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Treatment with group psychotherapy for chronic psychogenic nonepileptic seizures

Sinem Zeynep Metin [a,]*, Mine Ozmen [b], Baris Metin [c], Seren Talasman [d], Seher Naz Yeni [e], Cigdem Ozkara [e]

[a] *Antalya Kumluca State Hospital, Clinic of Psychiatry, Turkey*
[b] *Istanbul University, Cerrahpasa Medical Faculty, Clinic of Psychiatry, Turkey*
[c] *Ghent University, Faculty of Psychology and Educational Sciences, Department of Experimental Clinical and Health Psychology, Belgium*
[d] *California State University, Fullerton, USA*
[e] *Istanbul University, Cerrahpasa Medical Faculty, Clinic of Neurology, Turkey*

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ABSTRACT

Although there have been a number of psychotherapy trials for chronic psychogenic nonepileptic seizures, evidence-based treatment options are limited. We developed an eclectic group psychotherapy which combines psychoeducation and behavioral and psychoanalytic techniques. Nine patients completed 12 weeks of psychotherapy. Patients were interviewed with SCID-I. They also filled in the following measures at the beginning and end of the therapy: Beck Depression Inventory, Dissociative Experiences Scale, Spielberger State–Trait Anxiety Scale, SF-36 Life Quality Scale, and Toronto Alexithymia Scale. Seizure frequency was assessed before and after the therapy and on follow-up visits at the fourth, sixth, ninth, and twelfth months. After one year of follow-up, the decrease in seizure frequency was highly significant ($p < 0.001$). In addition, we observed significant improvements in the mental health subscale of the SF-36 ($p = 0.03$) and the state ($p = 0.006$) and trait ($p = 0.02$) subscales of the Spielberger State–Trait Anxiety Scale at the end of the therapy. These results suggest that group psychotherapy might be a treatment option for chronic psychogenic nonepileptic seizures.

1. Introduction

The prevalence of psychogenic nonepileptic seizures (PNESs) is approximately between 2 and 33/100,000 [1]. The incidence is predicted to be 3/100,000 [2], and lifetime prevalence is reported as 3.7–3.8% [3,4]. Even though it is now easier to differentiate epileptic seizures from PNESs with video-EEG, it takes, on average, 7 years to make a correct diagnosis of PNESs, and 3/4th of the patients are treated with an anticonvulsant until that time [5,6]. Informing some patients about the nature of the seizures or treating comorbid anxiety and depression may be enough to stop the seizures. However, two-thirds of patients with PNESs continue to have seizures even after four years after the diagnosis [7].

To date, several trials of pharmacotherapies, psychodynamic therapies, cognitive-behavioral therapy (CBT), or group therapies for the treatment of chronic PNESs have been published. Lafrance et al. conducted a placebo-controlled, randomized study on 38 patients with PNESs diagnosed by video-EEG [8]. Different dosages of sertraline were administered for 12 weeks, and seizure frequency was reduced in the treatment group compared to the placebo group. Cognitive-behavioral therapy has been found to improve coping skills and reduce comorbid anxiety, depressive disorders, and health expenses. In some studies, it has been shown that CBT also reduces seizure frequency [9–12]. In addition to CBT, other psychotherapy methods can also be used. Kalogjera-Sackellares published her 15 years of experience in psychodynamic therapy for PNESs, and the results suggest that this method might also be effective in treatment [13]. In another study, the effectiveness of short-term interpersonal psychotherapy has been assessed [14]. The authors reported that at the end of therapy, 22.5% of the patients stopped having PNESs and that 40.4% of patients had more than 50% reduction in seizures. Health service use was also reduced at the end of therapy compared to the beginning.

Another therapy modality that has been used to treat PNESs is group therapy. Group therapies are reported to benefit individuals with PNESs because of a number of factors. Group experience may normalize the problems. Information is captured and disseminated easily, a support network is created, and social isolation is reduced. During sessions, members may witness symptoms similar to their own and may observe the psychological factors that trigger and end their seizures and those of others. Coping skills might be learned and accepted more easily after interaction with other group members [15]. There have been three reported studies of group psychotherapy for PNESs [16–18]. Zaroff et al. conducted a 12-week open-label group therapy study which was based on psychoeducation [16]. Prigatano et al. published a 24-week open-label group therapy study based on "facts" about PNESs [17]. In another study, Barry et al. reported a

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* Corresponding author.
E-mail addresses: sinemzbaser@gmail.com (S.Z. Metin), drmineozmen@gmail.com (M. Ozmen), baris.metin@ugent.be (B. Metin), seren@csu.fullerton.edu (S. Talasman), snaz@istanbul.edu.tr (S.N. Yeni), cigdem.ozkara@gmail.com (C. Ozkara).

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form of group psychotherapy based on the fact that seizures were a somatic way of self-expression along with anxiety and affect dysregulation [18]. Sessions lasted 32 weeks, and twelve patients attended more than 75% of the sessions.

From all of the studies mentioned above, it can be concluded that information about seizures, anger and its management, developing coping strategies, verbalizing somatic expressions, and finding previous traumatic events are important in the management of PNESs. In addition, we predicted that families have an important role in intensifying the image of seizures as a kind of “sickness” and they could strengthen secondary gains but also, with appropriate guidance, help in reducing seizure frequency. The aim of this study was to offer a treatment which covers all of these approaches in a limited time period.

