, I had to leave class on Monday and go to the nurse's office and then again on Wednesday, but today I was fine.

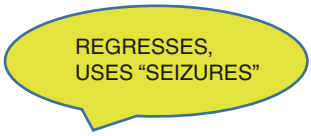


Therapist: That's too bad. You were doing so well.

Teen with tears in her eyes: Yes, the snobs also had something to say about this. They said that I am just trying to get everyone's attention and not have to do all the work.

Therapist: How did that make you feel?

Teen starts to cry.



Therapist: Looks like they hurt your feelings.

Teen: If I didn't have seizures, they would not be mean.

Therapist: Let's try figure out what was stressing you and made you have an episode.

Teen: Everything was fine. I just started to have seizures again.

Therapist: Well the difficulties you have had with school was one of the things that really stressed you out.

Teen: I have been doing great on my schoolwork with my tutor, and my teachers are happy with my progress. My mom thinks it was just that I was doing too many things at the same time, school, cheerleading, my boyfriend, and my youth movement activities.

Therapist: I see. What about your brother?

Teen: He has actually been behaving well and not bothering us.

Therapist: And with mom and dad?

Teen: My father has been away, and my mother has been very busy working on the next cheerleader camp.

Therapist: What's happening with cheerleading?

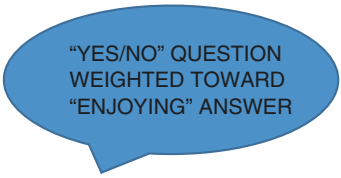
Teen: The games are starting and I have practice everyday. We will be having games also on Saturdays.

Therapist: How are you managing this heavy schedule?

Teen: Okay. I am getting all my schoolwork done.

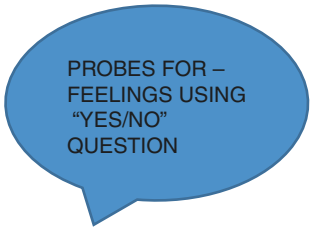
Therapist: And are you enjoying the cheerleading?

Teen with weak smile: I am very glad to be back.

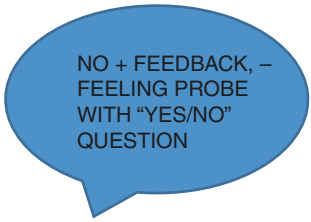


Therapist: Because….?
Child: That's what I love to do.

Therapist: Is there anything you don't like about it?
Teen: Sometimes the girls get very clicky.



Therapist: Does that affect you?
Teen: Not really.



Therapist: What else don't you like about cheerleading?
Teen: The new junior coach is very strict.

Therapist: Does that make you scared?
Teen: No.

Therapist: So is there any other possible thing that is stressful for you at school and that might be connected to your episodes?
Teen looks down.

DENIES

Therapist: What at school might be making you anxious?

Teen: Nothing really.

PREMATURE DIRECT PROBE FOR CAUSES

REGRESSES USING "SEIZURES," DENIES STRESS-NES LINK

Therapist: Well if you have another episode at school, please try and notice what happened just before.

Teen: My seizures usually just come on by themselves.

GIVES HOMEWORK, REPEATS NES-STRESS LINK!!

DENIAL CONTINUES

Therapist: I understand but try and make a note of it.

Teen: I'll try but there usually is nothing.

INSISTS ON HOMEWORK!!!

Therapist: On Monday and Wednesday when you had an episode, did you go to cheerleading?

Teen: The coaches said it is not a good idea.

PROBES FOR STRESSOR (GOAL 2), BUT PREMATURE STRESSOR-NES LINK

EXPRESSES – FEELINGS + FEAR

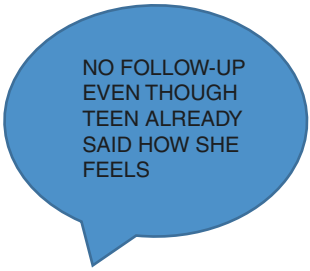
Therapist: How did you feel about that?

Teen: Not good. There aren't enough people on the team. If this keeps on happening, they will kick me off the team.

PROBE FOR EMOTIONS (GOAL 1)

Therapist: How does that make you feel?

Teen: Not good.

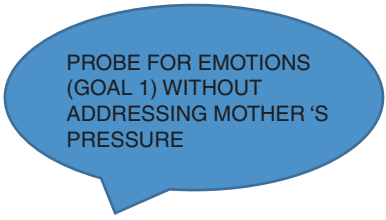


Therapist: I understand.

Teen: My mom thinks I could have gone but the coaches said no.

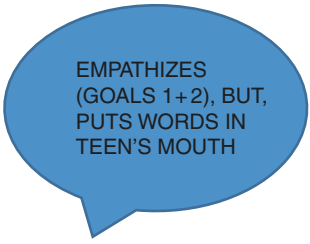
Therapist: And how did you feel about it?

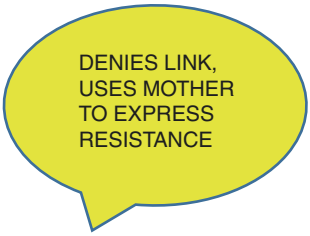
Teen: I wanted to go.



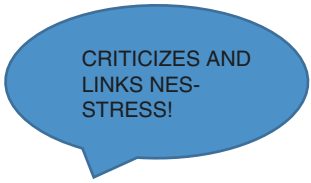
Therapist: That's a difficult situation to be in. When you woke up on Monday and Wednesday, were you glad you had practice that day?

Teen: I was fine.

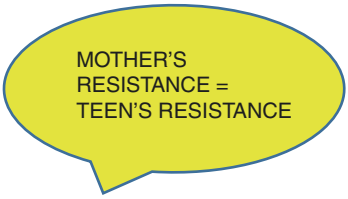




Therapist: So you have had two episodes this week, and even though we know that in the past the stress of learning difficulties caused your episodes, now you can't think of anything that might be stressing you or making you anxious.

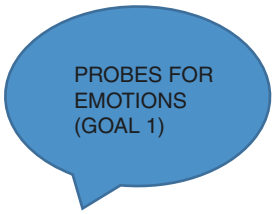


Teen: Nothing I can think of. My mom says that if I have any more seizures, she wants me to see another neurologist.



Therapist: How does that make you feel?

Teen: Her friend works in the school office and heard the principal say that if I have anymore, I cannot go to school.



Therapist: Maybe I should talk with your mom and with the school principal.

Teen: That's a good idea.

Comment: In contrast to the previous dialogue, from early in the conversation, the therapist repeatedly made the connection between the girl's episodes and stress without acknowledging the girl's nonverbal signs of discomfort and resistance. The teen also verbally expressed her resistance to the therapy by informing the therapist of the mother's plan to get a second neurological opinion (i.e., doctor shopping) as well as the girl's concern that she might be kicked off the team and out of school because of her episodes.

Summary

Child Long-Term Treatment Goal 4: Connect Stressors, (–) Emotions, and NES Symptoms

Make this connection **only** when the child is able to:

Talk about (–) feelings
Identify stressors
Understand the connection between the stressors and (–) feelings

How to?
Apply Goal 1 techniques for probing for negative feelings and Goal 2 strategies for identifying stressors
Normalize physical responses to stress (Goal 3)
Revisit stressful events the child has shared and the child's associated bodily sensations

Remember: If forced on the child before the child is ready emotionally, connecting stress, (–) emotions, and episodes (or other conversion physical symptoms) can result in resistance and end the therapy

Child Long-Term Treatment Goal 5: Problem-Solve

9

The Challenge of Problem-Solving

Figure 9.1 summarizes techniques you can use to help the child begin to problem-solve adaptively rather than maladaptively by avoidance. Similar to your work on the child's other long-term goals, gradually work on problem-solving strategies with the child. Be sensitive to nonverbal and verbal cues of resistance. If you meet with resistance, proceed cautiously. Also, see Chap. 15 for CBT approaches to problem-solving for anxiety disorders and depression associated with PNES and Appendix L for exercises the child can do to practice problem-solving techniques.

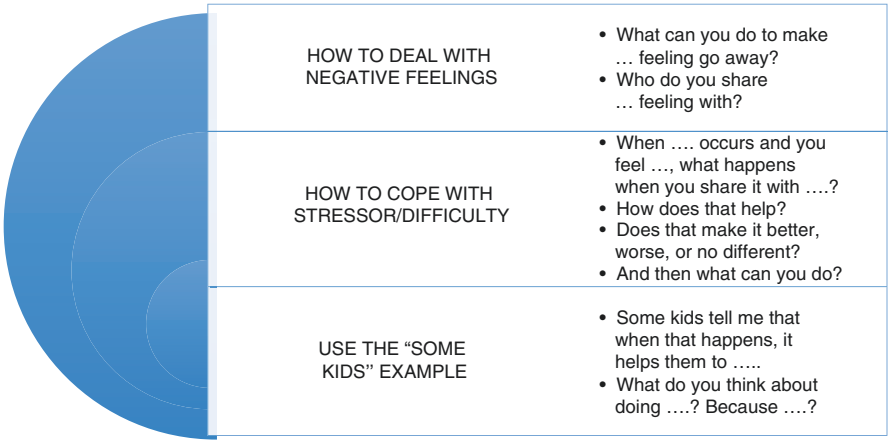


Fig. 9.1 Techniques to help the child problem-solve

R. Caplan et al., *Pediatric Psychogenic Non-Epileptic Seizures*,
DOI 10.1007/978-3-319-55122-7_9

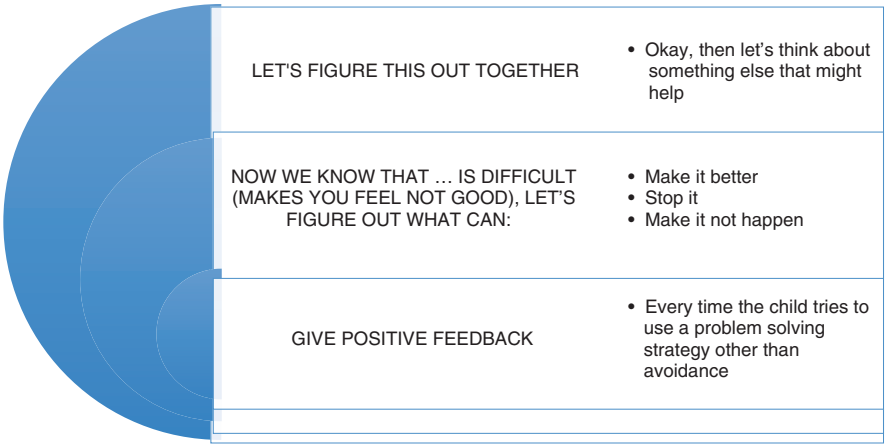


Fig. 9.1 (continued)

Techniques That Encourage Problem-Solving

What to Do with Repeated "Nothing Works" Child Responses?

Empathize with the child stating, "Sounds like that is really difficult." If the child expressed negative emotions, provide positive feedback even if the child is not open to any problem-solving suggestions. Role-play is a helpful technique. The child can act as the source of the problem and you be the child. Express the negative emotion the stressor causes you in your role as the child. Try to verbalize what makes it difficult for you (i.e., the child) to problem-solve. Then come up with a game plan that works.

Resistance

If the child is quite resistant to your problem-solving suggestions related to a stressful event the child describes, stop talking about it. At the next session, tell the child that you have been thinking about possible ways to fix the situation and would like to hear what the child thinks about them. Informing the child that you were thinking about the child's issues since the last session means that you care and really want to help the child. This can strengthen the therapeutic relationship even if the child continues to resist your problem-solving suggestions.

Can Parents, Friends, Teacher, You, or Others Help?

Make sure the child feels comfortable asking for help from others before suggesting it. Normalize asking for help. The child might feel more comfortable if you, not others, help problem-solve. Offer your help to the child only once it is clear to you that the child is fearful of asking for help or sharing his/her difficulty with parents, teacher, or friends. If parents are part of the problem, see Parent Long-term Goal 5 in Chap. 14 on how to address the issues between the child and parents.

Dialogue: Problem-Solving Approaches

This eleven-year-old boy with epilepsy was referred to rule out the role of psychological factors for his "breakthrough seizures" that began shortly after the beginning of the school year. The father accompanied the boy, but knew little about his medical, neurological, and emotional history. He claimed that other than seizures and some mild learning problems, maybe ADHD, the child had no emotional or behavioral problems. A vEEG and psychiatric evaluation confirmed a diagnosis of PNES. The frequency of the boy's episodes decreased markedly during the first few weeks of therapy in parallel with the parents' acknowledgment of his testing results that confirmed a wide range of learning problems and with additional accommodations put in place at his special education school. The dialogue below occurred during the third month of therapy. As for previous dialogues, the blue bubbles present comments on the therapist's approach and the yellow bubbles on the child's responses.

Therapist: Hi, you have your cell phone in your hand.

Child: To remind me that I wrote down stuff.

Therapist: Great. So, what do you have on your phone?

C looks at phone: Nothing really happened.

Therapist: Hmmm and then what?

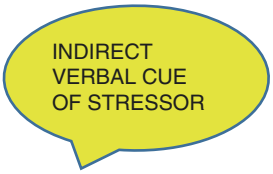
Child: Well, it's really no big deal.

Therapist: Great that you have started to write down things that bother you when they happen.

C smiles: Thanks.

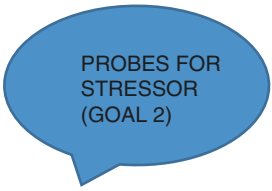
Therapist: You've been back at school now for 2 weeks. How are things going?

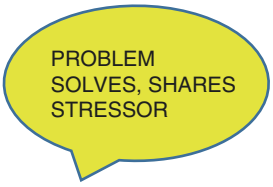
Child: Okay.



Therapist: What are you and your resource teacher doing in your reading class?

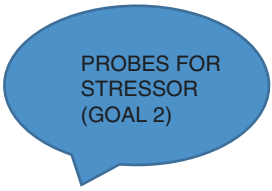
Child: A lot of reading.





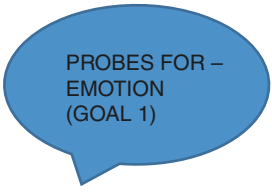
Therapist: What are you reading now?

C looks at phone: Now I remember, she said I need to pay more attention.



Therapist: And how did that make you feel?

Child: It's a very long period from 10 to 10.50.



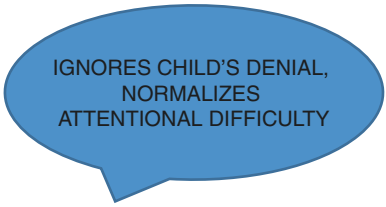
Therapist: So, it's difficult to pay attention for so long.

Child: School starts at 8 a.m. and I am there by 7.45. That's a long time.

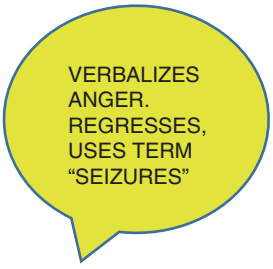
Therapist: Kids tell me when things are difficult for them, like if they don't understand something, they stop paying attention. How about you?

Child: I am a good reader.

Therapist: I know some things we read are hard to understand, and then we get distracted.

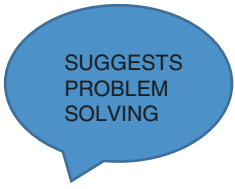


Child: That's what happens to me.

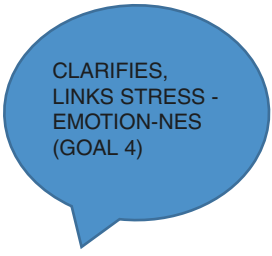


Therapist: How about you tell that to your teacher?

Child: She made me leave the class because I had a seizure.



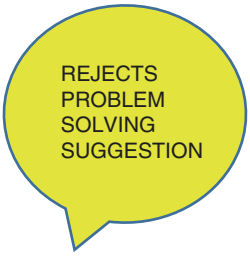
Therapist: Oh, now I understand. Let me see if I got this right. The reading was difficult to understand, and that made you feel not good. And then your body took over and had an episode.



