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The psychotherapeutic aspect of psychic trauma in epilepsy

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Abstract

Background: The management of epilepsy can be reviewed in a multidimensional way, medical, psychotherapeutic, familial and social. In this regard, we are talking about the position given to the patient suffering from epilepsy. From a psychopathological point of view, there is a system of interactions between crisis and personality based on confusional anxieties, related to ambiguity and the feeling of crisis for the subject. The psychotherapeutic understanding of the patient suffering from epilepsy is situated in a bio-psycho-familial and social context. Whether it is the first, the second, or the next crises, they point out that there is an intrapsychic trauma.

Conclusions: System of interactions between epilepsy, the patient and the environment contributes to the creation of the framework that will provide opportunities to help the patient. Psychotherapy sessions allow the patient to reintroduce the crisis in his history. The description of psychological experiences that are associated with the evolution of epilepsy symptoms, will allow us to form an idea about the influence of psychic trauma on the clinic and the dynamics of epilepsy, which could help identify an approach to the patient's adaptation.

Key words: epileptic seizures, psychic trauma, psychotherapy.

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Introduction

The child builds his inner world by integrating his experiences and surroundings. Depending on the age of onset of the first seizure, epilepsy more or less disrupts this process [1]. If most people with epilepsy feel completely normal outside of seizures and the number of seizures can be reduced, then some patients (about a third of the total number) are severely affected by their disease. They can be affected by the repetition (high frequency) of epileptic seizures, but also by the physical, psychological and social consequences that they involve, which makes their life impossible in their normal environment [2].

Epilepsy alters parents-children and social interactions. The function of doctors is not only to cure the disease, but also to take into account all the surrounding factors (social, family, school) to facilitate the harmonious development of the sense of identity [1]. Caelius Aurélien points out that "Epilepsy takes its name from what captures both the senses and the mind" and draws consequences [3].

Before discussing the issue of epilepsy, it is worth considering how the child is psychologically constructed. Referring especially to the work of Anzieu (1995) "Le Moi Peau", it can be said that the mind derives from the body. Thus, the child builds his inner world by integrating his own experience and the experience of his environment. Epilepsy

in childhood is a source of difficulty, since it is responsible for intermittent or permanent neurological dysfunction, which will disrupt the messages in the body and will disrupt the internalization of bodily sensations. The earlier the epilepsy begins, the more severe the disorders, sometimes leading to arrest or even regression of psychological development [4].

When it comes to identifying landmarks, one must consider the time of onset of epilepsy. A disorder at an early age will not have the same effects as when the disease occurs in a person who has already developed a balanced personality. The fusional relationship of the mother with the child will be paralyzed by the existence of seizures. To this, we must add that the child evolves in a system that, from the beginning, occurs only with the parents and becomes more complex as he grows up. Every day we notice the importance of parents' narcissistic satisfaction with their child when he is well and, in the mirror image, the jubilation of the child who is identifying himself with parents or other images of the entourage. These interactions, so important for the correct development of mental development, can be disrupted when epilepsy occurs [5,6].

At this time of the announcement of the diagnosis, regardless of the severity of the disease and whatever the child's age, parents ask themselves: is my child's epilepsy a source of suffering? Is it a failure? A fatality? Or is it for me,

the parent, the opportunity for an individual and emotional experience? If the parental couple is united and if the professionals who will take care of the child agree to take all the necessary time to accompany them in an authentic way, then they will be able not to fall into depression, they will be able to overcome the pain. They will be able to be with their child, what Beauchesne calls "supportive parents" [6].

In the process of the psychotherapeutic approach to epilepsy, it is essential not to talk about epilepsy, but about people with epilepsy, who are the subject of their seizures. In this sense, we are talking about the place given to the patient suffering from epilepsy to allow him to express himself and others to strive to listen to him. At the family level, it is, in fact, desirable to listen to the fears and anxieties caused by crises. The information should allow the family to avoid extreme attitudes, both excessive protection and unjustified rejection [7,8].

Psychotherapy sessions allow the patient to reintroduce the crisis in his history and the opportunity to make sense of it. It is equally dependent on another system of interactions between epilepsy, the patient and the environment. The family and social approach to epilepsy contributes to the creation of the framework that will or will not provide opportunities to help the child to mentalize and conflict with what he or she is experiencing and has so many difficulties in understanding [9-11].