2. Methods

In this study, we developed an eclectic group psychotherapy using psychoeducation and behavioral and psychoanalytic techniques at the same time. Weekly sessions that lasted 90 min were held for twelve weeks. An IPA-certified psychoanalyst and psychiatrist (MO), who acted as the group leader, and two cotherapists ran the sessions. One of the cotherapists was a clinical psychologist, and the other cotherapist was a last-year psychiatry resident who has a basic knowledge of cognitive-behavioral and psychodynamic therapy techniques.

Patients and families were given a booklet describing the illness and methods for coping with anger, trauma, loss, and mourning. Families were gathered four times for 1 h during the whole study. They were not included in the therapy process and met just before the group sessions. Families were encouraged to ask questions and talk about seizures, and behavioral management strategies were advised.

After the group therapy, patients were seen in standard psychiatric care by the cotherapist (psychiatry resident) for nine months. These outpatient visits were done once a month and lasted 45 min, but these were not individual psychotherapy sessions.

Charters to record weekly PNES frequency were handed out. Each week at the beginning of the sessions, patients were asked how many seizures they had in the previous week. Families were informed about these charters and were responsible for checking the accuracy of seizure frequency. Seizure frequencies were recorded by the therapists monthly before and during the therapy and on follow-up visits at the fourth, sixth, ninth, and twelfth months.

2.1. Subjects

Thirteen patients with video-EEG-confirmed PNESs who did not respond or comply with the standard psychiatric care were included. Patients had an IQ > 70 based on the results of the Alexander IQ Test for elementary school graduates or the Catell Culture Fair Intelligence Test for those with a higher educational level. During the study, concurrent pharmacotherapies were not changed, and patients who started with new psychotropics within the previous two months were excluded. Nine patients (eight women and one man) attended more than 75% of the sessions. The average age of these nine patients was 22.5, with the youngest being 16 years old and the oldest 43 years old. Five of them graduated from elementary school and four from high school. Four of them were married, and five were single. Six of them had comorbid depression, one had dysthymic disorder, two had posttraumatic stress disorder, one had generalized anxiety disorder, and one had pathological mourning.

2.2. Measures

Patients were interviewed by a psychiatrist and evaluated with SCID-I [19]. A preliminary psychodynamic understanding/formulation for each patient was also included in this evaluation. At the beginning and end of the therapy, the patients filled in the following measures: Beck Depression Inventory, Dissociative Experiences Scale, Spielberger State–Trait Anxiety Scale, SF-36 Life Quality Scale, and Toronto Alexithymia Scale [20–24].

2.3. Therapy progress

At the beginning of the group psychotherapy, the following primary therapeutic goals were set: educating about PNESs, preventing secondary gains, learning the meaning of the symptoms, and then reducing the frequency of PNESs. As sessions progressed, psychodynamic conflicts, the meanings of symptoms, and traumatic experiences were addressed and explained on a “here and now” basis.

To reduce the frequency, duration, and intensity of PNESs, we used operant conditioning techniques. We instructed the group to ignore seizures during the sessions. If a patient disturbed the session with a seizure, we asked him/her to wait in the next room or to go to the emergency department and rejoin the group when the seizure stopped. In this way, the group's progress was not interrupted, and the seizures did not become the point of focus.

In the first sessions, the group was educated about the mechanism and triggers of seizures. Group members gave examples from their own experiences and discussed the possible causes of their seizures. The importance of recognizing negative feelings and expressing them in an appropriate and positive manner for a healthier mental status and communication/relation was emphasized. Members developed relations during the therapy process and had conflicts with both the therapists and themselves. These conflicts had been a chance for group members to learn how to express negative feelings. Therapists tried to be a model in containing these feelings and in their efforts to understand an angry patient in the face of a conflict and finally in building a positive response and explanation. Patients were encouraged to think about and search for the unconscious motivations of their seizures retrospectively after observing seizures which occurred during sessions.

As soon as these unconscious motives and, especially, needs behind seizures were voiced out, the patients' embarrassment and defensive manners disappeared, and they started to join in our efforts to understand the causes of the seizures. With the help of the therapists' observations and the observations of each group member, a connection between the seizure and each of the patients' personal history was built.

Therapists defined the seizures as a temporary solution for problems with an extremely high cost and a burden for the patients. The seizures were solutions that were built up when the patients were children or mentally in danger, which helped them to survive and adapt at that time, but they were making their life difficult as an adult.

Observing another patient having a seizure during the session had a beneficial effect especially on younger group members who defined their secondary gains and agreed that they had to find another way.

In the last sessions, as themes of loss and abandonment were dominating the group work, therapists also emphasized that the return of the seizures was not something to be afraid of and that they could be managed in a similar way when they came back. Expecting a cure for patients whose seizures existed for a long time would not be realistic, but the goal was a reduction in frequency and intensity.

Four patients did not continue attending the sessions. One patient had lost her two brothers because of a neurological disease. Her seizures resembled her brothers' symptoms, but she did not agree with this interpretation of the therapists. After a couple of sessions, she quit the therapy. A few months later, she spontaneously called to ask if another group was going to be convened and if she could continue her treatment. Another patient who grew up with a mother with epilepsy stated that she could not bear seeing other patients' seizures. She stopped coming, and she did not even answer phone