Child: It's a long and boring book.

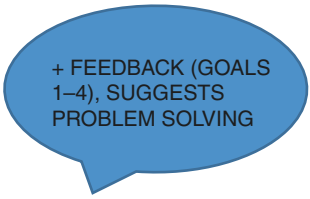
Therapist: Kids mean a lot of different things when they say boring. Some mean not interesting, some mean hard to understand, and some mean they don't like doing it again and again. Which one works for you?

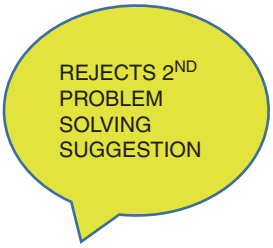
Child: A little of each.



Therapist: That is very helpful for me to understand. I think it would really help your teacher if you can explain that to her.

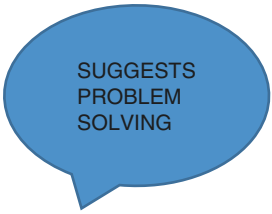
Child: She is very busy and has no time to talk with me.





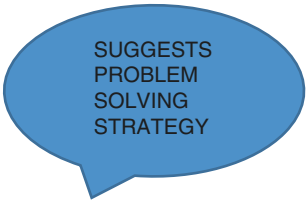
Therapist: Maybe when your next class with her starts, you can tell her what you told me.

Child: She doesn't like me to waste any time.



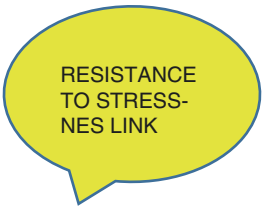
Therapist: Would you like me to speak with your teacher and explain this to her?

Child: Yes.



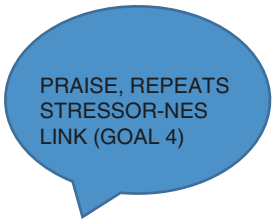
Therapist: You have done a great job today. You brought a reminder note on your cell and helped me understand some of your reading difficulties.

Child smiles.

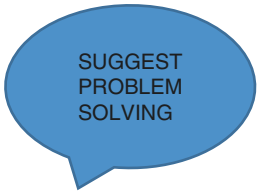


Therapist: And you also helped me understand that when you feel upset like you did with your teacher, your body spoke for you by having an episode.

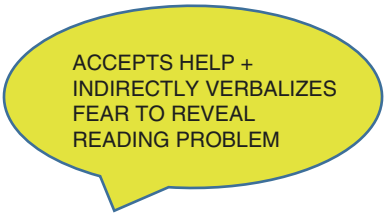
Child: My teacher thought that was a seizure.



Therapist: Here's an idea. The next time you are reading something that is hard to understand, use the breathing trick, and then let her know that you don't understand what you are reading.

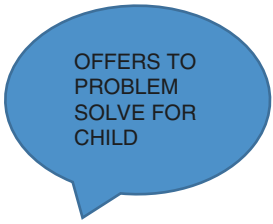


Child: She doesn't like me to waste any time.



Therapist: When I speak to your teacher, I will explain this to her as well.

Child: Okay if you think she will listen.



Comment: Despite the child's difficulty acknowledging his reading and attentional difficulties, the therapist normalizes these problems and gradually tries to clarify the extent of this stressor. When the therapist links stressor-negative-emotion-episode, the child rejects the interpretation and regresses. He says that his teacher remarked that he was having a seizure. The therapist then understands the need to back off from the stress-negative emotion-episode link and tries to help the child problem-solve. If, however, the child had said that he had a seizure in the class (rather than the teacher saying this), that would be a cue for the therapist that problem-solving would be premature. The therapist steadily and gently makes problem-solving suggestions that the child rejects. In the absence of increasing negative emotion which might reflect resistance, the therapist succeeds in finding out that the boy would like the therapist to problem-solve for him with the teacher. Being able to accept help to problem-solve is an important step forward in the treatment of children with PNES. The child responded well to the positive feedback the therapist gave him during the session.

Summary

Child Long-Term Treatment Goal 5: Problem-Solve

What?
This is the ultimate goal of therapy
When?
Early in therapy and continues throughout
How?
Encourage child to verbalize and talk about stressors, difficulties, and problems as well as the related (−) emotions
Help child figure out what strategies the child is comfortable with and when to use them
Teach child to ask for help from parents (unless part of the problem), teachers, friends, therapist, or others
Praise every problem-solving effort the child makes: verbalizing, sharing, asking for help, coping, and not avoiding

Sensitively time problem-solving to prevent the child's resistance

Working with the Parents

10

Parent Goal 1: Revisit How Parents Manage Their Distress During Child's NES Episodes

As described in sections "Techniques for Building Rapport with the Parents" and "Behavioral Management of PNES: The Parents' Role" of Chap. 4, from the initial phase of therapy, it is necessary to help the parents recognize the emotions that their child's NES and other physical symptoms provoke in them. Understanding how they feel during episodes is essential for you to help them develop responses that will be most appropriate for the management of the child's symptoms. It also helps the parents be open to the techniques described below that you model and practice with them.

Parent's Fears

Ask the parents about their fears of what might happen to the child during an episode or when the child has other physical complaints. Do they feel their child is being physically hurt? Do they fear that there is something dangerous happening in their child's brain and body?

The Child's Distress

Find out how the parents know their child is distressed during an episode and how they typically respond. Work with them to be calm in these moments of high distress. Help the parents understand their child's physical and emotional experiences during episodes, as well as the body's physiological response to the stress episodes invoked. Emphasize that these symptoms will not damage the body.

R. Caplan et al., *Pediatric Psychogenic Non-Epileptic Seizures*,
DOI 10.1007/978-3-319-55122-7_10

The Child's Other Physical Symptoms and Their Association with Stress

Work with the medical providers (epileptologist, neurologist, and/or primary care provider) to help the parents better understand which symptoms should and which should not be medically evaluated. Regarding other physical symptoms, as for the child's PNES symptoms, the parents should pay minimal attention and not overreact to the symptoms.

Relaxation

Remind the parents to use the relaxation techniques for parents described in Appendix C.

The Importance of Minimal Attention

Shift the parents' attention away from symptoms during an episode and when the child complains of other physical symptoms. They should not ask how the child feels (physically). But they should calmly acknowledge the child's symptoms using one of the following approaches:

- I see you are having an episode.
- These symptoms are scary but you will be okay.
- Use your relaxation techniques to help you calm down.
- I will stay close but let you calm yourself because we know that works best.

The parents should avoid touching the child. To refocus or distract themselves and the child from the NES symptoms, they should suggest, "Let's complete this activity and then see how you feel." If, however, the child does not attempt to calm himself/herself, they should remind the child to use the relaxation techniques the child has learned (see Appendix D). If possible, the parents should not stop all family functioning because of the child's episode. Most importantly, they should refrain from logging episodes and other physical symptoms because they reinforce these behaviors.

Support the Parents When Setbacks Occur

Remind them that these *might recur* even after a period without episodes because it will take time for the child to acquire the problem-solving skills needed to cope with stressors. Nonmedically concerning symptoms might also represent emotional setbacks that occur when the child experiences stressors. When the child complains of feeling sick with a headache or stomachache, encourage the parents to use the techniques they apply during the child's episodes.

Summary

Parent Goal 1: Revisit How Parents Manage Their Distress During Child's Episodes

Help parents:

- Recognize/acknowledge distress during the child's episodes/physical symptoms
- Model relaxation for the child
- Distract the child and themselves
- Move to an adjacent room unless the child's distress increases

Parents should not:

- Ask how the child is feeling physically
- Talk to or touch the child
- Give attention to the child's physical symptoms
- Rush to the neurologist/pediatrician for the child's nonthreatening physical symptoms

Parent Goal 2: Understand and Facilitate Family Communication

11

Recommended Techniques

Choose from the techniques in Table 11.1 to help the parents improve family communication.

Table 11.1 How to improve family communication

Communication	How to fix it
To facilitate parent-child communication, parents should:	• Schedule alone conversation or fun time with child • Talk with the child about nonemotionally weighted topics, and focus on what the child wants to talk about or do • Avoid checking in about homework or chores • Develop a list of neutral topics that are easy to discuss, and generate conversation • Tell the child that they are open to talking about difficult topics once communication improves • Help them initiate conversation about child's stressors that are obvious to them • Consider sharing difficult feelings they have regarding their own stressors to model for the child • Praise the child for openly communicating with them, regardless of content and (−) emotions the child expresses or if the parents agree with what the child says
Manage communication breakdowns	
Child pushes parent's or parents' buttons −→ Parent(s) react(s) emotionally −→ Communication breaks down/ stops	During active conflict, parent(s) should: • Continue the conversation later after calming down • If frustrated/overwhelmed, ask the other parent to take over (tag-team approach) • Intervening parent should de-escalate by advising child and other parent to calm down and back off After child and parent have calmed down: • They should discuss what they were thinking and feeling and what lead to the communication breakdown

R. Caplan et al., *Pediatric Psychogenic Non-Epileptic Seizures*,
DOI 10.1007/978-3-319-55122-7_11

Table 11.1 (continued)

Communication	How to fix it
Parent(s)–→ communication breakdown by: Not listening Upsetting the child in some other way	Parent(s) should: • Calm down • Avoid defensive approach that further fuels the fire • Apologize for upsetting the child • Ask the child to explain how parent(s) upset(s) the child • Empathize • If breakdown continues, request that the other parent mediate the conflict

Differences in Perception

It is essential that you recognize that it is common for the child and parents to differ in their perception about various topics, particularly about arguments between them. Thus, the child might not always give you accurate information. The child might present only part of what transpired between the child and parents. The same applies regarding the parents. With this in mind, carefully approach the parents with suggestions on how to communicate and behave with their child as in the example below of the child's perception.

Parent: How did you do in your dance competition today?

Child: I placed third in the overall routine!

Parent: That's great! What did the other girls do differently?

Child: They were both older… and you know they were the ones who won last year.

Parent: I thought you were better than them at last year's competition too. Hopefully you'll have some more time to practice this year, and you'll do better competing with them in the next competition.

The child reported that the parent focused on the child's need to work harder in order to get the first or second place. However, the parent reported the following:

Parent: How did you do in your dance competition?

Child: I placed third in the overall routine!

Parent: That is great! That was a hard routine! What were the routines of the other girls?

Child: They were the older girls, the ones who won last year. They are so much better than me.

Parent: I thought you were better than those girls last year! Don't worry, I am sure that you will do even better in next year's competition.

In other words, whereas the child described the parent as being critical, the parent perceived herself as being supportive of the child. For this reason, it is always important to hear both perspectives.

Joint Sessions

Suggest joint child-parent sessions when you have a good understanding of the parents' communication and parenting styles. Most importantly, the child needs to feel comfortable enough to work with you and their parents on issues between

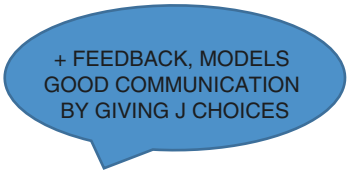
them. In these joint sessions, ensure that the child and parents feel that they are being heard by you and by each other on the issues they raise. Use these joint sessions to model and help them be more sensitive to the impact their communication style has on each other.

Dialogue: Button Pushing

J is a 16-year-old junior in high school. He plays sports and specifically enjoys football. He presented to the clinic with NES at the end of his sophomore year. After several weeks of therapy, his NES symptoms were under good control, and some of his underlying struggles became more clear. When J presented to the clinic, he and his parents denied stressors because he was a good student with mostly A's. He also was a successful athlete and socially popular. However, early in therapy, it became obvious that his needs to be a good student and athlete were significant stressors for him. J would spend many hours on homework, typically well into the night, to get good grades. He also put a lot of pressure on himself to be a good athlete. Despite working very hard at schoolwork and sports, his parents criticized him if he brought home a grade that they thought was not at the level of his real capabilities. They also responded negatively if he did not play well during a game. Their responses often lead to conflict between them and J, and he put more pressure on himself to do better at school and sports.

The dialogue below includes a communication breakdown between J (yellow bubble) and his parents (mother = green, father = orange bubble) about a common problem, the allocation of time spent on his school and social activities, and how the therapist (blue bubble) helps the family communicate better.

Therapist: Thank you everybody for coming today. I know we haven't done this too often, but J and I talked last week and thought it might be helpful to talk together about one specific issue that has come up several times since we all started working together. I thought it might be helpful to try to problem solve this situation as a group. J, do you want me to start talking about it, or would you like to talk about it?



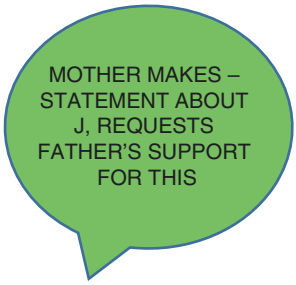
J: You can.

Therapist: Ok. So we have all talked a few times about how to manage school-related difficulties, including completing homework on time. This seems to be an area where there is some disagreement with everyone involved on how to manage this situation. Does that seem accurate?

Everyone: Yes.

Therapist: J, I thought that it might be helpful for your parents to hear a little bit about what you feel frustrated about. Would you feel comfortable talking about that?

J: Yeah, ok. I know that school comes first and all that, and I have been working on homework and getting caught up, but I'm not as far as we agreed on by the time football starts. And I still want to be able to play. I mean, I have been staying after school almost every day. It just takes longer than we thought, but I will still catch up. I mean, I just want to be able to play.



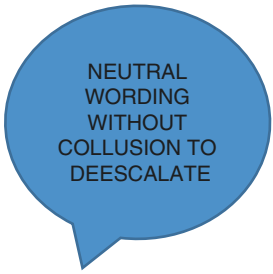
Mother interrupts: We agreed a month ago that you needed to get caught up before signing up. I am not saying you aren't working, but maybe you need to put in a little more effort. You are still getting together with your friends. You could spend a few weekends doing homework instead of going out, and you would get it all done. I still feel that you need to be caught up before playing a sport. Don what do you think?

Father: I agree. J, you have worked hard, but we know you are capable of so much more. In freshman and sophomore years you got straight A's. Now, we are working on Cs.

J: Dad, I spend a lot less time with my friends than everyone else I know. You just don't care if I have life.

Mother: Now that is not what we are saying...

Therapist: Ok, let me just try to summarize. J, you kind of wanted this meeting to ask permission to play football from your parents because the agreement had been you couldn't do that unless you were caught up in school.



J: Yeah, but they are being unreasonable ….

Therapist: … And you feel like that original agreement was a little too hard to meet those demands and still have a little bit of time with friends?

HELPS J COMMUNICATE PROBLEM

J getting upset: Yes. I mean they want me to work all the time. It's not like they understand; you don't even have a job right now Dad; I don't see you spending all this time finding a job.

Father red faced and angry: That's inappropriate. We aren't talking about my job here. We are talking about you being lazy when it comes to school.

Mother raising her hands trying to calm the father: It's your job to get yourself caught up. Your Dad's layoff is a totally a different situation ….

Therapist: Alright, let's all stop for a second. Everyone seems pretty upset or angry right now. I'm glad that you are all talking about it. I am also happy that you are all sharing how you feel right now, so I'm going to ask everyone to try to be sensitive to what the other people might be experiencing. While on the surface, this might seem like it's just about homework, it seems to be about other things to me, like your expectations (looking at parents) and what you feel is fair (looking at J). Why don't we talk a little about those two things? Because this seems to be kind of emotionally charged, I'm also going to ask that only one person talk at a time and then give me the chance to respond so that we can all be sure we are understanding what is being communicated. J why don't you start? Can you talk a little about what you think about your parent's expectations?

DEESCALATES WHEN FAMILY MISCOMMUNICATES, SUMMARIZES, + FEEDBACK FOR GOOD COMMUNICATION MODELS CONSTRUCTIVE COMMUNCIATION

EXPRESSES STRESS, FRUSTRATION OF NOT MEETING PARENT'S EXPECTATIONS

J: I think they don't get it. I think they feel like I shouldn't have a life.

