



The role of companions in outpatient seizure clinic interactions: A pilot study



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ABSTRACT

Purpose: This study explored contributions that patients' companions (seizure witnesses) make to interactions in the seizure clinic and whether the nature of the companions' interactional contributions can help with the differentiation of epilepsy and psychogenic nonepileptic seizures (PNES).

Methods: Conversation analysis methods were used to examine video recordings and transcripts of neurologists' interactions with patients referred to a specialist seizure clinic and their companions.

Results: The companions' behavior correlated with interactional features previously observed to distinguish patients with epilepsy from patients with PNES. Patients with PNES, but not those with epilepsy, tended to exhibit interactional resistance to the doctor's efforts to find out more about their seizure experiences and, thereby, encouraged greater interactional contribution from companions.

Conclusion: The contributions that companions make (in part, prompted by patient's interactional behavior) may provide additional diagnostic pointers in this clinical setting, and a number of candidate features that may help clinicians distinguish between epilepsy and PNES when the patient is accompanied by a seizure witness are described.

However, companion contributions may limit the doctor's ability to identify linguistic and interactional features with previously demonstrated diagnostic potential in the conversational contributions made by patients themselves. To help offset potential diagnostic losses, doctors may need to explicitly discuss the role of the companion in the consultation when a seizure witness (or another companion) accompanies the patient.

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1. Introduction

Qualitative researchers have studied doctor–patient interactions since at least the 1960s. More recently, qualitative (microanalytic) methods of studying interaction have been used diagnostically – assessing patients' interactional behavior to help identify and distinguish between medical conditions [1–4].

Predominantly applied in neurological settings, this use of qualitative methods marks a new and important field of enquiry for researchers exploring doctor–patient interactions and for clinicians in these diagnostic fields. There is now a substantial body of work that demonstrates the diagnostic potential of microanalytic, sociolinguistic, and conversation analysis (CA) inspired observations that can be made in the talk of patients with PNES and patients with epilepsy, and in patients with functional problems and those with neurodegenerative memory complaints, when they speak to a neurologist. To date, these studies have been carried out with German, English, and Italian speakers [5].

Most of these studies have focused on patients seeking advice about seizures. Unlike epileptic seizures, PNES are not the result of abnormal electrical discharges in the brain, but are generally interpreted as physical manifestations of psychological distress [6–7]. Epileptic seizures and PNES have superficially similar visible manifestations, and differentiating between the two can be difficult. Yet it is crucial to get the diagnosis right because the choice of treatment critically depends on the cause and nature of the seizures. People with epilepsy are treated with antiepileptic drugs, and people with PNES may benefit from psychotherapy. Despite advances in biomedical technologies, interictal tests such as brain magnetic resonance imaging (MRI) and electroencephalogram (EEG) have inadequate specificity and sensitivity in this setting [8–9]. The diagnostic “gold standard”, the video-electroencephalographic recording (video-EEG) of a typical seizure, can be difficult to access, or its use may not be feasible because of the low frequency of events [10]. Consequently, the act of taking and interpreting history remains the most crucial part of the diagnostic process for seizure disorders.

So far, most studies aiming to help with the differential diagnosis of patients with seizures have focused on encounters in which patients talked to doctors on their own. However, patients with seizures are routinely invited to bring along a companion when they attend outpatient

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appointments. National guidelines and studies focusing on the risk of misdiagnosis underline the importance of obtaining descriptions not only from patients, but also from witnesses of events [11–14].

In this pilot study, we examine the contributions that patients' companions make to interactions in the seizure clinic and explore whether the companions' contributions yield additional diagnostic pointers to the diagnoses of epilepsy or PNES.

2. Methods

2.1. Participants

To explore the contribution of companions to seizure clinic encounters, we recruited 31 accompanied patients (aged over 18 years) attending the specialist clinics of one of two participating fully trained specialists in the assessment of seizure disorders at the Royal Hallamshire Hospital (Sheffield, UK) between January 2010 and March 2012. Patients were eligible for inclusion if they had been referred to the clinic for a first initial (diagnostic) consultation. Inclusion and exclusion criteria are detailed in Table 1. Consecutive eligible patients and their companions were invited to take part and, if they agreed, provided written informed consent to participate. The consultant neurologists participating in the interactions were encouraged to conduct consultations in their usual manner and not to modify their routine history-taking method for this study. Researchers were not present during the consultations, which were filmed using a stand-alone device. Detailed verbatim transcripts of all recordings were produced based on a simplified version of the Jeffersonian system [15] used in previous research [3].