Results

Epilepsy is one of those unfavorable circumstances, that is a source of suffering, of rejection; it is responsible for the difficulties encountered at school; brings prohibitions, limitations in daily life; it can finally be the cause of the child's total impasse. It is possible to oppose the care, to manipulate treatments or result in total passivity [12,13].

We also notice disorders in the psychopathological field. Most often, they are related to the anxiety generated by the disease. Symptoms of depression are very common; this changing mood can turn into the severe depression with the risk of suicide or an exacerbation of risky behavior. Hyperactivity that is often associated with epilepsy in childhood becomes a severe obstacle and deserves specific management [14, 15].

Entering adolescence is also a delicate time in the development of the child with epilepsy. The child knows that he is ill; he has learned the limits imposed by the disease, the constraints that it brings. He feels guilty that he is ill and is responsible for his parents' suffering [16, 17]. All this weight becomes unbearable in adolescence when there is a search for a new identity with the desire for autonomy and the desire to transgress the limits imposed by his usual environment. On the other hand, non-epileptic manifestations can also appear during this period, the adolescent not knowing how to "exist" in the eyes of his environment, other than with convulsions [18, 19].

The work of the psychotherapist allows to pay attention to early symptoms and to "decentralize" what is cruci-

al in epilepsy problems. For Gilbert Diebold, a physician, psychiatrist and psychoanalyst, a member of the French League Against Epilepsy, epileptic seizures often have a precise meaning, which must be taken into account to heal the patient. The suffering of living, the presence of death, this confusion must be revealed in order to be able to express the inexpressible convulsions [20].

Lucien Mélése releases, from his long years of psychoanalytic practice with people with epileptic seizures, a theory of critical phenomena that justifies what the clinic has brought: a possibility of dismantling the "neurological storm" machine, returning the family story and especially the genealogical one. The theory of trauma, history and genealogy constitutes the essential background of these neurological manifestations. Re-appropriation of patient's transfer during the analysis often allows the subject to develop a way out of this nightmare. Epilepsy becomes the model of the crisis (fear, flight, non-existence) for any treatment practice, especially in the psychosomatic field [21].

It is common for a child with epilepsy to experience his first seizures after the psychological trauma endured [22]. Mourning will be found in a huge number of observations. In the process of working with the child who is experiencing epileptic seizures we need to consider three key points: the subjective experience of convulsions by the child; their representative value of unconscious phenomena; their special psychosomatic quality. Since the epileptic seizure occurs in a state of unconsciousness, it is possible to think that it is driven by unconscious factors [23].

As Ferenczi described the return to motor behavior and a resolution of consciousness, in which the individual finds his prenatal state and his postnatal emotion in a regressive movement, the phenomenon referring to "birth trauma". Ferenczi offered us a psychoanalytic interpretation of epilepsy, based on the hypothesis of a regression to embryonic state; therefore, he postulates the existence of a memory persistence of this extremely passive degree, although he does not relate it to death or to the death instinct. Under this high patronage, it is justified to formulate the idea that the loss of consciousness, which is one of the major manifestations of many clinical forms of epilepsy, refers to the negative experience during intrauterine life and the child's fantasy of non-existence related to his prenatal experience [24].

Clinical case study

Patient S. was first consulted at the National Center for Epileptology, when he was 14 years old. He was sent to the consultation after being hospitalized six times for epileptic seizures. Treatment with anticonvulsant drugs was ineffective at that period. S. continued to have seizures with a frequency of about twice a week. According to his parents, S.'s epilepsy could result from neurosurgical intervention. It was difficult to establish any contacts with S. He ignored the people around him.

The attitude of his parents was special: they expressed their concern about epilepsy, but, on the other hand, com-

pletely denied the pathological behavior of S. The anamnesis showed that S. was a child whose birth was eagerly awaited. The mother's pregnancy went well. Parents reported a decrease in his development after the onset of the first seizure, which occurred at the age of 11 months. S. had psychotherapeutic sessions once a week, over a year. These sessions took place in the presence of his mother. For a few weeks, S.'s behavior did not change. The sessions were always the same: the teenager mostly kept silence. It was very difficult to get any feedback from him: he was completely indifferent. The interviews focused on the seizures he had. The surgery was rejected and only drug solutions were recommended, though they were ineffective.

