identical) developmental background of patients with epilepsy on the one hand and dissociative seizures on the other is reflected by similar (but not identical) psychiatric comorbidity profiles. More specifically, epileptic seizures are a risk factor for the development of dissociative seizures, may precipitate or trigger dissociative seizures, and comorbid epilepsy may contribute to the perpetuation of dissociative seizures disorders. My talk will provide some food for thought about two seizure disorders often associated with high levels of disability which are theoretically different but which - in practice - have much in common.

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4 PSYCHOLOGICAL THERAPIES IN PARKINSON'S DISEASE

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10.1136/jnnp-2019-BNPA.4

Richard Brown is Professor of Neuropsychology and Clinical Neuroscience and Head of Department of Psychology, at the Institute of Psychiatry, Psychology and Neuroscience at King's College London. He is a faculty member of National Institute of Health Research Maudsley Biomedical Research Centre. He has worked extensively in the field of clinical neuroscience and his primary interest is the field of movement disorders and particularly Parkinson's disease. He undertook his PhD with Professor David Marsden and worked for 10 year at the MRC Human Movement and Balance Unit, Queen's Square. He has published over 200 scientific works and his research has involved laboratory-based and clinical research and spanned a range of movement, cognitive, emotional and social aspects of brain disorder. He has been involved in the development and evaluation of novel psychological approaches to management of non-motor symptoms in patients with Parkinson's disease including depression, anxiety and impulse control disorders. He is also an Honorary Consultant Clinical Psychologist with the South London and Maudsley NHS Foundation Trust, Neuropsychiatry Service, where he supports the psychological management of patients with acquired brain injury and neurodegenerative disorders, with a particular focus on Parkinson's disease.

Non-motor symptoms (NMS) are ubiquitous in Parkinson's disease and are increasingly seen as core features of the disease. Often predating the onset of motor symptoms, they typically increase in number and severity as the disease progresses, increasing disability and overall disease burden. The high prevalence of psychiatric disturbance in PD and its impact on outcome has been recognised for many years, with increasing recognition of the emotional distress and social impact associated with other disabling motor and non-motor symptoms.

While medical treatments are available to ameliorate many NMS, management remains problematic. Psychological approaches are increasingly common in the field of long-term conditions; for symptom management as well as tackling wider psychological issues such as adjustment and relationship function. However, they continue to play a relatively minor role (or are inaccessible) in routine PD care. This presentation will summarise some of the main areas where psychological approaches have demonstrated or potential value. Depression, and more recently anxiety, has been the subject of study for many years and supplies most of the existing (if limited) empirical evidence for psychological approaches. The strengths and limitations of that research will be considered to suggest how we might best meet the existing needs of patients using existing treatments, particularly CBT.

Even though evidence is limited or lacking, the talk will consider the potential for psychological approaches to contribute to the management of neurocognitive symptoms including impulse control behaviour and apathy, as well as other disabling and distressing problems such as sleep disturbance, fatigue, pain and motor fluctuations.

The presentation will conclude by considering some of the new or emerging treatment approaches offering alternative to CBT that may have advantages in terms of efficiency, accessibility and acceptability.

5 DEEP BRAIN STIMULATION FOR OCD: AN UPDATE

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10.1136/jnnp-2019-BNPA.5

Professor Joyce's research focuses on neurocognitive dysfunction in the early stages of schizophrenia and how this relates to brain structural changes and clinical manifestations of the disorder. Professor Joyce received a degree in psychology from the University of Cambridge where she also completed her PhD in dopamine psychopharmacology with Susan Iversen. She went on to study medicine at Cambridge and trained in psychiatry at the Maudsley Hospital. She spent her higher clinical and research training in the neuropsychiatry department of Professor Alwyn Lishman which was followed by a period of time as a research associate at The National Institute on Alcohol Abuse and Alcoholism, USA. She returned to the UK in 1991 to take up a senior lectureship at Imperial College and remained there until 2005 when she moved to University College London.

Deep brain stimulation (DBS) is an emerging treatment for people with severe OCD who have not responded to SSRI medication, prescribed either at high doses or augmented with additional medication, and several courses of CBT including inpatient treatment. Since it was first described in 1999, there have been 5 randomised controlled trials comparing sham and active DBS at two brain targets: the ventral capsule/ventral striatum site (VC/VS) and the anteromedial subthalamic nucleus (amSTN). A study directly comparing DBS at both sites in the same 6 patients with very severe OCD found that they have equivalent efficacy for reducing OCD symptoms.* Neuroimaging evidence suggested that DBS at each site modulates different brain circuits and has different behavioural actions. VC/VS DBS was much more effective than amSTN DBS at improving mood and affected a circuit connecting the