Consultations were selected for inclusion in this study according to systematic criteria designed to create a homogenous sample of patients with PNES and epilepsy (see Table 1). All consultations involving patients diagnosed with PNES or epilepsy who were accompanied to their appointment by a spouse or partner who had witnessed at least one of their seizure episodes were identified.

The diagnoses of PNES or epilepsy were confirmed by the patient's consultant neurologist six months after the original assessment when test results were available and initial treatment outcomes were known. All patients were investigated with MRI, interictal EEG, and ECG. Some diagnoses had been confirmed by video-EEG by the end of this study.

2.2. Data analysis

Clinical and demographic differences between patient groups with PNES and epilepsy, and differences between participant discourse spaces and the lengths (minutes) of consultations of patients with

PNES and epilepsy were analyzed using nonparametric statistical methods. Two-sided p-values of <0.05 were considered statistically significant throughout.

To help ensure comparability between the patient groups with PNES and epilepsy, the discourse spaces of participants (the number of words spoken by a particular participant as a proportion of the total number of words spoken by all participants in the interaction) were calculated, and the discourse space 'structures' of consultations assessed (for an overview of methods, see Robson, Drew and Reuber [16]). To assess if consultations were similar in overall topical trajectory, the content of consultation history-taking phases was thematically analyzed using discourse analysis methods [17].

Conversation analysis (CA) methods were used to examine the history-taking phases of consultations containing patient and companion descriptions of events and discussions of periods of reduced patient consciousness and unconsciousness. As described by Drew and Heritage [18], CA is the systematic analysis of the sequence and organization (verbal and nonverbal) of 'naturally occurring' interactions; "the goal is to identify the patterns, practices or devices which underlie meaning and action" (p. 9). The method has been widely applied in the study of doctor–patient interactions [18–19].

The turns-at-talk and the conversational activities of participants leading up to the point at which companions 'gained the floor' [20–21] to describe what they had witnessed and to 'tell their story' were the particular focus of analysis.

To aid readability, the extracts presented to support our findings include characteristics such as pauses, repetitions, and hesitations, but forego other conventional CA markers, such as overlaps and intonation, which are referred to in the detailed analyses. Capitalization and punctuation have also been added to the extracts to improve readability.

3. Results

Thirteen consultations were identified in which patients with epilepsy or PNES were accompanied by a spouse who had witnessed at least one seizure (six of these patients had epilepsy, seven had PNES).

3.1. Clinical and demographic features

There were no significant differences between the samples of patients with epilepsy and PNES in terms of age or gender ratio. There was a significant difference in the lengths of consultations of patients with PNES and epilepsy, as measured in their entirety. However, there was no significant difference in the lengths of history-taking phases of PNES and epilepsy consultations (see Table 2). Typically, proportionally lengthier exchanges about the explanation of the condition, its etiology, and best treatment were found in PNES consultations compared with epilepsy consultations.

3.2. Topical features and 'discourse structures' of consultations

As shown in Table 2, there was a significant difference in the ratio of consultations of patients with PNES and epilepsy undertaken by the two participating doctors. However, no significant differences were found between the discourse spaces of participants in the consultations of patients with PNES or epilepsy, or between the two participating doctors (see Fig. 1).

Similarly, no differences were identified between the topical content of history-taking phases of consultations undertaken by the two participating doctors, or between the consultations of patients with PNES and epilepsy. The topical history-taking phases identified in the data reflect those recommended in national epilepsy guidelines [12]. History-taking phases typically included discussion of: 1) problem presentation, 2) basic patient information, 3) general medical history, 4) patient and 5) companion descriptions of seizure events, 6) seizure condition chronology and changes in seizure events over time, 7) other 'unusual'

Table 1
Inclusion and exclusion criteria.

Study exclusion criteria ^a	– not fluent in English; or – has learning disabilities; or – has previously assessed for major neurological surgical intervention.
Sample inclusion criteria	– the patient was accompanied to their appointment by a companion (31 patients) ^b ; and – a diagnosis of PNES or epilepsy was confirmed by the consultant neurologist at six-month follow-up (23/30); and – the patient was accompanied by a companion that had witnessed a seizure event (16/23); and – the companion was the patient's spouse or partner ^c (13/16).

^a This information was gathered from the patients' medical records prior to their attendance at the clinic. If uncertainty remained, patients (and where applicable, their companions) were approached while they waited to be seen and were informed about the study, and inclusion/exclusion criteria were discussed and checked.

^b To ensure comparability, one interaction, concerning an accompanied patient with (expressive) aphasia, was removed at this stage.

^c We considered that accompanying persons who were the parents or friends of patients might interact differently to their spouses or partners.

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