Therapist: You feel like their expectations about this schoolwork are unfair?

J: Yeah. I don't know how they expect me to do more than what I am doing.

CLARIFIES WHAT J IS SAYING, MODELS GOOD COMMUNICATION

Therapist: Can you break it down for me a little and tell me what you are doing with your homework? How much time are you spending? When do you stay after school?

J: I stay after school on Monday, Tuesday, and Thursday for an hour and a half with Ms. Potts.

MODELS GOOD COMMUNICATION IDENTIFIES POSSIBLE COMPONENTS OF PROBLEM

Therapist: Is she the special education teacher?

J: Yeah. She kind of tutors me on math.

CLARIFIES WHAT J IS SAYING

Therapist: Do you feel like she is helping you with the math and getting caught up?

PROBES FOR – FEELINGS (CHILD GOAL 1)

VERBALIZES DIFFICULTY

J: Yeah, but I still don't really understand it. I know what to do when I am with her, but then when I get home, I can't remember how to do it all the time.

VERBALIZES – FEELINGS

Therapist: How does that make you feel?

J: Frustrated. Kind of like what's the point?

PROBES FOR FEELINGS (CHILD GOAL 1)

Therapist: That's a lot of time to spend with a person and still feels like it's hard to remember and do on your own.

J: And that's not all I do. When I come home, since I don't have any sports right now, I come home from school, eat, and then do homework until 9 or 10 o'clock.

EMPATHIZES (CHILD GOALS 1– 5)

Father interrupting: In-between texting all the time ….

Therapist holds up hand and stops the father from interrupting.

LIMITS – COMMUNICATION, PREVENTS FURTHER ESCALATION

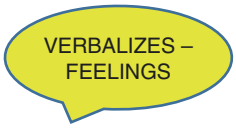
J: You think I'm a robot; I have to have some time to talk to my friends!

Therapist: Thank you J for clarifying the time you spend on things. It sounds like you do spend a lot of your time trying to complete work. And some of it seems like it's pretty hard for you.

J: Yeah.

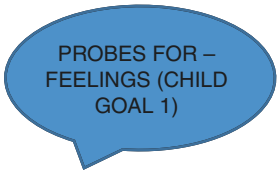
Therapist: You mentioned before that you feel like your parents think you are a robot?

J: They think I can wake up every day and be at school ALL day and then stay after with Ms. Potts and then come home and work ALL night.



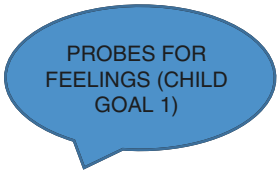
Therapist: How do you feel thinking about all that work?

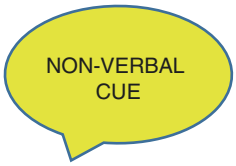
J: I feel tired. It makes me tired even talking about it… (trailing off).



Therapist: You feel tired. Are there other things that you feel about it? About how your parents feel about your work?

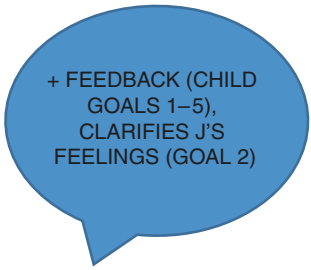
J: I feel like, what's the point? I work so hard and still don't catch up or really do well. It seems hopeless kind of thing. And I think they think I am lazy.





Therapist: Thank you for telling me how you feel. It seems like you are feeling pretty bad about all of it. Like there is no point, it's hard, and even when you work as hard as you can, your parents still think you are lazy?

J nods, looking down.



Therapist: Ok, thank you for telling us that. I know it can be hard to talk about that kind of stuff sometimes. Mom and Dad, I'm wondering how you feel about what you've heard J describe.

+ FEEDBACK, EMPATHIZES, INVITES PARENT'S RESPONSE AFTER DEESCALATION

Mother: J, we don't think you are lazy. You are a really smart kid. You used to be able to just come home and get your stuff done and stay on top of things, but since the episodes and missing so much school, you just got behind and you've got to catch up.

+ FEEDBACK

J frustrated and kind of sad: I know! I'm trying!

Therapist: Mom and Dad, it seems like J understands the spot he's in, but it seems that even with a lot of support and *a lot* of work on his part, he is still struggling, he's still behind, and he feels a bit hopeless about how to catch up...

SUMMARIZES FOR PARENTS

+ FEEDBACK, DOESN'T PICK UP ON J'S HOPELESSNESS

Mother: I know; I can see that (moving to pat his arm). We know you can do it; you are smart….

Therapist: I wonder if maybe we can try to brainstorm some ways of helping to make this situation better. Do you both feel like the picture that J described about his work is accurate?

ASKS FOR PARENTS' PERCEPTION SO ALL CAN WORK TOGETHER

Mother: Yes ….

Father: Yes, mostly.

Therapist to father: What would you add to what J said?

RECOGNIZES FATHER'S RESERVATION

Father talking to J: I know that you are working. I see you working. I just think you can be more focused ….

J looks away and begins to tear up.

Therapist to father: My sense from what J has told us today is that he is trying as hard as he can, and he doesn't know what else to do. And I think he has said in a few different ways that he thinks you don't believe how hard he is working or like he could do more.

Father: It's not that I think you are lazy. It's just hard … frustrating to be in this spot.

GENTLY REPEATS J'S PERSPECTIVE & FATHER'S LACK OF ACCEPTANCE OF J'S DIFFICULTIES

Therapist: You feel like it is frustrating to see J in this position?

Father: To be struggling, it's hard to see him struggling when I know he is smart.

EMPATHIZES WITH FATHER

Therapist: It can be hard as a parent to see your kids struggle and not feel like you can do anything to help them.

Father: Yeah, it's really hard. That's why I'm on you so much J; I'm just trying to help push you along, but I didn't realize it was making you feel so bad.

CLARIFIES AND VALIDATES FATHER'S FEELINGS

FATHER NOW EMPATHIZES WITH J

Therapist: Thank you Dad for clarifying how you feel. You don't think J is lazy; you're just trying to motivate him to work harder because you know he can do it.

Father: Yeah.

+ FEEDBACK TO FATHER, + REFRAMES FATHER'S EARLIER NEGATIVE COMMUNICATION

Therapist: And it's hard for you. You feel badly watching him struggle.

Father looking teary eyed: Yeah.

Therapist: I'm wondering if maybe we can try to work together on a plan for reasonable time spent on work, and then perhaps I can help speak with the school so that they can aid with that plan too. What do you think J?

J: Yeah, I would like that.
Mother and Father: Yeah.

Comment: The therapist sensitively paces the communication and de-escalates the conflict. She models how to respond to negative emotional expression, communicate in a way that encourages continued conversation among the three family members, and problem solve about a difficult family problem.

Summary

Parent Goal 2: How to Understand and Facilitate Family Communication

Parents promote (+) communication if they:	Parents promote (−) communication if they:
• Schedule time alone with child	• Interrupt the child
• Talk about neutral topics	• Engage in other activities, yawn, or sigh during conversation with child
• Do fun things with child	• Ignore what the child is talking about and change the topic of conversation
• Are open to and gently discuss difficult topics and child's stressors	• Focus only on their own concerns about the child which might not address child's sources of frustration and anxiety
• Share their stressors with child	
• Praise child for sharing information	
• When communication breaks down:	
• Engage in conversation once everyone has calmed down	
• If not, uninvolved parent mediates	

Parent Goal 3: Recognize the Child's Stressors

12

How to Help the Parents Recognize the Child's Stressors

To help achieve this goal, consider the use of the techniques described below.

How to Identify the Child's Stressors

Remind the parents that they are your co-therapist and that you need them to understand what the child is struggling with and to help the child problem-solve. Make them aware of behavior changes that might signify that the child is struggling with something, such as becoming isolative, less talkative, and more irritable, as well as crying easily, eating less, and sleeping poorly.

Encourage them to check-in (as described in the parent communication goal in Chap. 11) with the child when the child demonstrates any of these behaviors. The child might then talk to the parents about ongoing stressors or difficulties. Provide the parents with the language they can use to let the child know that they are aware of a stressor and want to help the child manage it. For example:

Parent: How did the math test go?
Child: Okay I guess.
Parent: I know your math grades haven't been so good. *Should we try to figure out how to help you with math*?
Parent: I haven't heard you talk about any of your friends lately.

Child does not respond.
Parent: I know that you've been struggling with … lately. *I am here to talk about it whenever you want*.

Only with permission from the child, inform the parents about the child's stressors that they are unaware of or have ignored. The lack of awareness about these stressors might make the parents respond defensively. Please see the dialogue below

R. Caplan et al., *Pediatric Psychogenic Non-Epileptic Seizures*,
DOI 10.1007/978-3-319-55122-7_12

for suggestions on how to manage this defensiveness and help the parents understand the child's perspective on his/her stressors.

Proactively Manage New and Unexpected Stressors

The parents need to be mindful of the child's schedule and commitments prior to adding to the child's responsibilities and increasing their demands from the child. This is particularly important at times that are commonly more challenging, such as before tests and finals or when projects are due at school. Suggest joint sessions with the parents and child for stressors due to problems in the parent-child relationship if the child is not yet comfortable discussing them with the parents without you.

Dialogue: How to Help Parents Recognize the Child's Stressors

This dialogue demonstrates the difficulty parents might have in recognizing their child's stressors and how this can lead to parental resistance. It also emphasizes the importance of dealing with the parents' resistance without countertransference by supporting them while at the same time highlighting the child's difficulties. It illustrates how to create a holding environment by validating and respecting both the parents' experience and the child's stressors.

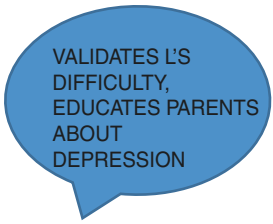
L is a 15-year-old freshman in high school (yellow bubbles), who has been in therapy for 6 months for treatment of his PNES and associated symptoms. L's parents presented for a family session today. Although L has not experienced any episodes in over 3 months, he has exhibited symptoms of depression. Namely, he began to be more aware of feelings of sadness and fatigue. His parents (mother = green bubble, father = orange bubble) noted increased irritability and a tendency to withdraw to his room early each night. His interaction with peers has steadily declined since the onset of his PNES. While his parents feel positive about his episodes being under control, they have become concerned and somewhat frustrated by these new behaviors.

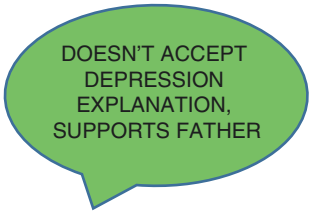
Therapist: It sounds like L is having a difficult week.
Mother: Yes, he seems to be even more withdrawn this week than last. I feel like he's sleeping all the time. Don't you think so (looking at father)?
Father: Yes, I think he's taking a nap nearly every day after school now. And he seems to sleep every night for maybe 10 hours He's not getting his homework done and talks a lot about being too tired to do it. When I have asked him about getting it done, he gets pretty angry. I think we've fought at least twice this week about it. So I told him he can't do anything this weekend until it's done. I'm tired of the excuses.

Therapist: These newer symptoms do sound like they are getting worse and more disruptive. When kids are depressed ….

Father interrupting: I know you mentioned depression last week, but I am not sure that I agree that he's depressed. I mean, I think he has control over this. He is making choices that are making it harder for him.

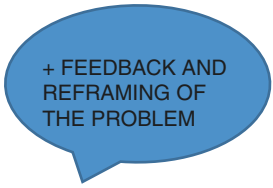
Therapist: I understand that it can seem like he's setting himself up by not completing things that then make it harder for him in the long run. One of the things about kids who are depressed is that they don't really have the emotional energy to problem-solve. They just feel like everything is so hard and so exhausting that they can't motivate themselves well to do some of those things.

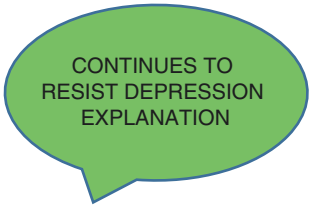




Mother: Sometimes I feel like it's all a convenient excuse. I don't want him to make excuses for not getting a work done by acting like he's got something emotional going on. Doesn't that just make it more likely that he'll keep doing that to avoid things that are hard?

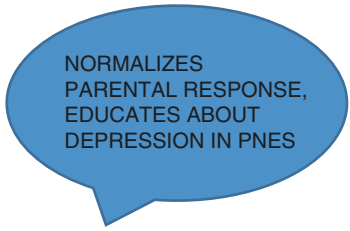
Therapist: That is a good question. It seems that one of the things we need to do is help him to find some balance in managing these symptoms while still having expectations about what he needs to work on.





Mother: I just don't understand what he could be depressed about. You've said that a few times now, and I feel like things are going better; he's got the episodes under control; we got him some help at school. What could he have to be depressed about and what's causing it?

Therapist: It can be hard sometimes to see progress in some areas and then have these symptoms come up. Sometimes, I find that kids who are going through these things have been having feelings of depression for some time, but it didn't come out in the way that it is now; it came out as the PNES.



Father: So you think he's been depressed for a while?

Therapist: You mean do I think that the depression has been going on since his PNES or even before it?

Father: Yes.

CLARIFIES

FATHER IS QUITE RESISTANT TO THE POSSIBILITY OF DEPRESSION

Therapist: Yes, I think from my work with him that he experienced some of these feelings for a while but just didn't really know how to express them.

EXPLAINS DURATION OF L'S STRESSORS AND HIS DIFFICULTY VERBALIZING THEM

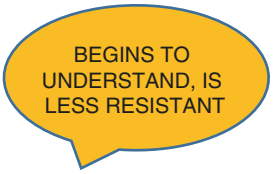
Father: What has he told you that is making him depressed? Is it something that happened to him? Or has he told you why?

Therapist: There are some things we've talked about that have made me feel that this has been going on for a little while. You know I discussed with L that I would be talking to you both about this today, and he felt comfortable with me telling you about some of the things we've discussed, in particular, his performance at school.

UNDERSCORES IMPORTANCE OF PATIENT CONFIDENTIALITY

ANGRY BECAUSE L SHARED WITH THERAPIST NOT PARENTS

Mother: But there are things he didn't want you to tell us. Don't you think we should know these things as his parents?



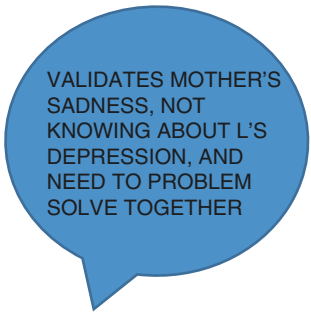
Therapist: Let me make sure that I address both of those questions. First, in preparation for talking with you both today, I talked with L about what he thought would be helpful to discuss with you, things that he wasn't sure he knew how to talk about on his own. Sometimes when kids with PNES are struggling with things, they have a good sense of what that stuff is, and other times they really don't know. One of my jobs is to help them figure this stuff out, and when that starts to become more clear to them, sometimes it's hard for them to figure out how to talk about it with other people, including their parents.

Father: So it's not like he's known this stuff and just not wanted to talk about it.

Therapist: No, I don't think he understood it in the way he does now. This is not an uncommon experience for kids who develop PNES. Now for your second question, about whether as parents you should know. Certainly, in cases where I am worried about safety, yes, I definitely think you should know right away. But often, I find that as kids learn about themselves and their feelings, they have a harder time talking about some of those things with their parents for a while, and this is one of the things we are working on in therapy.

Mother: It's just really hard seeing him this way. I mean I always thought he was such a happy and typical kid, and after this last year, I feel like I don't even know him. I don't know how we didn't pick up on all of this stuff... (tearful).

Therapist: Thank you for letting me know how difficult this is for you. It is hard to see him going through these things and not knowing how to help him. But I don't think you missed anything that was very clear. I really believe that most often children develop these struggles over time and do the best they can to cope. Often it's not knowing how to cope or coping in a way that doesn't really make things better that we start to see symptoms coming out. Though this is a hard spot right now and will take a lot of work, I am happy that we now have a better understanding of how L is feeling, and now we can all work together to help him cope differently with it.