Taking into account little progress, the father was recommended to attend the consultations. It was found out during a consultation with the father that S.'s sister died at the age of four. The father claimed that they were shocked by the death of their first child. The patient's father considered that the soul of his first child lived in his sick son, and epilepsy took for him the meaning of repeating the death experiences that S. was suffering from some kind of death conspiracy. His wife, S.'s mother, shared these ideas. Later, sessions allowed discussing the differentiation between S... and his deceased sister and about the need to leave it in the past. Subsequently, S.'s behavior changed a lot. His parents began to perceive him as a definite separate personality, although epileptic seizures continued regularly.

In this observation, a trauma, that of the experience of S.'s first crisis, awakened another, associated with the daughter's death. The effect of the crisis on the parents, through this traumatic repetition, had disastrous consequences for the mental structure of the child, who did not exist for his parents in their own perception. Awareness of the trauma and its repetitions had the effect of "thawing" the representations and allowed S. to exist as a person.

Discussion

We often underestimate the impact of trauma of announcing a disability on the parental process, and therefore, on the child's psychological structuring. In fact, it has been established that the disclosure of disability interrupts the fragile process of the parenthood. The imaginary reverie that existed around the child interrupts the foreign representation of anything that had been imagined until then. It is a brutal separation: the child becomes another personality, a stranger. This is a real psychological trauma. Parents, caught between guilt and an attempt to remedy, must build a story contrary to this emptiness: for them it is about the meaning of this event, in an attempt to overcome the trauma [25-27].

At present the task of professionals to offer parents their capacity for empathy and emotional sharing to overcome trauma. Parents are usually diagnosed with depression at the time when the effects of trauma which, in Ferenczi's words, "acts as an anesthetic in the face of shock, unexpected, unprepared and overwhelming..." [28]. This traumatic shock

leads to the inability to work out the psychic connection and the inability to experience this emotional catastrophe. Dialogue with parents is difficult: "they know everything, but they feel nothing", according to Gianna Tissier (Sarfaty et al., 2000). Hence the need to create the safe environment for the child, in which parents and professionals share the emotions aroused by the child. From this experience the trauma can be recognized, spoken about and overcome [29].

Epileptic seizures (when generalized) cause parents to experience their child's death. This reinforces the trauma and leads to overprotective attitudes towards the child. These are the classic prohibitions that apply to all patients with epilepsy. Managing the autonomy of the child with a certain level of risk-taking is often difficult for professionals who have often had to experience accidents, sometimes fatal, related to crises. And yet risk-taking is a condition of empowerment.

As described in Freud's article, mourning and melancholy find their complement in Totem and Taboo, where it is indicated that the fundamental ambivalence of love relationships suggests that the work of mourning will never be simple. Mourning is indelible: new investments will always have a deep connection with those that came before them, which are never completely abandoned. The success or failure of suffering is a matter of degree [30].

However, the difficulties and anxieties of parents in the face of disability are not the only factors that influence mental construction. The other equally important factor is the effect of seizures on the child's construction. The child builds the world around him through a continuous connecting activity in which he matches his perceptions with the memory traces of previous perceptions in order to build the coherent representative system. The conditions of this constructive work are both a functional perceptual system, an ability to analyze the various sensory channels and to synthesize the received signals. Therefore, continuity must be internal and external. We know the role of the environment in the construction of the child, and all the works on the lack of maternal care showed the need for this continuity. It is ensured especially by the mother or the person who takes her place and by the connections between the different people who take care of the child [31].

Parents of children with epilepsy have a personal difficulty in performing mourning work. This difficulty manifests itself in different ways: the case is particularly serious if parents suffered mourning before the birth of the child. The child could have felt it, therefore, mainly through the reactions of his parents, he will feel the effects. When parents do not react adequately enough to the loss of one of their objects of love, the child feels it and may be disturbed by it. On the other hand, it is possible to think that the deficiencies that the parents of this child will manifest later, when faced with a regression, will be the testimony of a psychological difficulty that could have already intervened in the patient's epileptic predisposition [32].

