



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



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ARTICLE INFO

Article history:

Received 17 November 2016

Revised 8 February 2017

Accepted 9 February 2017

Available online xxxx

Keywords:

Functional non-epileptic attacks

Dissociative seizures

Non-epileptic attack disorder

Treatment

CBT

Intervention

Psychogenic nonepileptic seizures

ABSTRACT

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-behavior 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) [1]. Generally, psychological treatment is considered to be the most appropriate treatment [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 [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 [2]. A number of psychoeducation approaches have been described and generally reported to be beneficial [6–10]. Psychodynamic approaches have been examined [11], and cognitive-behavioral therapy (CBT) has been found to be effective in two pilot RCTs [12,13], although a Cochrane review published in 2014 concluded there was little reliable evidence to support any treatment for FNEA, including CBT [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 [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) [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 [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” [16] (p. 291). The term is used to describe a variety of trauma-related experiences including depersonalization, derealization, flashbacks, and emotional numbing [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

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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 GSH 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 a CBT approach was utilized, drawing links between patients' thoughts, feelings, behaviors, and physical symptoms. Data from 16 patients (FNEA: $n = 10$; Other: $n = 6$) indicated significant improvements on the SF-36 subscales of 'role limitation due to emotional wellbeing' and 'emotional wellbeing'. Group psychoeducation was also trialed by Chen et al. (2014), who randomized patients into either group psychoeducation or the control group [9]. Patients in the psychoeducation group received 3 monthly sessions, addressing identifying FNEA triggers, stress management, activity scheduling, and distress tolerance. Patients' family members were also encouraged to attend. Although they found no significant improvement in terms of attack frequency after treatment, they did report significant improvements in terms of general functioning (measured using the Work and Social Adjustment Scale).

Psychoeducation in both individual and group formats has been shown to be a potentially beneficial part of treatment of FNEA. Psychoeducation offered in a group format has a number of advantages, including: treating a number of patients at the same time making it cost effective; patients can meet others with FNEA; learning that the condition is not rare; and patients can learn from and support one another [25]. However, the best way to deliver group psychoeducation remains unclear and a greater evidence base is needed. In line with the emerging evidence, an innovative CBT-based psychoeducation group was developed as part

of routine care within a neuropsychiatry service. This evaluation focused on the group's effectiveness with respect to patients' attack frequency and changes in mood and illness perception, as well as patient feedback about the intervention. The extent to which patients' level of dissociative experiences impacted on the effectiveness of the treatment was also investigated.

2. Method

2.1. Participants

Participants were outpatients who were diagnosed with FNEA by the epilepsy neurologists at the regional neurosciences center, St. George's Hospital, London. They were subsequently seen at the Neuropsychiatry clinic closely allied to the epilepsy clinics. Patients were referred to the psychoeducation group sessions following an assessment by a neuropsychiatrist. Seven groups ran in total and range of attendance was between 2 and 4 patients for each group; on average 4 patients. Data were collected as part of routine clinical practice to evaluate the intervention. Patients were excluded if they were not able to understand written/spoken English, had severe learning disabilities or were acutely psychiatrically unwell. Patients were not excluded if they had comorbid epilepsy.

2.2. Intervention

Patients were invited to attend 3 CBT-based psychoeducation group sessions, running over the course of consecutive weeks. The group sessions were 90 min in length. Information was presented in a lecture format by a neuropsychiatrist 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 the session commenced, and at the end of the session. Patients were given homework tasks following the first and second session and were asked to bring their completed work to the following session. Patients had the chance to discuss this with their group-peers and share any comments/suggestions on their experiences of the tasks. Patients were provided with the PowerPoint presentation slides in a hand-out format.

The CBT-informed psychoeducation group sessions were written by 2 of the authors (SC & NA). The aims were to help patients understand their diagnosis and to meet others with the same diagnosis. The sessions also focused on what may be contributing to the maintenance of their FNEA, with the aim of improving patients' self-management. While attending the group, no patients were attending any other psychotherapeutic interventions. A summary of the group sessions' content can be found in Table 1.

2.3. Outcome measures

Participants completed all measures before and after the group sessions, with the exception of the Dissociative Experiences Scale, which was only completed prior to the first session.

Table 1
Brief summary of group content.

Session 1	Explained the diagnosis of FNEA and introduced the CBT model.
Session 2	Discussed behaviors and responses to FNEA that may be maintaining them, e.g., avoidance, monitoring body for signs of a FNEA. This session also introduced techniques to help manage symptoms such as sensory grounding strategies and distraction methods.
Session 3	Introduced cognitive aspects such as recognizing and challenging unhelpful thoughts. This session also included relaxation strategies. Patients were encouraged to set realistic goals regarding using what they had learned.

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