Comment: In this difficult session, the therapist models for the parents how to respect what their son had to say. She educates them about L's depression despite their resistance to this explanation for what he was experiencing. She prevents communication breakdown and mitigates the conflict between them by validating and helping each one of the family members understand what the others are feeling. The therapist also expresses empathy for what they were experiencing, encourages them to problem-solve together, and provides positive feedback when they are able to regroup.

Summary

Parent Goal 3: Recognize the Child's Stressors

Do	Don't
• Tell parents they are your co-therapists	• Assume parents are aware of their child's stressors
• Identify child's stress signaling behaviors	• Speak about the child's stressors without the child's permission
• Encourage frequent checking in with child	• Underestimate parents' discomfort when they do not know what upsets their child
• Suggest how parents can talk with child about obvious stressors	• Schedule parent-child sessions before child is ready and willing to share openly with the parents
• Guide parents how to protect child from unpredictable stress	
• Help parents understand child's needs and stressors	

Parent Goal 4: Identify Family Stressors

13

Why Is It So Challenging?

This goal can be the most challenging part of the child's treatment for several reasons. Parents often feel guilty that they did not recognize that their child has a psychiatric and not a neurological disorder. They fear criticism of their parenting skills and how this might have contributed to their child's disorder. So opening themselves up and sharing family stressors with you are difficult for these parents. In addition, the parents of children with PNES are frequently not "psychologically minded."

The metaphor of peeling the layers of an onion in your work with the child also applies to your work with the parents. Because the child frequently is the one who informs you about the family stressors, it is therapeutically inappropriate to talk about them with the parents. In fact, in some cases, the parents' focus on the child's PNES symptoms allows them to avoid addressing some important family stressors. Therefore, you first help the parents manage their own distress associated with the child's PNES symptoms and diagnosis (Parent Goal 1). Their rapport with you and trust in you will strengthen in parallel to remission of the child's episodes. As the parents learn how to communicate with their child (Parent Goal 2), recognize the child's stressors (Parent Goal 3), and begin to help the child problem-solve (Parent Goal 5); they might slowly become more open to bringing up other family stressors with you.

How to Achieve This Goal

Work Slowly

It is essential to be sensitive to the parents' needs, avoid overwhelming them, and time your discussions with them about family stressors appropriately to prevent discontinuation of treatment.

R. Caplan et al., *Pediatric Psychogenic Non-Epileptic Seizures*,
DOI 10.1007/978-3-319-55122-7_13

Who Should Be in the Sessions?

Ideally both parents should participate in sessions for you to identify the family stressors. But sometimes it is beneficial to meet with each parent separately to fully understand what the family stressors are, each parent's perspective, how they have tried to deal with the stressors, what has not worked, and why. But be sure to always maintain a neutral stance and do not align with one parent.

Parent's Problem-Solving Strategies

Ask how the parents manage current problems by first focusing on the child with PNES, then on the other children, and subsequently on larger family issues. Find out what works and what does not work. Be careful about appearing to be judgmental when suggesting that they use a different problem-solving approach. Always ask the parents to describe how they feel about what you are suggesting and your input. In case they hide how they feel about this, be sensitive to their nonverbal communication, particularly expressions of discontent. Use these cues to help you encourage them to tell you how they feel.

Practice Good Communication

Let each parent air his/her opinions even if they differ from those of their spouse. Praise the parents both for discussing their problems and for their attempts to solve them. If their problem-solving approach involving the child does not appear to be effective, suggest alternative strategies that might be effective based on your knowledge about the child. Most importantly, help the parents develop ways of working together and supporting each other's attempts at parenting.

Dialogue: How to Help Parents and Child Identify a Family Stressor

S is an11-year-old boy treated for PNES for 1 year. His episodes remitted after the first 3 months of therapy with occasional subsequent episodes. A month prior to his PNES diagnosis (not onset of episodes), S's grandfather, with whom he was very close, died. He was the oldest grandchild and was the favorite of both the grandfather and the grandmother. About 8 months after the grandfather's death, the grandmother started dating and married 2 months before the session below. Since then, she has had very little to do with her two daughters and their families, including the patient. In individual sessions, S has frequently brought up the topic of his grandmother and vacillates from feeling rejected to immediately stating that she has to live her life. S has mentioned that his mother on the one hand is sad but on the other hand justifies her mother's actions and that they should not be upset at the

grandmother. The repetitive nature in which S brought up the topic and the therapist's sense that his mother was not allowing him to grieve the loss of his grandmother's attention (the important therapeutic goal of verbalizing negative emotions) suggested a need for the family session presented below. The comments are in the blue (therapist), yellow (S), green (mother), and orange (father) bubbles.

Therapist: I thought it would be a good idea to have a family session today to get a sense of how everyone is doing.

Mother: We're fine. S has had no episodes.

Father: Yes, I would say S is doing pretty well.

DENIAL

DENIAL

NEUTRAL OPENING AS PARENTS AVOID TALKING ABOUT PROBLEMS

Therapist: And how do you feel about everything S?

S: Okay.

DENIAL

MODELS GOOD COMMUNICATION, INCLUDES S, PROBES FOR FEELINGS (CHILD GOAL 1)

Therapist: I understand that there have been quite a few changes in the family with grandmother's marriage. What's her husband like?

Mother: Okay.

S: She stopped working.

VERBAL CUE THAT GRANDMOTHER HAS TIME

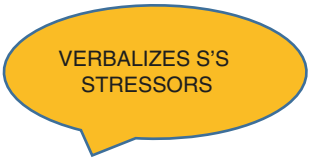
INTRODUCES POTENTIAL FAMILY STRESSOR WITH NEUTRAL QUESTION

Therapist: S used to sleep over at her on weekends and do fun things with her.

Mother: Well, she doesn't have time for that anymore.

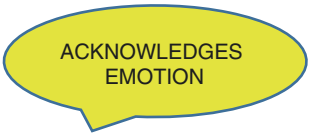
VERBAL CUE OF ANGER

INTRODUCES S'S STRESSOR IN NEUTRAL MANNER



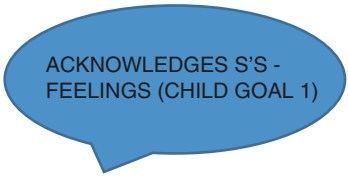
Father: He has lost grandfather and now grandmother.

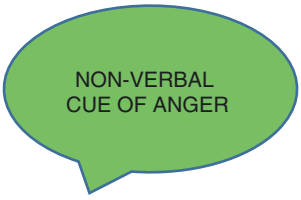
S tears up.



Therapist: S this makes you sad.

S nods.



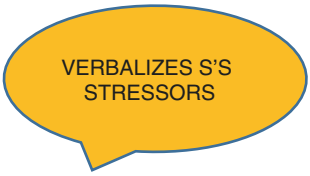


Mother rolls her eyes: But she now has economic security.

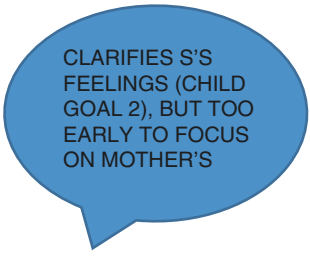
Therapist: Does that mean that she was in bad shape financially after your father's death?

Mother: Not really, and she knows that we could have helped her, if needed.

Father nods.



Therapist: So it sounds like that you appreciate her need for economic security, but it looks like this is hard for S.



Father: You need to understand. S was grandfather and grandmother's favorite. He had a special relationship with each of them and now has lost them both.

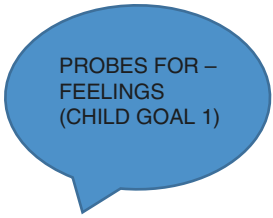
S starts to cry.

Therapist: I know that is hard for S but how about both of you, especially mom?

Mother: I'm fine. My sister is having a bad time because my mother was supporting her financially, and that has stopped.

S: Auntie told me she cries all the time.

Mother: Well she needs to get her act together and learn how to cope.



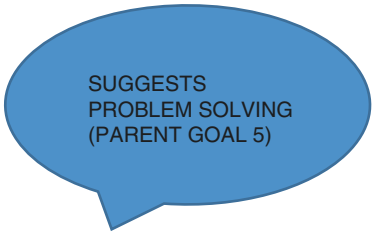
Therapist toward mother: It sounds like you have a lot on your plate and how you feel about your mother distancing herself from you all.

Mother: Yes, but we have to move on. There is no point dwelling on this.

Therapist toward both parents: Have either of you tried to speak to grandmother about how S is feeling about all this?

Father: I have and she said she would try and see him Friday's after school. But that hasn't happened.

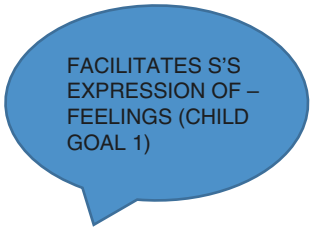
S tears up again.



Therapist: S, it looks like you really are missing grandmother.

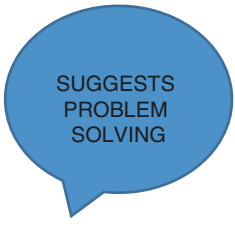
S: Yes, but she has to live her life.

Mother nods. That's right. There is nothing we can do about it.



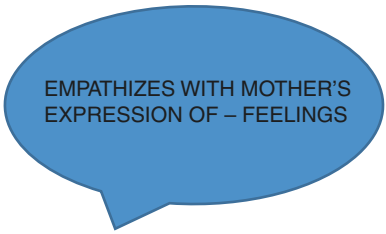
Therapist: Did you try to talk with your mother and let her know how bad you feel about this?

Mother: I tried but she doesn't want to hear this and have this conversation.

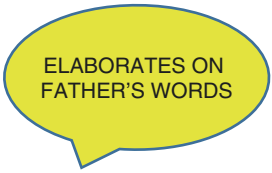


Therapist: That's hard.

Mother nods.

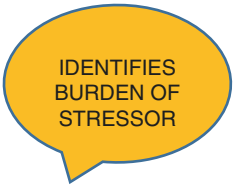


Father: What makes things worse is that grandmother is spending time with her new husband's grandchildren but not with the children of her daughters.



S: That's not okay. She can find time for us and for them.

Mother: Well, that's not happening and we need to move on.

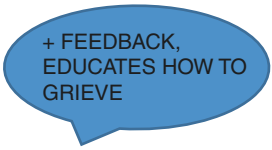


Therapist: It sounds like you all have a lot of hurt feelings. I understand the need to move on because there appears to be no choice. But it's hard. It takes time for the sadness and anger to go away. You are still dealing with grandfather's passing, and now you have all the feelings that grandmother's behavior has caused.

Mother nods.

Father: Yes it hasn't been at all easy for my wife and definitely not for S.

Therapist: But it is very good that you can come together as a family and grieve together. That helps, talking about the sadness, the anger, and other feelings all these causes.



Mother: Father and I talk about it a lot, but we don't want to burden S.

Therapist: I understand. But if you share your feelings with S that lets him know that it is okay to talk about this and share his feelings with you.

Mother: Hmm, we didn't realize that. S we are here for you. You know that. We can all be sad together.

S smiles.

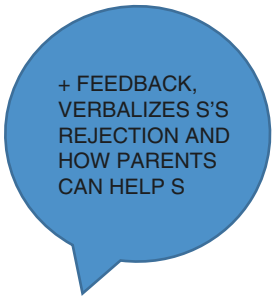
Father: That's right. Whenever you want to talk about this, we are here.

Therapist: You all have been very helpful in sharing how you feel with S and letting him know that he can speak about his pain and feelings of rejection by grandmother with you.

Mother smiles.

Father smiles: Thanks, this has been very helpful.

S smiles.



Comment: Being aware of the mother's avoidance of expression of feelings from sessions with the child and previous sessions with the parents, the therapist cautiously and gradually probes into the family stressor. She ignores the parents' denial and uses S's nonverbal expressions of sadness and mother's verbal cues of her negative feelings to slowly identify the stressor. She then gently suggests possible problem-solving approaches. The smiles and father's "thanks" at the end of the session indicate that she achieved the goal.

Summary

Parent Goal 4: Identify Family Stressors

Dos
• Ensure parents understand that child's psychological health is your focus
• Encourage both parents to participate in sessions
• Ask parents to discuss family problems
• Model active listening and communicating in session
• Always obtain parents' feedback to ensure they are comfortable with your understanding of the stressors they describe
• Praise parents for sharing their problems and problem-solving efforts
Dont's
• Allow parent sessions to become couple therapy
• Align with one parent against the other

Parent Goal 5: Help Child Problem-Solve

14

Problem-Solving Techniques

In addition to the techniques described below, section Helpful Hints for Parents of Chap. 15 presents important additional tips for how parents can also be coaches for the cognitive behavioral therapy (CBT) of comorbid anxiety and depression common in children and adolescents with PNES.

Conducive Ambience

It is important that the parents understand that they can help the child problem-solve only if they are calm and have ample time to discuss the problem. If either the parent or child is worried that the problem cannot be discussed calmly, suggest a child-parent session to understand the problem, and jointly explore appropriate problem-solving strategies. *But* make sure that both the child and parents feel comfortable discussing the problem in a family session. To help you achieve this goal, prior to the joint session, inform the parents of your goal for the session and parental responses that will create an environment and ambience that support your and their efforts to help the child problem-solve.

R. Caplan et al., *Pediatric Psychogenic Non-Epileptic Seizures*,
DOI 10.1007/978-3-319-55122-7_14

How to Help the Child Problem-Solve

Encourage the parents to empathize with the child about the problem and how difficult it can be to work through it. Suggest that the parents normalize and model problem-solving by sharing methods they use to deal with their own problems, such as:

- They should first "blow off steam" and use strategies to relax and calm down.
- When they are unsure on how to problem-solve, they should ask for advice.

The parents should give the child positive feedback for sharing the problem, talking about it calmly, and trying to problem-solve.

How to Address Parent-Child Problems

As described in Parent Goal 3 on communication, remind the parents about the importance of active listening and observing the child's verbal and nonverbal communication cues that might reflect the child's difficulties and stressors, including those involving the parents. If the child pushes one of the parent's buttons, the parent should let the child know that he/she will address the issue later. However, if the child needs an immediate response, the parent should delegate the responsibility to the uninvolved spouse/partner who can calmly deal with the problem. The parents should compliment the child if the child is willing to disengage following button pushing.

Emphasize the importance of praising the child rather than only making corrective statements (as most parents typically do) about the child's problem behaviors. Help the parents develop reasonable expectations for the child's schoolwork/interests given the child's strengths and difficulties.

Parents Should Advocate for Their Child

This not only helps the child problem-solve but also models an important problem-solving technique for the child. For example, the child insists on taking accelerated classes, but cannot keep up. Work with the parent's on how to advocate with the school to modify the courses and/or help the child understand that those classes might not be appropriate.

Consistent Parent Behavior

It is essential for the parents to be consistent in how they respond to their child's positive and negative behaviors.

Work on Family-Related Problems

Marital conflicts might underlie or reflect different parental approaches for managing the child's episodes and for dealing with the child's stressors. This might result in parents using inconsistent strategies when managing these problems. Help the parents work though these conflicts. However, if the marital conflicts continue to affect the child's progress during treatment, recommend that the parents go for couple therapy. Do this cautiously and *only* if they are open to getting help; otherwise, they might stop their child's treatment.

For conflicts between the siblings, help the parents establish ground rules for how to manage arguments and fights between their children. Where possible, they should problem-solve in a positive manner when negative interactions occur between their children. Work with the parents to support the individual interests of all their children and avoid favoritism and excessive attention to the child with PNES. Ensure that they facilitate one-on-one time with each family member, including between the parents.

Summary

Parent Goal 5 Summary: Problem-Solve

Parents play an important role in helping their child problem-solve adaptively

Helpful strategies you can teach the parents include:

Calm **ambienc**e

Consistent parenting

Active, sensitive **listening** to the child's perspective on his/her problem

Empathy for child's problem-related stress

Normalization of problems

Modeling of problem-solving

Praise for when the child asks for help and tries to problem-solve

Advocacy for the child

Addressing marital and other **family conflicts**

Cognitive Behavioral Therapy (CBT) Treatment of Anxiety Disorders and Depression in Pediatric PNES

15

How Common Are Anxiety and Depression in PNES?