The child's representative system must function well enough to integrate the various events experienced. Howe-

ver, epilepsy produces a very significant discontinuity. The crisis creates such mental chaos that it takes several hours and sometimes several days for the child to return to the normal functioning. This disorganizing effect is greater when the child is smaller and the seizures are more frequent. For example, epileptic diseases that occur at a very early age, such as West syndrome, have a mental prognosis that is worse the earlier the disease begins. Hence the importance of taking action on crises as early as possible [33, 34].

Usually, several brain disorders that include epilepsy in a large number of cases generate ubiquitous developmental disorders. This is the case with West syndrome, as we have mentioned, but also with Lennox-Gastaut syndrome. It can also be hypothesized that autism, when associated with Bourneville's tuberotic sclerosis, is directly related to early epilepsy which is often observed in this disease [34, 35].

All these questions should be identified and considered by the doctor. Care should allow this patient to integrate the representation of the disease, at the same time he must integrate all the changes that puberty makes to appear in his body. For example, to give the child the opportunity to express the subjective sensations that accompanies seizures. This internalization and intrapsychic delimitation of the body cannot be solved by an intellectualization of the phenomenon, but rather by a true intrapsychic work [36-38]. The work of the psychotherapist is complex in the case of epilepsy, since the patient feels the disease, to a large extent in the eyes of others (parents, friends, society), and this stigma is the possible cause of regression to an infantile self-image [39].

This situation requires the doctor to question his own projections and to remember that the epilepsy he treats cannot be considered in general. Supporting a patient with epilepsy and his family allows the reorganization of expectations and life plans, sometimes even values. This professional, collective or individual approach focuses on the personality and meaning of epilepsy for patients [40-42].

Conclusions

Patients with epilepsy are particularly vulnerable. Supporting a patient with epilepsy requires consideration of all the data presented in order to be able to respond effectively to his request. What is his request? In order for the doctor to be able to react to his illness competently, to answer the concrete questions that patient asks, whom he considers a person whose place he affirms in society. It is well understood that the physician, in this framework thus defined, cannot escape his emotional involvement in this human relationship. This requires a lot of discussion, advice, sometimes negotiations, intelligible medical explanations and real health education. It is essential for the doctor the collaboration with other medical specialists, social workers or psychologists; he is the interface between the patient and a specialized team. This is the priority function of the medical activities.

