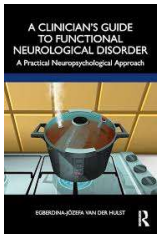
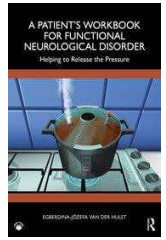


The role of psychosocial vulnerabilities in FND: Insights from the Pressure Cooker Model



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Introduction

- **The Pressure Cooker Model** (PCM; van der Hulst, 2023; van der Hulst, 2024) is a new biopsychosocial model for Functional Neurological Disorder (FND) and places heavy emphasis on the role of relationships and interpersonal processes in the emergence and maintenance of FND symptoms.
- According to the PCM, there is a **strong relationship** between the level of **verbal emotional expression and FND**. Emotional self-disclosures in a psychologically safe therapeutic relationship improve FND symptoms and outcomes (e.g. "Anna O's talking cure", Breuer & Freud, 1893; Bowman & Markand, 1999; Alsaadi & Marquez, 2005).
- In clinical practice, a phenomenon that is occasionally encountered in people with FND, is the **"unspeakable dilemma"** (e.g. Griffith, Polles & Griffith, 1998).
- The unspeakable dilemma refers to undisclosed personal (often highly sensitive) information that a person with FND might carry and keep to themselves.
- Release of the unspeakable dilemma risks rejection or ostracization; loss of important and meaningful relationships; "social injury"; and could even pose a threat to the person's psychological and physical well-being.

Aim

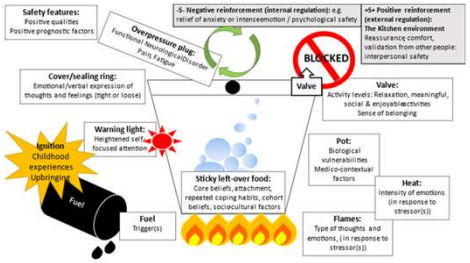
- The goal of the present case review was to highlight the impact of psychosocial vulnerabilities in the emergence and maintenance of FND in two patients with FND using the Pressure Cooker Model.

Table 1 – Demographic and clinical characteristics (n=2)

Variable	Patient 1	Patient 2
Age	39	38
Gender	Female	Female
Main symptom	Motor weakness	Motor weakness
Other diagnoses	Emotionally Unstable Personality Disorder	Social Anxiety Disorder
Length of stay	6+ months	6 months
Therapy duration (individual & group)	40 hours	23 hours
Liaison with other professionals	21 hours	7 hours
PHQ-9	-	Pre: 7, Post: 15
GAD-7	-	Pre: 10, Post: 5
HADS	-	Pre (anxiety): 5 Pre (depression): 6

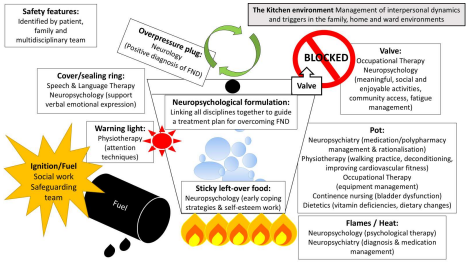
Method

Figure 1 - The Pressure Cooker Model of FND



Neuropsychology was embedded within the wider multidisciplinary and nursing rehabilitation teams:

Figure 2 – The multidisciplinary treatment of FND



Hypotheses

If both patients' FND symptoms are maintained by a reduced ability to **internally** regulate emotions (step 1), and **externally** regulate psychosocial vulnerabilities (step 2), then focusing treatment on addressing both emotion regulation problems and alleviating the psychosocial vulnerabilities will be key to improving FND symptoms. For this to happen, a person will be able to:

(1) Express the unspeakable dilemma, as well as the associated emotions, within a safe psychological space, on a regular basis [tight cover is opened]

(2) Additionally, regulate emotions via alternative means, e.g. through enjoyable activities and social connection [valve unblocked]

(3) Remove the "social functions" of FND [kitchen clean-up].

(4) …which will subsequently reduce the risk of developing or experiencing FND symptoms [no need for using the "overpressure plug"; see Figure 3]

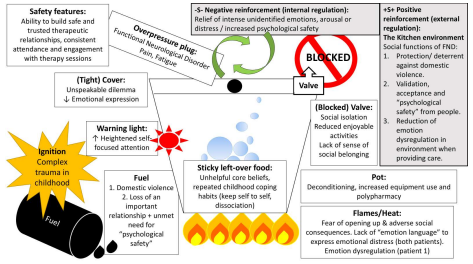
Results

•After an initial period of limited progress, both patients made positive gains, particularly after developing psychologically safe therapeutic relationships with staff members, and within those relationships, forming an ability to regularly express their emotions and release their unspeakable dilemmas (e.g. domestic violence and the loss of an important relationship).

•Multidisciplinary treatment for both patients was characterised by a psychosocial approach including:

1. Practical support from a social worker (safeguarding) to address domestic violence and potential repair of an important relationship.
2. Encouragement of social connection, relationship building and community links at the discharge destination.
3. Reduction of barriers through "SMART" goals for social connection and supporting the patients to "act on" the plans using behavioural experiments/activation.
4. "Absence" of the patients from their original social environment, away from interpersonal triggers for FND.
5. Practice of assertiveness skills to manage boundaries in day-to-day interactions with family. Family meetings for FND education and to address unhelpful dynamics (patient 2).

Figure 3 – The Pressure Cooker Model applied to patient 1 and 2



Outcomes

•Both patients regained their ability to walk independently: patient 1 mobilised fully unaided, whereas patient 2 used minimal equipment for longer distances.
•In addition, both patients no longer experienced severe social isolation and participated in activities of daily life, including personal care, simple and complex meal preparation, community access and social activities on and outside the ward.
•Subjective reports and behavioural observations suggested improved mood and continued engagement in both patients, as well as the absence of unhelpful behaviours (i.e. deliberate self-harm) and spontaneous suggestions for social activities (as opposed to avoidance/ withdrawal).

Although patient 1 experienced some episodes of tearfulness, and patient 2 demonstrated elevated scores on a mood questionnaire, this was deemed "progress" given the patients' newfound ability to express emotions (in contrast to "dissociation"). Emotions did not impact on rehabilitation and were appropriate in response to the stressors (i.e. transition to the home environment).

Conclusion

- FND symptoms were maintained by psychosocial factors. Patient outcomes in rehabilitation were strongly influenced by the active management of psychosocial vulnerabilities.
- It is imperative to include "psychosocial aspects" and "the system" in FND treatment, especially if patients experience persistent symptoms or a "relapsing-remitting" course.
- The Pressure Cooker Model is a helpful framework for systemic formulation and treatment for FND.

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Acknowledgements

Thanks to both patients who kindly shared their information and provided informed consent for the case studies. In addition, thanks to the wider multidisciplinary and nursing teams from St George's University Hospitals and South London and Maudsley NHS Foundation Trusts.