Anxiety is one of the most common mental health problems in childhood and adolescence with prevalence rates ranging from 6 to 20% [1]. The anxiety disorders include agoraphobia, panic disorder, specific phobia, separation anxiety, social anxiety (including selective mutism), and generalized anxiety disorder. These disorders are frequently unrecognized and untreated in childhood [2, 3]. Anxiety disorders are common in children with PNES, but there is very little data to indicate how commonly they occur. In a recent multi-center study, 83.6% of children with PNES also met criteria for an anxiety disorder [4].

Major depressive disorder (MDD) is also a frequent mental health problem especially in adolescence [3]. It is estimated that 2% of children and 4–8% adolescents have experienced an MDD with males and females having similar rates in childhood and females having higher rates in adolescence [5, 6]. Studies have demonstrated that approximately 5–10% of children and adolescents experience subsyndromal symptoms of MDD [6]. Rates of MDD in PNES are not known, but the recent study by Plioplys et al. [4] also reported that 43.6% of the 8–18-year-old PNES sample had depressive disorders. Similar to the general child and adolescent population, older age and female gender increased the risk of having both depression and PNES [4].

In many children and adolescents, anxiety disorders and depression occur before the onset of PNES and often remain after the NES symptoms are treated [7, 8]. As a result, it is important to recognize anxiety and depression as commonly occurring problems in children and adolescents with PNES.

Among the different types of psychotherapeutic or psychosocial interventions, exposure-based CBT has the most empirical support for treating children and adolescents with anxiety disorders. But, it is of utmost importance that you identify if and when is the most appropriate time to address these PNES comorbid conditions with CBT. This will depend on the child's response to the interventions to reduce PNES episodes, level of resistance, learning style, and rapport with you. It may be

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appropriate to try to incorporate CBT elements only after the child clearly understands and accepts the relationship among negative emotions, stress, and NES symptoms. As mentioned in the tips to treating PNES in Fig. 5.1 of Chap. 5, children with PNES, particularly those with learning difficulties, are often resistant to what might appear to them as "homework." Therefore, it is imperative that you introduce CBT at a much slower pace than would be typically utilized in a 10–12-week anxiety or depression CBT intervention protocol. If the child demonstrates nonverbal or verbal cues of discomfort or resistance, back off until you feel the child will benefit from CBT. Evidence-based protocols can be helpful to you, but you will need to carefully modify the timeline, order, and manner in which you introduce the CBT skills (see Appendix M for CBT resources).

Evidence-Based CBT in the Treatment of Anxiety Disorders and Depression

In CBT, the clinician or therapist helps to teach the child adaptive coping skills and introduces practice opportunities (exposures) to develop coping techniques or skills to overcome the anxiety symptoms or situations that increase stress and impaired functioning. There is compelling evidence that children with anxiety disorders have a better treatment responses compared to adolescents. There appear to be neurodevelopmental changes in the brain that facilitate learning in childhood and disrupt the acquisition of new learning in adolescents [9]. There is also evidence that children with anxiety disorder have even better outcomes if a multimodal approach is utilized, and CBT is introduced in combination with a selective serotonin reuptake inhibitor (SSRI). Combined CBT and sertraline, an SSRI, has the highest response rates (80.7%), whereas CBT alone produced response rates (59.7%) similar to those of medication alone (54.9%) [10].

CBT is also recommended for depressive disorders in children and adolescents although its efficacy is not as strong as has been demonstrated in anxiety disorders [6]. Therefore, in children and adolescents with severe depression, antidepressants are indicated as soon as possible [6]. Psychotherapy can be introduced at the same time as medications are started or at some point afterwards. In adolescents, the response rate for combined CBT and SSRI treatment was 67% compared to 38.6% for usual care [11]. In children with depression, however, the evidence for CBT is less compelling as few clinical trials have been conducted in this age group (See review in [11]).

Treating Anxiety Disorders in Children and Adolescents

This section briefly describes the essential elements or key factors that have been deemed to be the most important when treating anxiety disorders in children and adolescents. It also explains how CBT works and what CBT components work better than others.

Eisen and Silverman [12] reported that cognitive restructuring and relaxation training produced similar reductions in anxiety. Silverman et al. [13] also found that skills training and contingency training reduced anxiety symptoms. More recently, Nakamura et al. [14] found that exposure tasks were important for achieving treatment gains. Peris et al. [15] recently attempted to determine the essential components of CBT in the treatment of anxiety disorders using data from a large-scale treatment trial (Child/Adolescent Anxiety Multimodal Study; [10]). The authors hypothesized that relaxation training, cognitive restructuring, and exposure would be imperative to reach treatment goals. Two techniques clearly contributed to treatment outcomes, and these included exposure and cognitive restructuring. These techniques reduced symptoms of anxiety and were linked to improved functioning. Relaxation training did not appear to significantly contribute to the reduction in symptoms of anxiety or change the course of treatment.

Cognitive Restructuring

This CBT element is comprised of multiple building blocks which ultimately teach the child or adolescent to identify and begin to conquer the thoughts that facilitate the production of anxiety responses or feelings of anxiety.

Thoughts and Feelings

First, it is important to teach the child and adolescent about the relationship between thoughts and feelings. There are a number of examples that have been used to introduce this relationship. Wagner [16] suggests using the example of "noise at the window." If there is a noise at the window at night, a child's emotional response depends on what the child thinks caused the noise at the window. This, in turn, will determine how the child feels about the noise. If the child believes it is a robber or thief, the child will be terrified and likely fear for his/her safety. If the child thinks that the noise is only a branch rustling outside, the child may briefly notice the noise and fall quickly to sleep.

Identifying thoughts and feelings seems like a simple task. But it is often a difficult concept for many children and adolescents with anxiety disorders to understand and learn. In the context of PNES, this is particularly difficult because these children typically have problems identifying negative feelings. In addition to the suggestions how to probe for emotions in Chap. 5, several simple exercises can help the child with PNES identify thoughts and feelings related to positive or negative feelings. See the following examples.

- What would you think if the teacher called you to the front of the room? What are some thoughts that would run through your mind?
  - Am I in trouble?
  - What did I do wrong?
  - Maybe I made a good grade, and the teacher wants to use my paper as an example?

- What are some feelings that might be connected to those thoughts?
  - Sad
  - Mad or frustrated
  - Very happy to finally have my work noticed by the teacher!

Once the child begins to recognize the relationship between thoughts and feelings, it is important to have the child monitor and identify the thoughts associated with anxiety or negative feelings. This is also a difficult task because many children and adolescents have never considered that their thoughts are associated with their feelings of anxiety, fear, and worry. It is helpful to begin to teach the child how to stop and catch the thoughts that appear before the feelings of anxiety. This can be a game that is played in the session and at home by asking, "What were you thinking just before you became upset?" and "What is the most distressing thought that you have?" Also, anxiety thoughts often occur quickly, almost automatically, so a child might need to make a play-by-play, moment-by-moment notation of all possible thoughts that may or may not be associated with anxiety. Suggest that the child use these questions in the context of keeping a daily thought diary, cutting out pictures of faces and scenes from a magazine to practice identifying possible thoughts and feelings, or even drawing simple figures using "thought bubbles" to identify potential thoughts.

Once the child begins to identify thoughts, it is important to teach the child a number of different techniques in order to help replace, restructure, reframe, and challenge the child's anxious and distressing thoughts. These techniques include, but are not limited to, Socratic questioning, social skills training, and problem-solving.

Socratic Questioning: It is difficult and unproductive to tell someone to stop having anxious thoughts. Socratic questioning allows the therapist or parent to address the anxiety directly without avoiding the distressing thoughts associated with the anxiety. Children with anxiety often do not challenge their thoughts or conduct reality testing to see if there is indeed a real possibility that something catastrophic will happen. Socratic question can often facilitate the process of examining anxiety from a different perspective and to determine if the information the thought provides is valid.

Examples of Socratic questions:

- What is the worst thing that could happen?
- What else could happen?
- What is the likelihood that this outcome would happen?
- What is the evidence that this is something that everyone will notice?
- What if it really happens?
- What could you do to change it?
- How beneficial is it for you to have that thought?
- Is that thought helpful?
- Does anxiety tell the truth?

Problem-Solving Skill Development: We often assume that children and adolescents implicitly learn to become problem-solvers with little explicit instruction. The truth is that many of them struggle with problem-solving skills. To restructure and change thoughts and perceptions that are anxiety laden, it is necessary to

identify possible solutions. Just thinking that things will be better or that they are not a cause for worry does not always make it so. Problem-solving allows the child or adolescent to deconstruct the thought or scenario and identify the core factors that the child can change or modify. Consider applying these techniques to your work on Child Long-Term Treatment Goal 5 (see Chap. 9 and Appendix L).

Problem-solving (adapted from [17])

- What is the problem? State the problem.
- What would make the problem better? Write down all ideas no matter what they are.
- What can you do to fix it?
- What else could you try?
- What else can you do? What else can be done?
- Who can help you with this problem?
- What would make this problem go away?
- Rank order your possible solutions to the problem!
- Keep trying each solution until the problem is solved!

Social Skills Development: Children with anxiety (and those with PNES) might lack social skills. Anxiety might also present in social contexts—asking questions in class, meeting new kids, finding a place to sit in the cafeteria, ordering at a restaurant, talking on the phone—just to name a few. A child needs to develop social skills in order to address fears related to social interactions via exposure tasks. Provide the child with opportunities to practice social skills in different situations to help the child acquire a key skill set.

Social skills

- Describe feared social situation.
- Identify the core fear or belief.
- Review possible scenarios or outcomes.
- List possible ways to cope with feared social situation.
- Practice before implementing—write-out or talk-out scenarios, rehearse with family, and rehearse in session.
- Discuss what to do if it all goes bad—one cannot promise that someone will not be rude.
- Provide scenarios that are small steps to the real-life situation that is feared.

Dismantling the Anxiety System—False Alarms and Avoidance: Anxiety is hardwired in each of us as part of our "fight or flight" fear system. When an anxiety disorder is present, this fear response system goes haywire. It acts like a car in a parking lot with the alarm sounding off when no one is nearby or like the smoke detector going off in the middle of the night because the battery is dying. There is no actual danger. When the anxiety alarm goes off, anxious negative thoughts occur almost simultaneously, and often there is a physical response that occurs. The heart rate may increase, breathing becomes shallow, sweating occurs, and even stomach upset might set in. These responses are similar to the physical symptoms described

in Goal 4 of the child long-term treatment (see Chap. 8 and Appendix H). This system functions to move us out of dangerous situations. But in anxiety disorders, the system overresponds and provides false information.

Naturally, children and adolescents believe the anxiety system without question when it begins to sound the alarm that they are in danger. However, in anxiety disorders this system is no longer trustworthy. This idea is a difficult one for children and adolescents to comprehend because past experiences have confirmed that their thoughts and body know when there is "real" danger. They also assume that their body would never trick them. Investigating the physiological or somatic responses of children with PNES, as described throughout this treatment guide, is important to demystify this relationship. Just because the worried thoughts appear at the same time as the body's response (stomach upset, sweaty palms, trouble breathing, etc.) does not mean that they are real (see Appendix H). To help demystify the implications of these physical symptoms, suggest that the child check his/her heart rate, run up a flight or two of stairs, and then recheck the heart rate. The child can see that the child is able to induce physical symptoms (increased heart rate and sweating) similar to those that occur when the child experiences anxiety. But the child does not worry when this physiological experience occurs, and nothing bad happens.

Somatic symptoms or physical complaints are often associated with the initial presentation of anxiety—my stomach hurts, my head hurts, or I feel nauseous—so I cannot go to school or complete a task. This is the first step in establishing the path of avoidance in children with anxiety, and it occurs early in the development of PNES. Avoidance is very effective. It works right away. A child worries or fears going to school, presents with a stomach ache, stays home, and avoids confronting the fear. Once this cycle starts, it is quite difficult to override.

Furthermore, as described in the other chapters of this treatment guide, avoidance never solves the problem. It is an integral part of the trickery of anxiety. It tells the child to avoid the situation because it is dangerous. But there is no danger. Because of avoidance, the child or adolescent does not learn by experience that the fear was false information. Avoidance does not help a child develop coping or problem-solving skills when situations go awry. Life is unpredictable, but we learn to cope with sudden changes or unexpected experiences and develop resilience as part of this process. If a child repeatedly avoids problematic or difficult situations and scenarios, the child does not develop the skills needed to problem-solve. A vicious cycle develops in which fear of situations leads to avoidance which, in turn, exacerbates the fear. The child does not have the opportunity to learn that the information the anxiety conveys to the child is wrong. As a result, the child does not develop coping skills to deal with stressful situations.

Exposure—Practice Confronting Anxiety: In the treatment of anxiety disorders in children and adolescents, exposure appears to be an essential element [15]. It involves confronting fears, anxiety, and worry. The principle of habituation is used to describe the mechanism that makes exposure effective. For example, if the child jumps into a lake or pool to swim in early summer, the child may feel quite cold. However, once the child bounces around in the water for several minutes, the

child gets used to it—the child habituates. Initially, when the child faces her fear, she may feel nervous, have sweaty palms, and her heart may be racing. Once she perseveres and follows through with the anxiety-producing task, the body works through the "feared unpleasant physiological response," and the child overcomes the fear or habituates.

Why is Exposure Important?

- Avoidance strengthens anxiety because the child does not gather contrary evidence.
- It teaches the child that anxiety is transient and not terminal.
- Exposure reveals that anxiety is not trustworthy.
- The child begins to understand that anticipatory anxiety is worse than the anxiety in real time.
- Anxiety will reduce over time following exposure.
- Exposure can demonstrate how strong and resilient the child really is.
- The child learns to face the biggest fears after having a little practice—exposure builds skills and confidence.

Chapters 5–14, describing the goals of PNES treatment, include CBT concepts for treating anxiety disorders, such as aspects of cognitive restructuring (Child Goals 3 and 4) and problem-solving (Child Goal 5).

Treating Depressive Disorders in Children and Adolescents

This section briefly describes the essential CBT elements or key factors for treating depressive disorders in children and adolescents [11].

Cognitive Restructuring

Similar to anxiety disorders, cognitive restructuring is an essential component of CBT for the treatment of depression. Depressed individuals have negative thinking that is directly related to their negative mood. Negative thinking reduces the child's ability to attempt tasks or consider other possibilities or options. To teach a child and adolescent the concept of cognitive restructuring, you need to be creative. Using techniques described under Child Long-Term Treatment Goals 1 and 2 in Chaps. 4 and 5, respectively, helps the child identify thoughts that have negative or distressing feelings associated with them. Thinking traps [17] or as Chansky [18] calls them—"thinking errors"—are thoughts that are much like the default settings on a computer or electronic device. Unless these default settings are changed, distressing thoughts produce two or three fixed response sets. Table 15.1 presents some of these types of thinking and their treatment.

Teach the child with PNES and depression to view a situation or circumstance from different perspectives and/or to consider different possible outcomes. By

Table 15.1 Thinking traps/errors and their treatment

Thinking traps/errors	Description	Challenge thinking
Catastrophizing	• Jumping to the most disastrous conclusions with no evidence • Predicting the worst outcome so that a small spark of a problem becomes a huge unstoppable wild fire • Assuming that this is an uncontrollable disaster	• Slow down thinking • Identify the actual scope of the problem • Come up with alternative ways to think about the situation
Mind reading	• Absolutely convinced that people are thinking or saying bad things about the child • Believing that people dislike her or think she is dumb • The child is not dissuaded from this thought or belief	• Find evidence for what people are actually thinking/saying about the child • Provide alternative explanations for a person's response or a particular behavior
All or none thinking	• If I cannot be the best, win, or make the highest grade, then it is not worth it at all to take a risk • I am the worst player or student or friend	• Have a more balanced view of skills and abilities • Reduce the use of always, everything, never, or all the time
Wearing horse blinders 	• Only seeing one point of view • Perceiving only the negative • Ignoring information or facts • Not seeing the entire picture	• Identify and examine additional information • Step back and get a wider view of the situation • Examine all the facts
The repeater	• It happened once so it will happen again—that is guaranteed • The outcome will always be the same	• What is the evidence that this will happen again and again? • What experience or what situation is this belief based on? • Is this really the same situation?

developing different perspective taking skills, the child will build alternative responses to the traps that so easily develop in thinking, limit the child's negative experiences, and promote a negative view of the world.