References

1. De Grissac H. Adolescence, epilepsy and physician. *Epilepsies*. 2009;21(2):137-141. doi: 10.1684/epi.2009.0226.
2. Salbreux R. Éditorial [Editorial]. *Contraste*. 2013;2(38):11-19. doi: 10.3917/cont.038.0011. French.
3. Leith D. The Diatrius and therapy in graeco-roman medicine. *Class Q*. 2008 Dec;58(2):581-600. doi: 10.1017/S0009838808000657.
4. Anzieu D. Le Moi peau [My skin]. *Enfance*. 1995:453-457. French.
5. Grasso F. Effets post-traumatiques du handicap sur le système perceptif et sur le psychisme des parents. Analyse et nouvelle proposition d'accompagnement des parentalités difficiles [Post-traumatic effects of disability on the perceptual system and on the psyche of parents. Analysis and new support proposal for difficult parenting]. *La psychiatrie de l'enfant*. 2012;2(55):397-484. doi: 10.3917/psy.552.0397. French.
6. Beauchesne H. L'enfant épileptique: psychologie et psychopathologie [The child with epilepsy: psychology and psychopathology]. *John Libbey Eurotext*. 2004:558-563. French.
7. Cole DA, Hoffman K, Tram JM, Maxwell SE. Structural differences in parent and child reports of children's symptoms of depression and anxiety. *Psychol Assess*. 2000;12:174-185. doi: 10.1037//1040-3590.12.2.174.
8. Fisher RS, Vickrey BG, Gibson P, Hermann P, Penovich P, Scherer P, Walker S. The impact of epilepsy from the patient's perspective. Descriptions and subjective perceptions. *Epilepsy Res*. 2000 Aug;41(1):39-51. doi: 10.1016/s0920-1211(00)00126-1.
9. Fernandes PT, de Barros NF, Li LM. Stop saying epileptic. *Epilepsia*. 2009;50(5):1280-1283. doi: 10.1111/j.1528-1167.2008.01899.x.
10. Jacoby A, Snape D, Baker GA. Epilepsy and social identity: the stigma of a chronic neurological disorder. *Lancet Neurol*. 2005 Mar;4(3):171-8. doi: 10.1016/S1474-4422(05)01014-8.
11. Gutermann J, Schreiber F, Matulis S, Schwartzkopff L, Deppe J, Steil R. Psychological treatments for symptoms of posttraumatic stress disorder in children, adolescents, and young adults: a meta-analysis. *Clin Child Fam Psychol Rev*. 2016;19(2):1-2. doi: 10.1007/s10567-016-0202-5.
12. Jacoby A, Austin JK. Social stigma for adults and children with epilepsy. *Epilepsia*. 2007;48 Suppl 9:6-9. doi: 10.1111/j.1528-1167.2007.01391.
13. Wo MC, Lim KS, Choo WY, Tan CT. Factors affecting the employability in people with epilepsy. *Epilepsy Res*. 2016 Dec;128:6-11. doi: 10.1016/j.epilepsyres.2016.10.003.
14. Chiosa V, Ciolac D, Vataman A, Groppa SA. Features of presurgical assessment of patients with pharmacoresistant epilepsy. *Arch Balkan Med Union*. 2016;51(1):195-199.
15. Allwood MA, Dyl J, Hunt JI, Spirito A. Comorbidity and service utilization among psychiatrically hospitalized adolescents with post-traumatic stress disorder. *J Psychol Trauma*. 2008;7:104-121. doi: 10.1080/19322880802231791.
16. Sarfaty J. Épilepsie et structuration psychique de l'enfant [Epilepsy and psychic structuring of the child]. *Contraste*. 2013;2(38):143-154. doi: 10.3917/cont.038.0143. French.
17. Lipschitz DS, Winegar RK, Hartnick E, Foote B, Southwick SM. Posttraumatic stress disorder in hospitalized adolescents: Psychiatric comorbidity and clinical correlates. *J Am Acad Child Adolesc Psychiatry*. 1999;38(4):385-392. doi: 10.1097/00004583-199904000-00010.
18. Miele D, O'Brien EJ. Underdiagnosis of posttraumatic stress disorder in at risk youth. *J Trauma Stress*. 2010;23(5):591-598. doi: 10.1002/jts.20572.
19. Spear L. Le développement du cerveau et les patterns de conduites typiques pendant l'adolescence (première partie) [Brain development and typical behavioral patterns during adolescence (part 1)]. *Psychiatry Child Teenage*. 2008;6:149-54. doi: 10.1007/s11836-008-0068-9. French.
20. Diebold G. L'Épilepsie, une maladie refuge [Epilepsy, a refuge disease]. Paris: Calmann-Lévy; 1999. doi: 10.1016/S0014-3855(00)80144-9. French.
21. Mélese L. La psychanalyse au risque de l'épilepsie [Psychoanalysis at the risk of epilepsy]. *L'Évolution Psychiatrique*. 2003;68(3):483. doi: 10.1016/S0014-3855(03)00102-6. French.
22. Ignatenko A, Arzy S, Ghica J, Kaplan PW, Groppa S, Seeck M. Nonepileptic seizures under levetiracetam therapy. *Epilepsy Behav*. 2010;19(3):526-527. doi: 10.1016/j.yebeh.2010.09.002.
23. Kapfhammer HP. Acute and long-term mental and physical sequelae in the aftermath of traumatic exposure – some remarks on „the body

