



Positive psychological interventions for people with epilepsy: An assessment on factors related to intervention participation

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ABSTRACT

Background: Positive psychological interventions (PPI) are increasingly employed as a coping strategy with physical and mental conditions, including neurological diseases. Its effectiveness on improving wellbeing in people with epilepsy (PWE) has been shown in a few studies. This study aimed to explore factors related to participants' willingness to engage in psychological interventions from the perspective of patients with epilepsy.

Methods: Participants answered a needs assessment questionnaire eliciting information about their illness perception (Brief Illness Perception Questionnaire (Brief-IPQ)), emotions (Hospital Anxiety and Depression Scale (HADS)), willingness to participate in psychological interventions, preferences in types of PPI and intervention designs, as well as barriers in seeking mental health services.

Results: A total of 154 patients with epilepsy participated, with a mean age of 37.3 years (range 16–86 years). Most patients had focal epilepsy (68.2%), and drug-resistant (59.1%). Majority (71.4%) of them indicated a strong willingness to participate in PPI. Out of nine types of PPI, character strengths, mindfulness-based and expressive-based interventions were highly preferred. Those with negative illness perception ($p = 0.001$), anxiety ($p = 0.004$), and being unemployed ($p = 0.048$) were more willing to participate in PPI. Most participants preferred group rather than individual session, and a shorter duration (30 min) was favored by most.

Conclusion: This study captured the self-report willingness to participate in psychological interventions. Findings suggested that psychological interventions delivered in short-group session were highly preferred. Future study is required to determine the feasibility of such design for patients with epilepsy.

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1. Introduction

The incidence of psychological disorders is higher in people with epilepsy (PWE) than in the general population [1]. It is estimated that 20–30% of PWE have psychiatric comorbidities; the prevalent is substantially higher in those with drug-resistant epilepsy [2]. The profound physical, psychological, and social consequences of epilepsy can impact quality of life (QOL) due to various reasons, including medication side effect, cognitive disturbances, unpredictability of seizure, its stigmatizing nature, and academic and vocational difficulties [3,4].

Considerable efforts have been dedicated to develop psychological interventions for PWE aiming to improve QOL and other health outcomes. These treatments include educational intervention [5], cognitive-behavioral or behavioral treatment [6], self-management intervention [7], and mind–body intervention [8–10] – most showed evidence in reducing

psychiatric symptoms, modifying maladaptive beliefs, and attitudes toward the diagnosis. A number of recent reviews also summarized the evidence of using psychological treatment in enhancing QOL [11,12]. Quality of life is a broad, multidimensional concept that includes subjective evaluations of both positive and negative aspects of life [13].

Studies have shown that PWE diagnosed with depression have poorer QOL, mediated by negative illness perception [14]. According to Leventhal's self-regulation model (SRM), behavior in relation to illness depends on individual's perception of their health problems. He proposed five components in the SRM, namely the following: illness identity, causes, timeline, consequences, and cure/controllability [15]. Beliefs held by patients about their disease determine their sensitivity to depressions and its impact on QOL. Moreover, anxiety in epilepsy, in particular – seizure worry, has been found to be the most important factor affecting QOL [14]. According to a review by Kotwas et al. on self-control of epileptic seizures, the wellbeing and QOL of individuals were influenced by self-perceived control over their seizures and health. Those with greater control showed more resilience and reported higher QOL [14]. Therefore, understanding illness perception in relation

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to intervention participation may help future design of psychological interventions. That being said, enhancing individuals' resources (i.e., inner potentials) to improve and maintain personal health is an important issue, especially when the epilepsy is drug-resistant. Most of the existing psychotherapeutic techniques for PWE, however, oriented toward symptomatic reliefs; the promotion of pursuing psychological wellness and positivism were not as much emphasized.

Positive psychology (PP) focuses on synthesizing both positive and negative human life experiences to understand and actualize human potential [11]. It considers disorder or distress as the genesis to develop interventions that promote good mental and physical health. It is showed that psychological wellbeing is possible via a deliberate attempt to engage in 'positive interventions' [11,16]. The most common components in these interventions include the cultivation of positive feelings, behaviors, and/or cognitions, e.g., gratitude visit, savoring, and usage of character strengths [11]. Positive psychological interventions (PPI) had been applied on medical populations such as people with diabetes [17,18] and breast cancer [19]. Evidence showed that these approaches could help reduce negative emotion and relapses, improve medication adherence, and prolong longevity.

The effectiveness of PPI on people with neurological disorders was found in a handful of studies in patients with epilepsy, traumatic brain injury, migraine, and patients with neuromuscular disease [8–10,20–22]. The identified techniques included mindfulness-based approaches, counting blessings, and signature strengths. These interventions showed benefits on a wide range of health measures, including psychological wellbeing (e.g., increased positive affect and life satisfaction), illness conditions (e.g., reduced symptoms distress), cognitive functions (e.g., improved attention span and working memory), as well as emotional regulation (e.g., decreased anxiety/depression symptoms). One of the commonly used PPI for PWE was mindfulness-based techniques (MBT). This method involves training on the observation of one's own mental state, using attention control and process-orientated awareness. Findings showed improvement in QOL, and psychological states [8,23,24], although the effect on seizure control was not consistently reported in other studies [9,10].