These common thinking errors can shape a child's view and result in avoidance in the following ways:

- Not trying an activity unless the child will be the best!
- Generalizing that if it happened once it will always happen!
- Expecting the worst! Bad things always happen and good things never happen!
- Exaggerating the impact of an event or circumstance.
- Blaming self—it is my fault!
- Not tolerating when things go wrong.

Correcting the child's errors in thinking is an important step in reducing the negative consequences of this type of thinking. You can accomplish this by helping the child determine the actual cause of the error in thinking, not exaggerating or over generalizing from one time to always. Also, ask the child what this will mean to the child in a week, month, or year.

Behavioral Activation

In adolescents, more so than in children with depression, withdrawal from friends, family, and daily activities is not uncommon. Depressed adolescents will often withdraw to their rooms and be increasingly self-focused. They may drop out of extracurricular activities and refuse to go to school. Others may attend school but drop any social interactions. Additionally, their postings on social media may reveal desperation in their thinking and provide a glimpse into the potential extent of their depressive symptoms.

One intervention that appears to be beneficial is increasing pleasurable activities or behavioral activation. The mere experience of having a positive interaction oftentimes helps the adolescent experience some level of pleasure. Positive outcomes allow for a window of hope in the adolescent's ongoing hopelessness and desperation. The idea or concept behind behavioral activation is that pleasurable activities by their nature can reverse a depressed mood because positive feelings and thoughts occur in this context. They provide alternate experiences for the child or adolescent with depressed mood. Provide a list of potential pleasurable activities to the adolescent, as in Table 15.2. Alternatively, suggest that the adolescent generate a personal list of pleasurable activities that is relevant to him or her.

Establish daily goals. But initially, it may be a challenge to have the adolescent participate in any pleasurable activities. So, suggest weekly instead of daily goals. Encourage the adolescent to start small and have attainable goals. When feeling depressed, the adolescent may have no energy or desire to go do an activity outside of the home or with anyone other than family or close friends. If this occurs, pleasurable activities like taking a bath or watching a favorite movie may be the only attainable prospects.

Table 15.2 List of pleasurable activities

Activity	Date scheduled	Date completed
Take a long bath		
Go to a movie		
Binge watch on Netflix		
Have lunch or dinner with a friend		
Take time to read for pleasure		
Listen to music		
Spend a few hours with a friend(s)		
Walk		
Do yoga		
Go dancing		

Helpful Hints for Parents

Parents of children with anxiety, depression, and PNES often are unsure how to help their child or adolescent. They frequently feel as if they have tried *everything* but *nothing* worked. Parents often ask, "What can I do to help my child or adolescent?" When treating anxiety and depression, it is important to educate the parent or caregiver about the purpose and techniques used in CBT, why they are important, and the essential CBT elements—cognitive restructuring, exposure, and behavioral activation.

The purpose of this section is to help you add to the parents' skill set, described in Chaps. 10–14, so that they can guide the child during CBT, a process that is not always easy for the child. But this is contingent on resolution of child-parent conflicts. Involvement of one or both parents in this role should not exacerbate past problems between the child and parents due to parents nagging (or getting angry with) the child to do things the child avoids.

Most importantly, parents should be able to encourage and reinforce new coping strategies in the child or adolescent. When they apply successful strategies to help their child learn new coping strategies, they, in turn, gain more confidence. The child needs to be prepared to cope with future life stresses and to handle these situations in a positive and productive manner with love and support from their parents, family, and friends.

What follows are important points to give to the parents to help them understand ways in which to provide the child with assistance, guidance, and coaching. They complement the techniques suggested for your work with the parents in Chaps. 11–14). Be sure to inform the parents that some children and adolescents apply these new coping techniques right away, and other children may have to have several sessions before they begin to implement what they are learning as a part of their CBT-focused sessions.

Modeling

Parents play a pivotal role in helping their child learn to apply coping strategies and problem-solving skills so the child can manage daily stressors. Improved coping reduces anxiety, depressive responses, and problem behaviors. Children

mimic how their parents respond to or behave in stressful situations. It is important that parents demonstrate non-anxious, positive coping. When the child's anxiety rears its ugly head, they should have a planned response how to react to the child.

Consistency and Structure

Consistency and predictability are often important to an anxious child. Anxious children and adolescents frequently also benefit from structured events rather than unstructured experiences. So, guide parents on how to inform their child of changes in the schedule before and as they occur.

Positive Experiences

Advise parents how to create positive experiences for them and their child or adolescent, such as having breakfast together, taking 10 minutes to listen to the child talk uninterrupted, or playing the child's favorite game. This experience should not be contingent on the child's good behavior. If promised, the activity should occur regardless of unwanted behavior.

Positive Feedback and Rewards

It is difficult for anxious or depressed children to confront anxiety, fears, worries, and sadness. Help the parents establish rewards for the child's brave and courageous behavior when trying to confront his/her difficulties. The rewards do not have to cost anything but must hold value for the child.

Do Not Reward Unwanted Behavior

It is very easy for parents to unintentionally reward unwanted behavior. This typically occurs before parents realize that it happened. For example, if they allow their child to watch TV or play video games on days of school refusal, they reinforce missing school with pleasurable activities. Additionally, providing reassurance repeatedly increases overall attention of the child and ultimately reinforces anxious behavior. When the child is aroused or distraught, the parents should limit communication with the child. Interactions with the child at this point only increase disruptive responses and make the fire grow out of control. They should only engage with the child when the child is calm.

Encourage Problem-Solving Skills

As described in Chap. 14, parents can help the child develop active problem-solving skills (see Chap. 14 on Parent Goal 5 How to Help the Child Problem-Solve). Preferably, they should do this in situations that are somewhat stressful. This allows the child to practice these skills before needing to apply them in more distressing situations.

Encourage Use of Self-Calming Strategies

When a child becomes reactive and distressed, the child needs to identify ways to reduce stress. The child has to learn to utilize self-calming strategies like deep breathing (see Appendix D), progressive muscle relaxation, and mindfulness

activities to face a stressful situation. As noted above, if parents help the child practice these calming strategies in less stressful or no stress situations, self-calming becomes more automatic and part of the child's second nature.

The parents might have difficulty using some of these approaches. Give them the checklist in Fig. 15.1, and find out what they think does and does not work for them. Also, remind them, that like their child or adolescent, they too should practice these techniques so that they can better help their child.

Fig. 15.1 Checklist of suggested parent responses

Summary

Anxiety disorders and depression commonly co-occur in children and adolescents with PNES, often before onset of NES symptoms and after their resolution
CBT is effective in the treatment of pediatric anxiety disorders and adolescent depression but less effective in depressed children
Determine if child with PNES can benefit from CBT based on: • The child's progress in therapy and understanding/acceptance of the relationship among negative emotions, stress, and NES symptoms • The presence of a learning disorder and resistance to doing CBT "homework" • Unresolved parent-child conflict
Essential components of CBT for anxiety disorders include cognitive restructuring and exposure. Start with low-anxiety exposure tasks to gain confidence Essential components of CBT for depressive disorders include cognitive restructuring and behavioral activation. Avoid thinking errors and stay active!
Parents are role models/coaches for the child's daily application of CBT after resolution of child-parent conflicts

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What Have You Learned and Where to Now?

16

What Have You Learned?

Although PNES is rare, the high morbidity and long-term psychiatric, psychological, and medical implications for untreated youth underscore the need for early diagnosis and treatment to stop the episodes and, most importantly, to treat the underlying psychopathology. This treatment guide has provided you with the most relevant clinical details needed to correctly diagnose, give feedback, and thoughtfully and sensitively treat children and adolescents with PNES. Armed with this knowledge, you are ready to start working with these patients and their parents. The experience you acquire through your work will help you acquire expertise in the treatment of youth with PNES.

How to Work with Children with PNES

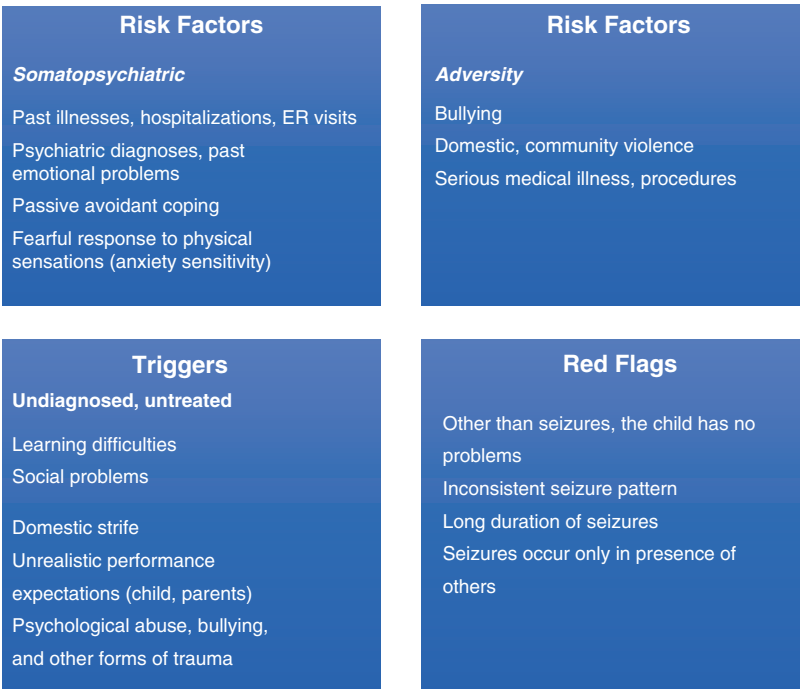
- The ABCs below of PNES treatment list some of the main therapeutic elements you should keep in mind.

  A Always remember to ask the child, "How does/did that make you feel?"
  B Behavioral approach effectively controls NES symptoms.
  C Cues, care/careful, clarify, coping, and CBT are important C techniques.
  D Distress in the child and parents due to episodes needs to be explored.
  E Empathy helps the child and parents talk.
  F (+) Feedback facilitates communication between the child-you, parents-you, and child-parents.
  G Generate and tailor strategies that encourage the child to talk about (−) emotions, stressors, problems, and difficulties.
  H Humor helps facilitate communication.
  I Incrementally and gradually work on linking stressors, (−) emotions, and NES symptoms.
  J Judgment about information child or parents share with you can cause resistance.

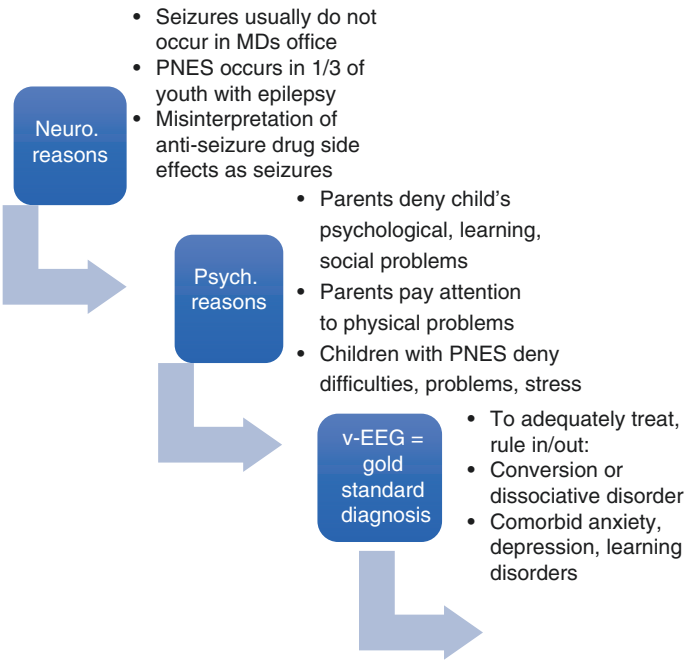
R. Caplan et al., *Pediatric Psychogenic Non-Epileptic Seizures*,
DOI 10.1007/978-3-319-55122-7_16

K Know how to prevent resistance by well-timed and sensitive interpretations of (−) emotion-stressor-NES symptom link.
L Little by little you will achieve long-term treatment goals.
M Model how to express (−) emotions and problem-solve.
N Normalize experiencing stress and (−) emotions, having problems or difficulties, and the challenges of problem-solving.
O Obtain the child's permission to share information with the parents.
P Premature linking of stressors → (−) emotions → episodes and will cause resistance.
Q Question to understand before reaching conclusions and making premature interpretations.
R Rapport with the child and parents is essential.
S Storytelling is a great technique with younger children.
T Time when you make interpretations wisely.
U Understand and help parents and child prevent and undo communication breakdowns.
V Validate information the child shares using (+) feedback and clarification of what the child says.
W Work on understanding the child and parents' verbal and nonverbal cues.
X Xerox (copy) these ABCs for your therapy tool box.
Y Your willingness to work with these children and their parents fills an important treatment gap for a highly morbid disorder.
Z Zoom ahead using sensitive treatment skills.

- Youth with uncontrolled seizures who present with any of the following risk factors, triggers, and red flags might have PNES.



- The diagnosis of pediatric PNES is challenging.



HOW to Overcome Diagnostic Challenge?

Separate child, parent interviews

Comprehensively assess all psychiatric diagnoses

"What?" "How?" + follow-up validation, not "Yes/No" questions

Empathize with child to encourage information about stressors, problems, and difficulties

Give + feedback for any problem-related information child provides

Normalize stressors, problems, difficulties, (-) emotions

- The multidisciplinary team should prevent doctor shopping as a result of their feedback on diagnosis and treatment by:
  - Tuning into what the parents are open to hearing
    - Psychiatric/psychological or medical disorder
  - Providing separate feedback about the diagnosis and treatment plan to the parents and child
  - Avoiding pitfalls by:
    - Clearly stating that the child is not faking
    - Leaving time for parents' questions
    - Scheduling a follow-up session to ensure parents accept the diagnosis and treatment plan

- Tables 16.1 and 16.2 include the short-term treatment goals, the child long-term treatment goals, some recommended techniques, and treatment settings.

Table 16.1 Short-term treatment goals and location

Goals	Details
Psychoeducation about PNES	Child
	Parents
	Epileptologist/neurologist, primary care physician
	School staff
Development of rapport	Enables child and parents to accept diagnosis, engage in the therapy, and prevent doctor shopping
PNES symptom control	Behavioral approach
	Parent's role is essential
Reestablishment of regular life routines	Child returns to school once symptom control begins
	Teamwork with school ensures reintegration, episode management at school, intervention for learning difficulties, catch-up of missed schoolwork
Treatment settings	
Outpatient	Most children with PNES
Inpatient	Uncontrolled seizures
	Recurrent and prolonged school absence
	Severe comorbid psychopathology
	Abuse risk at home
	Uncooperative parents
Partial psychiatric hospital program	Unsuccessful school reintegration
	Lack of or poor outpatient treatment response
	Severe comorbid psychopathology
Medical/rehabilitation facility	Child and/or parents are rigidly invested in medical diagnosis and treatment

Table 16.2 Child long-term treatment goals, techniques, and tips

Child goals	Techniques	Tips
Recognize, identify, and monitor emotions	Probe, acknowledge emotions, particularly (−) emotions	
	Identify, monitor emotions	
	Note nonverbal and verbal discomfort cues	
	Model expression of (−) emotions	
	Enhance emotion and body awareness	
Identify stressors		**C**s to Remember
	Map stressors	**C**ues
	Use storytelling	**C**oping
	Revisit child's worries, dislikes, difficulties	**C**are/careful
	Provide + feedback, empathy when child verbalizes (−) emotions, stressors	**C**larify
	Lay adaptive coping building blocks	

Table 16.2 (continued)

Child goals	Techniques	Tips
Verbalize emotions associated with stressors		**COMFORT** acronym
	Empathize when child expresses (−) emotions and stressors	**C**reate safe, holding environment for stressors and (−) emotions
	Probe for, acknowledge, facilitate expression of (−) emotions and stressors	**O**ffer (+) feedback for verbalization of stressor and (−) emotions
	Identify, respond to nonverbal/verbal discomfort cues suggesting a stressor	**M**odel how to express (−) emotions
	Provide (+) feedback for verbalization of stressor and (−) emotions	**F**acilitate description of stressors and (−) emotions
	Clarify child's description of stressors and feelings to ensure you understand	Use every **O**pportunity that child expresses-emotions
		Maintain **R**apport by being respectful of child's struggles
		Tell the child that (−) emotions are normal
Connect (−) emotions to NES symptoms		Only when child can:
		• Identify stressors
		• Talk about (−) feelings
		• Understand stressor (−) feelings link
Problem-solve	Ultimate therapy goal	
	Sensitively time when and how to suggest problem-solving	
	Introduce from early in therapy but back off if child resists	
	Help child figure out problem-solving strategies	
	Teach child how to ask for help	
	Praise child for each problem-solving attempt	

How to Work with the Parents

Your parallel work with the parents is essential to attain the child's short- and long-term therapy goals. And, it frequently is more challenging than the work with the child. Remember to pay attention to the points highlighted below.