- keeps the score". *Psychiatr Danub*. 2018 Sep;30(3):254-272. doi: 10.24869/psyd.2018.254.
24. Ferenczi S. A propos de la crise épileptique (écrit vers 1921). Le développement du sens de la réalité et ses stades [About the epileptic seizure (written around 1921). The development of the sense of reality and its stages]. *Psychanalyse*. 1968. French.
 25. Novakova B, Harris PR, Ponnusamy A, Reuber M. The role of stress as a trigger for epileptic seizures: a narrative review of evidence from human and animal studies. *Epilepsia*. 2013;54:1866-1876. doi: 10.1111/ept.12377.
 26. Olff M. Choosing the right instruments for psychotrauma related research. *Eur J Psychotraumatol*. 2015;6:30585. doi: 10.3402/ejpt.v6.30585.
 27. Thordardottir EB, Valdimarsdottir UA, Hansdottir I, Hauksdottir A, Dyregrov A, Shipherd JC, Gudmundsdottir B. Sixteen-year follow-up of childhood avalanche survivors. *Eur J Psychotraumatol*. 2016;7:30995. doi: 10.3402/ejpt.v7.30995.
 28. Ferenczi S. Trauma and anxiety. In: Ferenczi S. *Confusion of tongues between adults and the child*. 1955. p. 249-250.
 29. Sarfaty J, Tissier G, Wojakowski M. L'approche de l'enfant atteint d'un handicap et de ses parents. Traitements précoces, traitements conjoints [Approaching children with disabilities and their parents. Early treatments, joint treatments]. *Bulletin du Groupe Waimh Francophone*. 2000;7(2):256. French.
 30. Nardi AE. Mourning and Melancholia, Sigmund Freud (1917) – The 100-year anniversary of the publication of this landmark essay about depression. *J Bras Psiquiatr*. 2016;65(4). doi: 10.1590/0047-208500000137.
 31. Kolaitis G. Trauma and post-traumatic stress disorder in children and adolescents. *Eur J Psychotraumatol*. 2017;8(Suppl 4):1351198. doi: 10.1080/20008198.2017.1351198.
 32. Rodenburg R, Marie Meijer A, Dekovic M, Aldenkamp AP. Family predictors of psychopathology in children with epilepsy. *Epilepsia*. 2006;47(3):601-614. doi: 10.1111/j.1528-1167.2006.00475.x.
 33. Soulas B. Deuil et apparition des crises épileptiques chez l'enfant [Bereavement and onset of epileptic seizures in children]. *Revue française de psychanalyse*. 1978. French.
 34. Groppa SA, Zota E, Chiosa V. New methods of diagnosis and treatment, implemented in local neurological practice. *Inno Views, Academy of Sciences of Moldova*, 2009:3-4.
 35. Lesley M, Arnold MD, Michael D, Privitera MD. Psychopathology and trauma in epileptic and psychogenic seizure patients. *Psychosomatics*. 1996;5(37):438-443. doi: 10.1016/S0033-3182(96)71531-1.
 36. Rosenberg H, Rosenberg S, Williamson P, Wolford G 2nd. A comparative study of trauma and posttraumatic stress disorder prevalence in epilepsy patients and psychogenic nonepileptic seizure patients. *Epilepsia*. 2000;41(4):447-452. doi: 10.1111/j.1528-1157.2000.tb00187.x.
 37. Beyenburg S, Mitchell AJ, Schmidt D, Elger CE, Reuber M. Anxiety in patients with epilepsy: systematic review and suggestions for clinical management. *Epilepsy Behav*. 2005;7(2):161-171. doi: 10.1016/j.yebeh.2005.05.014.
 38. Bardeen JR, Fergus TA. The interactive effect of cognitive fusion and experiential avoidance on anxiety, depression, stress and posttraumatic stress symptoms. *J Contextual Behav Sci*. 2016;5(1):1-6. doi: 10.1016/j.jcbs.2016.02.002.
 39. Josty IC, Narayanan V, Dickson WA. Burns in patients with epilepsy: changes in epidemiology and implications for burn treatment and prevention. *Epilepsia*. 2005;4(41):453-456. doi: 10.1111/j.1528-1157.2000.tb00188.x.
 40. Campen JS, Jansen FE, Pet MA, et al. Relation between stress-precipitated seizures and the stress response in childhood epilepsy. *Brain*. 2015;8(138):2234-2248. doi: 10.1093/brain/awv157.
 41. Batten SV, Orsillo SM, Walser RD. Acceptance and mindfulness-based approaches to the treatment of posttraumatic stress disorder. In: Orsillo SM, Roemer L, editors. *Acceptance and mindfulness-based approaches to anxiety*. Boston: Springer; 2005. p. 241-269. doi: 10.1007/0-387-25989-9_10.
 42. Cohen JA. Practice parameter for the assessment and treatment of children and adolescents with posttraumatic stress disorder (AACAP official action). *J Am Acad Child Adolesc Psychiatry*. 2010;49:414-430. doi: 10.1097/00004583-201004000-00021.

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EC conceptualized the idea, conducted literature review, wrote the manuscript, revised and approved the final text.

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Conflict of Interests

The author has no conflicts of interests to declare.