Evaluation of a pilot innovative cognitive-behavioral therapy-based psychoeducation group treatment for functional non-epileptic attacks

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A high proportion of patients presenting at epilepsy clinics experience functional non-epileptic attacks (FNEA), and while psychological treatment is generally thought to be the required intervention, evidence regarding psychological treatment of FNEA is limited. A small number of psychoeducation treatments have been evaluated, with promising results. As part of routine care within a neuropsychiatry service, a 3-session cognitive-behavioral therapy (CBT)-informed psychoeducation group was developed. Patients with comorbid epilepsy were included. The group’s effectiveness was evaluated in terms of attack frequency, mood, illness perception, dissociative experiences, and patient feedback. Pre- and post-treatment data were obtained for 19 patients. The proportion of patients experiencing attacks significantly decreased, with almost 40% of treatment completers reporting being attack-free at the end of treatment. Significant improvements were also found on level of psychological distress, illness beliefs, and understanding of the condition. No significant changes in mood or general functioning were observed. High satisfaction was reported by almost all patients. Treatment outcome was not significantly affected by the level of dissociative experiences. The results suggest that CBT-based psychoeducation group treatment can be a beneficial part of treatment for those with FNEA, even for those experiencing high levels of dissociation. Further controlled studies with larger sample sizes are required.

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1. Introduction

It is thought that between 10 and 22% of patients presenting to epilepsy clinics have functional non-epileptic attacks (FNEA)\textsuperscript{[1]}. Generally, psychological treatment is considered to be the most appropriate treatment\textsuperscript{[2–4]}, but there are currently no guidelines on psychological treatment of FNEA due to a lack of large randomized controlled trials (RCTs). Psychological treatment of FNEA is complex, as patients with FNEA are likely to have comorbid psychiatric diagnoses, such as depression, post-traumatic stress disorder (PTSD), and panic disorder\textsuperscript{[5]}. Various psychological treatment modalities have been reported in case reports and open-label studies and the majority of research has focused on the provision of individual psychological treatment for FNEA\textsuperscript{[2]}. A number of psychoeducation approaches have been described and generally reported to be beneficial\textsuperscript{[6–10]}. Psychodynamic approaches have been examined\textsuperscript{[11]}, and cognitive-behavioral therapy (CBT) has been found to be effective in two pilot RCTs\textsuperscript{[12,13]}, although a Cochrane review published in 2014 concluded there was little reliable evidence to support any treatment for FNEA, including CBT\textsuperscript{[14]}. In the International Statistical Classification of Diseases and Related Health Problems (ICD-10), FNEA are classified as dissociative convulsions, and come under the broader category of dissociative (conversion) disorders\textsuperscript{[15]}. In the Diagnostic and Statistical Manual of Mental Disorders (DSM-V), FNEA are classified as a sub-type of a conversion disorder (functional neurological symptom disorder)\textsuperscript{[16]}. There have been no direct causative factors found for why people develop FNEA, but many studies have identified associations between factors such as trauma, dissociative tendencies, emotion regulation difficulties, somatization, mental health difficulties, stressful and life events, and experiencing epilepsy or having a family member with epilepsy\textsuperscript{[17–19]}. Dissociation is a proposed mechanism in the forming of a FNEA (as evident by the term dissociative seizures). Dissociation is a broad term that refers to “a disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behavior”\textsuperscript{[16]} (p. 291). The term is used to describe a variety of trauma-related experiences including depersonalization, derealization, flashbacks, and emotional numbing\textsuperscript{[20]}, and is considered a key mechanism in FNEA, dissociative fugue states, dissociative identity disorder, and dissociative amnesia. Dissociation has been proposed to be part of “normal” experience, with “absorption” as an example of non-pathological dissociation on one end of a continuum, and dissociative disorders falling on the pathological end of a
continuum [20]. Severity of dissociation has been proposed to interfere with emotional processing during exposure-based PTSD treatment, but evidence for [21] and against [22,23] this theory has been found. To our knowledge, no previous research has examined the impact of the level of dissociation on treatment outcome for patients with FNEA.

NHS Scotland (2012) recommends that evaluation and treatment for functional neurological symptoms should include the following: 1. Functional neurological symptoms diagnosed and appropriately explained by a neurologist; 2. Brief and effective treatments offered when explanation alone is unsuccessful (e.g., brief guided self-help program); and 3. Services for patients with severe and intractable functional neurological symptoms [24]. Presenting the diagnosis of FNEA can result in the substantial reduction or cessation of FNEA [4], but explanation alone does not always result in cessation. Brief psychoeducation treatments have been evaluated in both individual and group formats, in line with NHS Scotland’s recommendations. Sharpe et al. [7] in an RCT evaluated the efficacy of an individual manual-based guided self-help (GSH) CBT intervention in people with various functional neurological symptoms including FNEA. They found that those who had received CBT-based GSH evidenced significantly improved subjective health at 3 months, in comparison to those without GSH. In addition, those patients with GSH also showed greater improvements in their presenting symptoms, as well as reduced symptom burden, less health anxiety, and greater satisfaction with care. At 6-month follow-up, the improvement in subjective health was no longer significantly better than usual care when measured on the 5-point clinical global improvement scale (CGI); but there were still significant improvements in symptoms, a significant reduction in the belief that the symptoms are permanent, and significantly greater overall satisfaction with their received care. Using a smaller sample, individual CSH was evaluated by Mayor and colleagues [8] for patients experiencing FNEA. No significant effect on attack frequency was observed, but examining on an individual patient level, 4 patients became attack-free and 3 patients had more than a 50% reduction in total number of attacks. A further study was carried out using the same psychoeducation intervention. A larger sample of patients received individual psychoeducation over 4 sessions. The authors found significant improvements in wellbeing and illness beliefs following the intervention. They did not find a significant reduction in attack frequency, but 48% of patients experienced a reduction in attacks or were attack-free at the end of treatment [10].

In a group format, Conwill and colleagues [6] investigated the effectiveness of a series of 4 CBT-informed group sessions designed to treat FNEA and other functional neurological symptoms. A focus on behavioral change was introduced and the CBT model was explained by a neurologist and a clinical psychologist (NA & SC) in the first session. The further 2 sessions were run by a clinical psychologist (SC) alone. Patients were encouraged to engage in brief group discussions regarding their personal experiences that were relevant to materials presented in the sessions. Patients also had the opportunity to ask any questions about the presented information as relevant to materials presented in the sessions. Patients with GSH also showed greater improvements in subjective health at 3 months, in comparison to those without GSH. In addition, those patients with GSH also showed greater improvements in their presenting symptoms, as well as reduced symptom burden, less health anxiety, and greater satisfaction with care. At 6-month follow-up, the improvement in subjective health was no longer significantly better than usual care when measured on the 5-point clinical global improvement scale (CGI); but there were still significant improvements in symptoms, a significant reduction in the belief that the symptoms are permanent, and significantly greater overall satisfaction with their received care. Using a smaller sample, individual CSH was evaluated by Mayor and colleagues [8] for patients experiencing FNEA. No significant effect on attack frequency was observed, but examining on an individual patient level, 4 patients became attack-free and 3 patients had more than a 50% reduction in total number of attacks. A further study was carried out using the same psychoeducation intervention. A larger sample of patients received individual psychoeducation over 4 sessions. The authors found significant improvements in wellbeing and illness beliefs following the intervention. They did not find a significant reduction in attack frequency, but 48% of patients experienced a reduction in attacks or were attack-free at the end of treatment [10].

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