Goal 1: Revisit how parents manage distress during child's NES episodes—If parents talk about and manage their distress during episodes, they will be able to apply the behavioral approach needed to stop the episodes. Most importantly, they should model relaxation for the child, tell the child they will be in an adjacent room until the end of the episode, and refrain from paying attention or talking with the child if they remain in the room with the child. They should also minimize attention

to mild physical symptoms frequent in these children, such as headache, stomach ache, and discuss how to handle moderate symptoms with you and the primary care physician.

Goal 2: Understand and facilitate family communication—Help parents communicate positively with their child on neutral topics that interest the child rather than on the child's neurological symptoms, problems, and difficulties. Encourage them to share some of their own difficulties with the child (if developmentally appropriate and not overwhelming). Positive feedback, listening without interrupting, multitasking, and/or abruptly changing the conversation topic encourage positive communication. When communication breakdown occurs, parents and child should disengage and reengage once they have had a chance to calm down. Joint child-parent therapy sessions can help them learn how to problem-solve during communication breakdowns.

Goal 3: Recognize the child's stressors—Remind the parents, that as your co-therapists, they should inform you of both positive and negative changes in the child's behavior as well as stressors they become aware of. Help them understand what stresses the child (with the child's permission) and how to avoid or prevent unnecessary stress to the child. When the child's stressors involve parent-child relationships, schedule joint child-parent sessions only with the child's agreement. Make sure that both the child and parents can deal with this without unnecessary escalation in the child-parent and parent-parent relationships.

Goal 4: Identify family stressors—This is a difficult goal to achieve and might only occur later in therapy after resolution of the child's episodes and once the parents perceive marked improvement in the child's behavior. To prevent parents being defensive, clarify that knowledge about family stressors is relevant because most children react to what happens in their immediate environment. Empathize with their difficulties, and avoid premature interpretations of what the parents might perceive as criticism of their parenting skills. Also, do not align with one parent, as this could lead to parent resistance and end the child's therapy.

Goal 5: Help child problem-solve—Parents play an important role in helping their child problem-solve adaptively. To do this effectively, they should try helping the child problem-solve when they are calm and able to sensitively listen to what the child is complaining about. This is particularly hard when the parent-child relationship is the main source of the problem. They should empathize with the child, and praise the child for asking for help or sharing the problem with them. Parents can model how they problem-solve when faced with difficulties. They also need to learn to advocate for the child if the child cannot do it alone. Joint child-parent sessions can model problem-solving for the parents and child and are especially helpful for child-parent conflicts.

Cognitive Behavioral Therapy (CBT)

Although anxiety disorders and depression, typically treated with CBT, commonly occur in pediatric PNES, carefully weigh if the child with PNES can benefit from CBT based on:

- The child's progress in therapy, specifically his/her understanding and acceptance of the relationship among negative emotions, stress, and PNES.
- A learning disorder might lead to resistance when you give the child CBT "homework."
- Unresolved parent-child conflict can hamper the parent's role as a CBT coach.

Essential CBT components for anxiety disorders include cognitive restructuring and exposure, and those for depression are cognitive restructuring and behavioral activation.

Where to Now?

Being equipped with this knowledge, you are ready to start evaluating and treating youth with PNES. There are several things you can do to consolidate your skills so that you will feel confident in your work with these children and their parents. Videotape your sessions with the child so you can pick up on missed subtle cues the child communicated to you or that you might have inadvertently expressed to the child during the session. Consider doing the same with the parent sessions and joint child and parent sessions. Supervision from an expert in the field for your first few cases can help improve your level of confidence with these challenging patients and their parents. Contact the authors (R. C., J. D., and J. J.) to obtain referrals for a local supervisor. Ultimately, children with PNES and their parents will most probably be your best teachers! And, most importantly, your willingness to work with these children and their parents fills an important treatment gap for a highly morbid disorder.

Appendix A: Educational Resources About Pediatric Psychogenic Non-Epileptic Seizures (PNES)

Websites

http://www.neurokid.co.uk/

Webinars

Non-epileptic Seizures in Children. What Parents Want to Know. Epilepsy Foundation of America, February 2012. http://connect.epilepsyfoundation.org/p72985712/?launcher=false&fcsContent=true&pbMode=normal.

Website Articles

Pediatric NES: Information for Children. http://www.epilepsy.com/epilepsy/newsletter/june10_PENS
Pediatric NES: Information for Parents. http://www.epilepsy.com/epilepsy/newsletter/june10_PENS

Website Video

How to Accurately Diagnose, Treat Conversion Disorder in Youth. http://www.healio.com/psychiatry/pediatrics/news/online/%7Bc1d096d1-9621-4925-9be5-cd8ccbd9c123%7D/video-how-to-accurately-diagnosis-treat-conversion-disorder-in-youth

R. Caplan et al., *Pediatric Psychogenic Non-Epileptic Seizures*,
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Appendix B: Example Letter for School

To whom it may concern:

I am writing to provide a brief overview of the clinical condition and educational needs of [patient]. [Patient] has been diagnosed with non-epileptic seizures, which are episodes that can look like seizures but are instead the body's reaction to coping with negative emotions and stress. These episodes are not medically dangerous; therefore, [patient] does not need medical intervention during or after the episode. It is important that all individuals interacting with [patient] closely follow the non-epileptic seizure behavioral response plan in order to best manage these episodes at home, at school, and in the community. The response plan will help those caring for [patient] to provide a safe environment and allow [patient] to return to normal activities as quickly as possible.

This letter is meant to assist school staff in responding to [patient's] non-epileptic episodes and is not meant to provide general recommendations for other behaviors or medical conditions that [patient] may have. Please refer to the non-epileptic episode response plan that was provided when working with [patient] to manage her non-epileptic episodes. The following are abbreviated recommendations:

If [patient] is having a non-epileptic episode (as described in her plan) do not call 911 or send her to the hospital unless you believe the episode to be significantly different from her prior episodes and/or she is not breathing adequately.

Follow the response plan provided.

Help [patient] to use breathing exercises (see attached handout) until she loses awareness.

If [patient] has lost awareness, help her to stay safe, do not hold her, or touch her unless you are trying to prevent her from falling or injuring herself. Moving to a safe quiet place should ideally be done prior to the student losing awareness (such as a quiet hallway, nurse's office, adjacent empty classroom). Once the student has lost awareness, it is not recommended that she be moved.

Do not continue talking to [patient] once she has lost awareness.

R. Caplan et al., *Pediatric Psychogenic Non-Epileptic Seizures*,
DOI 10.1007/978-3-319-55122-7

I recommend evaluating [patient] for an IEP or a 504 education plan with a goal to develop necessary educational accommodations to help (patient) to successfully transition to a full time school schedule. A one-on-one paraprofessional could help with the above and allow teachers/staff/students to carry on with their work during the (patient's) episodes at school. This is often a temporary need, but can be more easily provided when the student has a formal education plan in place.

Additional accommodations may be helpful, and I am happy to help advise you about additional supports.

Thanks you for your help, and please contact me if you have any questions.

Thank you.
Name of provider, Degree

Appendix C: Mindfulness and Relaxation for Parents

Mindfulness

The parents of children with PNES need to deal with the child's episodes and other problem situations in which they need to help themselves by calming down, distracting themselves, or coping with the challenging situation. Mindfulness, a state of awareness about one's thoughts and feelings, can help them achieve this goal. Advise parents to try to "tune-in," tell you, or write down the range of emotions they feel, what conditions they arise in, what they think when they experience these emotions, and how their body reacts:

Scared	• My heart is racing
	• I can't sit still, I feel like I need to race around
Helpless	• I can't help her, but I feel like I need to comfort her
	• I cry
Angry	• I raise my voice
	• I storm out of the room
Happy	•
	•
Embarassed	•
	•
Disappointed	•
	•

Application to PNES

Once the parents have completed the above exercise, ask them to start considering PNES-related scenarios:

1. How do you feel when your child has an episode?
2. How do you feel when you and your spouse do not agree on the approach to treat PNES? What happens when you feel this way?

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DOI 10.1007/978-3-319-55122-7

Relaxation

When something scary or frustrating is happening, it can be very difficult to relax. This is especially true at the beginning of PNES treatment when your child is still experiencing distressing symptoms. One of the best ways to help your child learn to relax during an episode is if you show the child that you try to do it even though you are feeling distressed when your child is having an episode. Here are some simple suggestions to try both during an episode and at other times when you feel overwhelmed, worried, or angry:

Breathing

When your child begins to have a PNES episode, it is important to ensure that the child is in a position that he will not get hurt, and then walk away to other side of the room or into an adjoining room if possible.

1. Get into a comfortable position.
2. Focus your attention on how you are breathing. If you are breathing rapidly or you feel your heart racing, try to focus on calming your mind by closing your eyes and on taking in a very deep breath through your nose.
3. In order to slow your breathing, count slowly in your mind for about 4 or 5 seconds. To ensure you are breathing deeply count like this "1001, 1002, 1003, 1004, 1005.
4. Once you have taken a full breath in, hold your breath for a second before exhaling through your mouth.
5. As you exhale, count from 1001 to 1005 as above, to ensure that you are getting all the air out of your lungs.
6. Start over.

Do this cycle as long as you need until you feel relaxed and your child has stopped having an episode.
Remember!
Your child is safe. You are only a short distance away. And your child must work on his own calming strategies to reduce the duration of the episode and to prevent additional episodes.

Distraction

Despite your best efforts, it might be very difficult to calm yourself with breathing when your child is having a PNES or in other stressful situations. For some people, distracting yourself can be very helpful, while you continue to control your breathing. Try these strategies:

1. Walk. Movement of the body has been shown to help people in a stressful situation. Walk into another room, walk around that room, find something to focus your attention on while you breathe, and remind yourself that your child is going to be okay.
2. Close your eyes. Try to visualize something that is neutral. Thinking about a beach or another favored activity might help you feel positive in certain situations. But when you are worried about your child, this will be difficult. Instead, try to focus on something that you do not have any feelings about. Try to visualize a neutral place, a thing, or even an inanimate object while you continue to try to calm yourself through breathing.
3. Reinforcements. If you are alone, call on your spouse or another support to just talk with you while the stressful situation is happening.
4. Find something to do. You might have something close by that you can organize, something you can clean or even something that you might just play with in your hands (like a fidget object) to help give you something to do while you are calming.

Appendix D: Deep Breathing for Relaxation for Children/Adolescents

It is important to practice breathing so that when you are in a stressful situation you can help keep yourself calm. It may be surprising that just breathing can make you feel better, especially when you do it all the time, and do not even think about it! I am going to teach you a special type of breathing to use when you are feeling stressed.

1. If you can, lie down on your back. But if you are at school, you can do this in your desk chair.
2. Put your hand flat on your stomach. This will make it easier for you to tell if you are breathing the right way. You should feel your stomach rise and fall each time you breathe in and out.
3. Now, breathe in slowly through your nose with your mouth shut. If you can, count in your head up to five seconds (1001, 1002, 1003, 1004, 1005) while you breathe in. By counting slowly you avoid breathing fast and feeling lightheaded or dizzy.
4. After you have breathed in for 5 seconds, hold your breath for 2 seconds (count 1001, 1002 in your head).
5. Then start to breath out slowly, over 5 seconds count (10,001, 1002, 1003, 1004, 1005), through your mouth.
6. You have just finished your first relaxation breath. Now continue to breathe in the same way for about 5–10 min. You will slowly start to feel more relaxed. Some people even begin to feel sleepy, so try not to fall asleep if you are in class!
7. Once you have finished the deep breathing exercise, you can get back to what you were doing.

Remember, deep breathing is one way that you can reduce your feelings of stress. If you practice deep breathing at least twice a day even when you feel good, this will make it easier to use when you are not feeling good. Pretty soon, because the deep breathing will help you feel relaxed, you will need to use it less often.

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DOI 10.1007/978-3-319-55122-7

Appendix E: Tune In to Body Sensations

Prior to the PNES diagnosis, the child may not be aware of bodily sensations that precede an episode. But there often are signals in the body that can alert the child that an episode might be coming on. Initially, the child does not recognize this as a "warning," and will report that nothing precedes an episode or that everything happens all at once or quickly. Help the child slow this process down by inquiring about what the child remembers from the child's episodes. What are the physical sensations the child feels?

Here and Now Feelings

How does your body feel right now? What do you notice about your body?
Does anything hurt?
Is there any part that feels uncomfortable?

Once the child recognizes a feeling of some kind, ask if the child was aware of the feeling before you asked the child to think about his body. The child often says no. Help the child understand that if we are constantly aware of an uncomfortable feeling or pain, we would have a really hard time focusing on anything else. So, one of the things our body does is tune out information that is not important at that moment. Tell the child that the same thing often happens in PNES. The body tunes out the signs that an episode might start until the feelings become so intense that the episode just happens. Explain to the child that your goal is to help the child learn to identify those early signs that the body gives, and teach the body to be calm even while the symptoms occur.

How do you know (feel) you are calm? What does your body do? Do you slouch? Lay back?
What does your body feel like when you are excited about something? Do you notice a change in your body?
What about when you are a little nervous? Like before you go up in front of class to give a speech or before a big game (match, performance, test)?

As the child describes different bodily cues, explain that these are responses the child's body has automatically learned to do when things that happen to the child.

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DOI 10.1007/978-3-319-55122-7

But, if the child becomes more aware of these responses, the child can actually learn how to control them, especially responses that do not feel good or happen just before an episode.

For children who have a really hard time tuning into their bodies, walk them through the example below:

Ask the child to focus, use all senses, and ignore or remove distracting thoughts. Then, let the child to touch a piece of ice, smell a strong mint, or play with sand. Find out what the child feels or tastes and if anything feels uncomfortable or intense.

Once the child becomes more comfortable identifying physical sensations in various situations, request that the child think again about the episodes using all the child's senses and what the child remembers feeling. Inquire about common sensations during an episode, such as hearing people speak to or touch the child as well as feeling that his vision becomes hazy. Encourage the child to then think about what happens in the child's body just before an episode. If the child identifies any feelings during this pre-episode period, explain to the child that this will allow the two of you to work together to interrupt the episodes—an important step toward stopping the episodes.

Relaxation

The child is now ready for you to teach the child one or two brief relaxation techniques. (see Appendix D.) Encourage the child to practice relaxation with you. Clarify that the child should immediately use the relaxation strategy as soon as the child experiences physical sensation(s) prior to an episode. The more the child practices this technique, the easier it will be to teach the body to be calm as soon as the child starts to experience distress. Most importantly, this technique will help prevent the child's episodes.