Malaysia is in a unique position as it serves as a confluence of three Asian cultures (i.e., Malay, Chinese, and the Indian) giving rise to three culturally bound beliefs that may influence the patients' decision to seek psychological treatments. Although the public has free access to the health professionals in Malaysian government hospitals, there are still barriers (e.g., time constraints, illness perceptions) in seeking mental health services. At present, there are no studies exploring treatment barriers to psychological care in PWE in Malaysia. Hence, it is useful to uncover factors that may dissuade them from seeking proper treatments. Many factors could affect the effectiveness of psychological treatments. Among which, the motivation of the participants was one of the most important variables. Low motivation to treatment would lead to dropout and nonadherence to treatment techniques [25]. To boost underutilization of services, it is worthwhile to explore from their perspectives, the design and preferences of psychotherapeutic interventions. To address these issues, the present study aimed to examine the factors associated with self-report willingness to participate PPI among PWE. We hypothesized that the success of PPI depends on the willingness to participate, which can be affected by sociocultural, clinical, and psychological factors.

2. Methods

2.1. Design

This study used a cross-sectional design. Participants were required to complete a pen-and-paper needs assessment questionnaire. This study was approved by the University Malaysia Medical Center (UMMC) Ethics Committee (MECID.NO: 2016814019). Written informed consent was obtained from each participant.

2.2. Participants and recruitment

A consecutive sampling method was adopted to recruit participants who were attending the clinical consultations at the UMMC neurology clinic. All patients (16 years or older) with a diagnosis of epilepsy by a neurologist who were able to read and write English were recruited. Patients with any of the following criteria were excluded: 1) a diagnosis of severe learning disability or cognitive impairment that affects individuals who are unable to comply with study procedure, 2) substance dependence, 3) suicidality, and 4) limited language proficiency. The screening and assessment on the inclusion and exclusion criteria were based on patient's medical records and the neurologist's (KSL) opinion.

2.3. Procedure

All eligible participants were approached in clinic by a research assistant who was a postgraduate health psychologist trainee (STL). The background of the study was explained, and they were given an information sheet that contained details of the study. They were recruited upon written consent. All participants completed the needs assessment questionnaire on the same day of recruitment. The questionnaire comprised the following sections; it required approximately 15 min to complete.

2.3.1. Clinical and sociodemographic information

The needs assessment questionnaire included a sociodemographic section inquiring age, sex, education, employment, marital status, and psychiatric comorbidity. Clinical information of epilepsy was obtained from the clinical epilepsy database, namely age at seizure onset, disease duration, seizure types, number of antiepileptic drugs (AEDs), and seizure control. Drug responsiveness was determined based on seizure freedom for at least 1 year with AEDs.

2.3.2. Brief Illness Perception Questionnaire (Brief-IPQ)

The Brief-IPQ was used to evaluate individual's perceptions toward epilepsy [26]. It consists of 8 items that assess cognitive- and emotional-illness representations, as well as illness comprehensibility. All items are scored on an 11-point Likert scale with endpoint descriptors. Total scores ranged from 0 to 50. Higher scores represent a more threatening view of the illness. Item-9 is a causal item that requires patients to determine three important perceived causes of epilepsy. This item was excluded due to its qualitative nature. The Brief-IPQ has been validated and translated in our local context for participants above age 18 [27]; it was also reported across studies for having strong internal consistency (Cronbach's $\alpha = 0.85$) [28].

2.3.3. Hospital Anxiety and Depression Scale (HADS)

To detect states of anxiety and depression, the HADS was used [29] as a screening tool for susceptible clinical conditions. It consists of a total of 14 items measuring anxiety (HAD-A) and depression (HAD-D). Each item scores from 0 to 3, with total scores ranged between 0 and 42. A score of 8 or higher indicates the presence possible state of anxiety and/or depression. Both HAD-A and HAD-D share the same cutoff point for borderline (scores of 8 to 10), and clinical (scores of 11 to 21) levels [30]. The HADS was tested in a Malaysian sample, who aged 18 years and above [31]; high internal consistency has been reported for HAD-A (Cronbach's $\alpha = 0.88$) and HAD-D (Cronbach's $\alpha = 0.82$) for a community epilepsy sample [32].

2.3.4. Willingness to participate

With an attempt to minimize question-order bias, participant's willingness to engage in psychological interventions was asked prior to describing the types of PPI to elicit individual's preferences. Participants were required to indicate on a scale of 0 (not at all willing to participate) to 10 (extremely willing to participate) on how willing they are to participate in psychological intervention to improve one's coping with epilepsy

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