Appendix F: PNES Response Plan

The medical and mental health team develops a response plan based on the individual child's specific needs. Each plan should include the presenting problem, a description of the child's episodes, as well as what to do during and after an episode. The example below walks you through these steps.

Presenting Issues

The attending neurologist working with XXX has determined that XXX has episodes of non-epileptic events that may look like seizures, but are not actually caused by abnormal brain activity. These events are not medical in nature and, therefore, do not warrant medical attention. They are also neither purposeful nor intentional and usually reflect difficulties coping with stress or anxiety. The mind causes the body to respond physically to these negative emotions, like the stomachaches or headaches some people experience when nervous or stressed.

It is essential that family members and school staff respond consistently to these non-epileptic events to minimize their impact on the child's daily functioning. This may require the child to leave class for short (10–15 min) periods of time during which she will miss some work. In the long term, these brief respite periods and the breathing exercises will allow the child to experience fewer events and will increase her ability to attend as many of her classes as possible.

Description of the Non-Epileptic Seizures

Increased stress precipitates XXX's NES events (episodes). However, they can occur at any time. They are infrequently linked to apparent stress or specific trigger. XXX's events often start with a headache in which she feels a stabbing pain that moves from her neck to the top of her head. She then feels that her heart is racing, and she often starts to hyperventilate (breathes fast). While hyperventilating, XXX frequently feels a tingling sensation in her hands and feet. She can usually hear and occasionally respond when experiencing these symptoms. After a variable period, XXX loses awareness and is unresponsive when people speak with her. Her parents

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also describe that her eyes roll into her head and she starts to shake. Several of these episodes evolve into full body shaking. She has also attempted to scratch herself and on one occasion tried to bite her mother who was trying to restrain her.
These episodes last from several minutes to a half an hour. When XXX has lost consciousness during these events, she has fallen, but has not hurt herself. Her parents described her falling slowly and has catching herself before she hits the floor. A headache and heart racing sometimes warn the girl that an episode is about to occur. When she experiences this warning, it would be appropriate to allow her to go to a designated area outside of class so she can apply the relaxation exercises. By doing this at home, school, or in another public setting, she will eventually be able to interrupt the longer events, return to her ongoing activities more quickly, and ultimately prevent the episodes.
But, XXX is still not always able to interrupt an episode. When an episode occurs, it is important to remember that these events resolve on their own without intervention and undue attention. Therefore, simply monitor XXX for safety, and allow the event to run its course. The table below summarizes the essential elements to include in the description of an episode.

Essential elements	Examples
Begin with physical sensations the child feels but others cannot see	Heart racing, pain in body, dizziness, tingling in extremities, feeling "strange"
Describe how an episode begins and evolves	Hyperventilation, loss of awareness, shaking of body or body parts
Note all physical signs during the episode	Laughing, crying, screams, staring, eyes rolling up, eyes open, eyes shut, hits, scratches
Report the time range for the duration of episodes	Seconds—minutes—hours
Include behavior after the episode	Immediate resumption of activities, appears confused

Response Plan for NES

1. If XXX is having an event or states that she is worried she may have one, talk to her briefly. Note if she can speak and respond to questions. This information can be helpful for her and her therapist. Briefly reassure and tell her what you are going to do as described below:

   - You are having one of your events. It's okay. You will be fine. Right now, you need some time to calm down. I will step away but stay close by so that you can have time to relax.
     Or
   - You are having an event, but you are okay and safe.

2. After this brief reassurance, **stop** interacting with her until the episode has stopped.

3. Ensure that she is in a position where she will not get hurt. Do not move her during an event because this draws attention to her situation and may increase her stress and anxiety. If she falls, keep her away from sharp objects, *and ensure her head does not hit a hard surface. D*o not place something in her mouth; she cannot swallow her tongue. But, avoid holding or restraining her during an event unless it appears that might injure herself. If XXX tries to scratch herself, give her something to hold on to.
4. If the episode occurs in class, and is brief, watch her closely but continue the class.
5. If other students are in the class, if possible, instruct them to return to their normal activities without interacting with her until the episode is over. Use language like, "XXX is having an event, but she is okay. Let's let her be, so that she can relax by herself."
6. If the episode occurs at home, everyone should leave the room. One person can monitor for safety, preferably from a distance or in the next room.
7. It is inappropriate to give XXX medications, send her away from class, call the paramedics, or encourage avoidance of certain activities after the episode.

What to Do After an Episode

1. Recall what happened just before the episode, and provide this information to the therapist.
2. XXX should resume "normal" activities as soon as is possible after the episode to minimize disruption to her daily life. Neutral, calm responses to these events by others will help her feel calm.
3. But if she appears stressed, worried, or fearful, she needs no more than a 10-min break before she resumes the activities that she was involved in.
4. Do not ask her to not participate in an activity because this undue attention can increase the likelihood of subsequent episodes when face again with this activity. Encourage her to engage in normal daily activities after an episode.

Appendix G: Checklist of Feelings

Some feelings are easy for us to express and others are much harder. Go through this exercise, and consider which ones are easy and how you typically express each emotion and to whom. Use the space under the emotion to write examples. You can do this with members of your family too. How do they express feelings? Which ones are harder for them?

- Happiness
- Excitement
- Frustration
- Worry
- Anger
- Jealousy
- Sadness
- Fear

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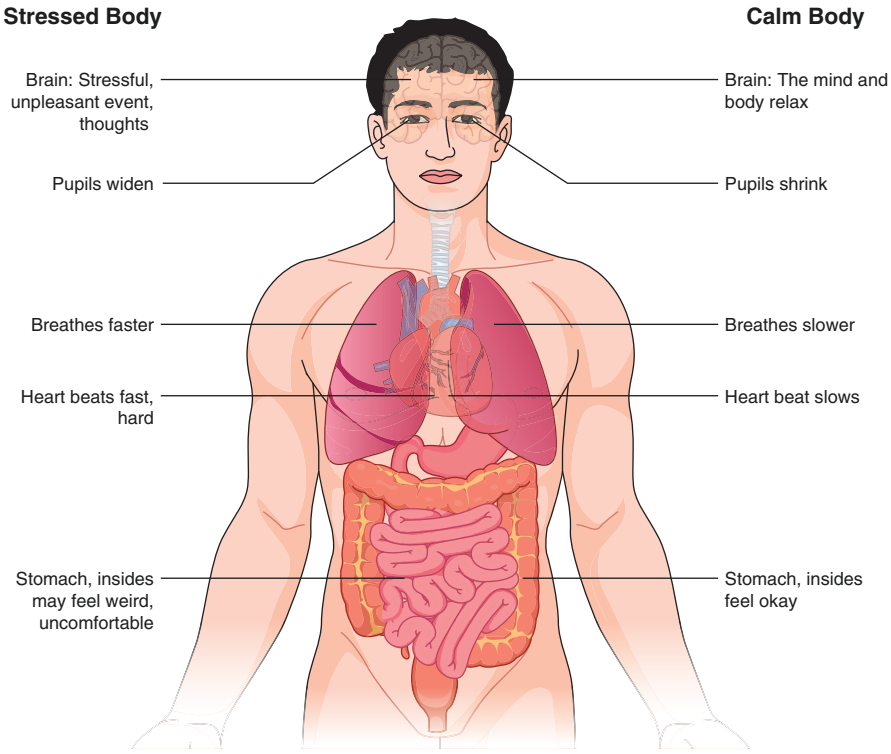
Appendix H: How My Body Feels



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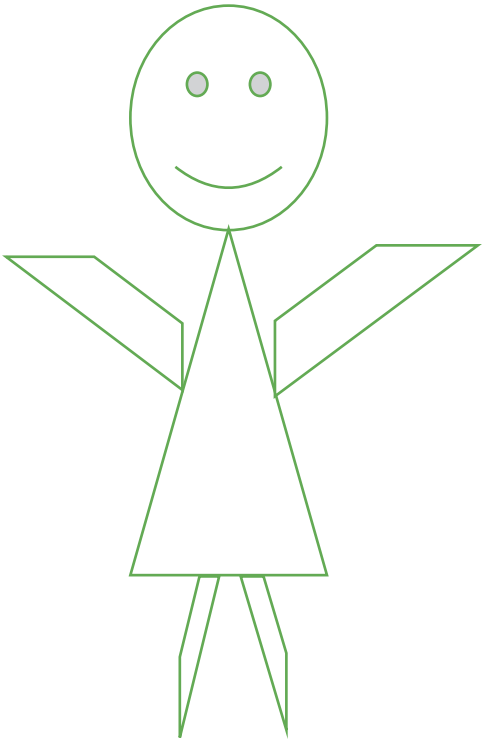
DOI 10.1007/978-3-319-55122-7

Appendix I: Draw How You Feel

Occasionally younger children find it easier to draw their feelings. Ask them to pick different colors to help represent certain emotions, i.e., blue is sad, red is angry, etc. Then talk about how they feel in response to certain situations and where in their body they feel it.



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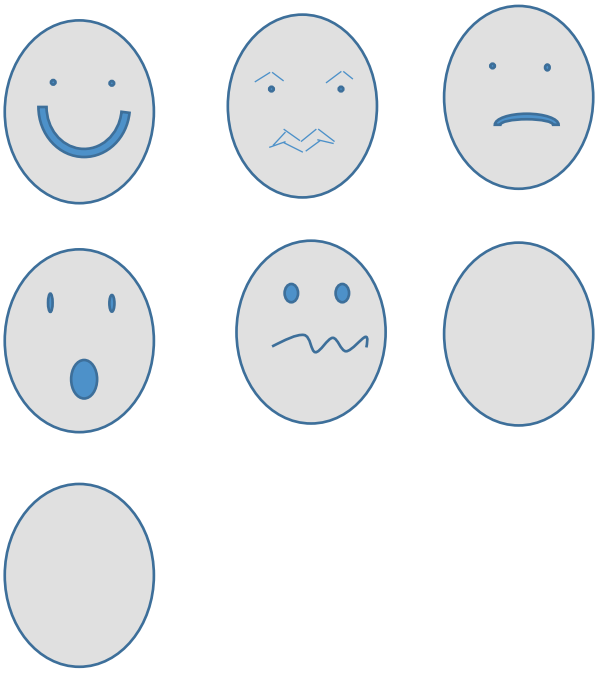
Appendix J: Feelings on Faces

Use the drawings below to ask the child to draw or choose a drawing that represents how the child feels when the child is talking about a difficult topic or having difficulty expressing how he/she feels.



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Appendix K: Checklist of Stressors

Some stressors are really easy for us to see and others are not. Look at the list below; do any of these seem stressful? If so, how much does it bother you—a little, a lot, or not at all? What are some stressors that are not on the list?

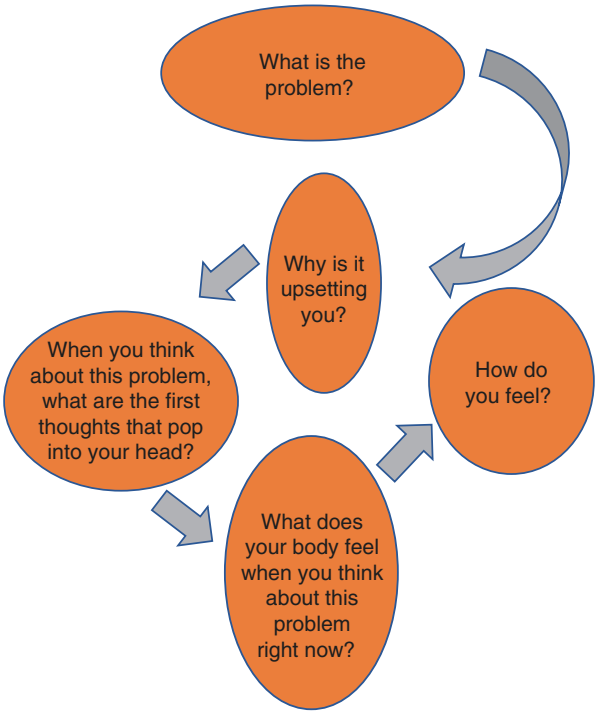
- School work
- Hard teachers
- Problems with friends
- Being bullied
- Problems with brother/sister
- Problems with parents
- Problems with extra activities like sports or clubs

R. Caplan et al., *Pediatric Psychogenic Non-Epileptic Seizures*,
DOI 10.1007/978-3-319-55122-7

Appendix L: Problem Solving

Step I: Define the Problem

Sometimes it can be hard to recognize how we respond to a problem, what we think about it, and how our mind and body react. Use this exercise to help child define the problem.



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Step 2: Problem List

Now that you have defined the problems, try to put them into big and small categories. Bigger problems might be ones that you think about more often or that affect how you feel much of the day. Smaller problems might bother you, but do not take up your thoughts a lot of or really effect how you feel. See the examples below.

My list of big problems	My list of small problems
1. I fight with my best friend	1. My sister is annoying after school and at night
2. I am failing a class at school	2. I scheduled two fun activities at the same time and can't do them both
3. My parents nag me all the time	3. I don't have time to watch TV

Step 3: What Are Possible Solutions for Each Problem?

Now that you have a list of problems, brainstorm about different ways that you might try to solve them. What has worked before? What have you tried, or what have other people that you know tried in these situations? Does your therapist have any ideas or examples of things other people have tried?

Big Problem #1 Solutions	Big Problem #2 Solutions	Small Problem #1 Solutions
• Seek advice from adult	•	•
• Write a letter expressing feelings	•	•
• Speak with friend		

Step 4: Create a Pros and Cons List

Creating a list for and against the possible solutions you just developed might help you feel more confident about using these ideas. Sometimes when faced with a problem, talk with someone about the reasons for and against your problem-solving ideas. This will help you determine which is the best way to solve the problem. If for big problem #1, fighting with best friend, the solution you came up with was to seek advice from an adult, the pros and cons are:

Pros	Cons
• Adult may have ideas you do not have	• Adult may give you advice that feels uncomfortable
• Adult might help you think differently about the solution	• Adult may not understand your concerns
•	•

Step 5: Create an Action Plan

You have defined the problem, come up with some possible solutions, and figure out how they might work. You should now develop a step-by-step plan to carry out the solution you developed. For big problem 1, fighting with best friend, see solutions below:

Solution 1: Speak with adult and get advice
Identified adult = Mom
Ask Mom for advice tonight after school
After hearing Mom's advice, determine if any of it can be done tonight
Solution 2: Write a letter to friend
Speak to Mom
After speaking with mom, write a letter to friend about fight and getting back together
Share letter with Mom, get advice about letter

Appendix M: Cognitive Behavioral Therapy (CBT) Resources

Chansky TE. Freeing your child from anxiety, revised and updated edition: practical strategies to overcome fears, worries, and phobias and be prepared for life--from toddlers to teens. New York, NY; 2014.

Chansky TE. Freeing your child from negative thinking. Da Capo Press: Philadelphia, PA; 2008.

Kendall PC, Hedtke KA. Coping Cat Workbook, 2nd ed (ages 7–13). Workbook Publishing, Inc.: Ardmore, PA.

Kendall PC, Choudhury M, Hudson J, Webb A. C.A.T. Project workbook for the cognitive-behavioral treatment of anxious adolescents (ages 14–17). Workbook Publishing, Inc.: Ardmore, PA.

Khanna MS, Kendall PC. Computer-assisted cognitive behavioral therapy for child anxiety: results of a randomized clinical trial. J Consult Clin Psychol. 2010;78:737–45.

Schab L. Beyond the Blues: a workbook to help teens overcome depression. Harbinger Publications, Inc.: Oakland, CA; 2008.

Shannon J. The Shyness and Social Anxiety Workbook for teens: CBT and ACT skills to help you build social confidence. New Harbinger: Oakland, CA; 2012.

Wagner A. Worried no more: help and hope for anxious children. 2nd ed. Lighthouse Press, Inc.; 2005.

R. Caplan et al., *Pediatric Psychogenic Non-Epileptic Seizures*,
DOI 10.1007/978-3-319-55122-7

Index

R. Caplan et al., *Pediatric Psychogenic Non-Epileptic Seizures*,
DOI 10.1007/978-3-319-55122-7