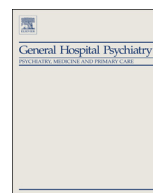




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Efficacy of brief interdisciplinary psychotherapeutic intervention for motor conversion disorder and nonepileptic attacks[☆]

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ABSTRACT

Objective: The objective was to compare a brief interdisciplinary psychotherapeutic intervention to standard care as treatments for patients recently diagnosed with severe motor conversion disorder or nonepileptic attacks.

Methods: This randomized controlled trial of 23 consecutive patients compared (a) an interdisciplinary psychotherapeutic intervention group receiving four to six sessions by a consultation liaison psychiatrist, the first and last sessions adding a neurological consultation and a joint psychiatric and neurological consultation, and (b) a standard care group. After intervention, patients were assessed at 2, 6 and 12 months with the Somatoform Dissociation Questionnaire (SDQ-20), Clinical Global Impression scale, Rankin scale, use of medical care, global mental health [Montgomery and Asberg Depression Rating Scale, Beck Depression Inventory, mental health component of Short Form (SF)-36] and quality of life (SF-36). We calculated linear mixed models.

Results: Our intervention brought a statistically significant improvement of physical symptoms [as measured by the SDQ-20 ($P < .02$) and the Clinical Global Impression scale ($P = .02$)] and psychological symptoms [better scores on the mental health component of the SF-36 ($P < .05$) and on the Beck Depression Inventory ($P < .05$)] and a reduction in new hospital stays after intervention ($P < .05$).

Conclusion: A brief psychotherapeutic intervention taking advantage of a close collaboration with neurology consultants in the setting of consultation liaison psychiatry appears effective.

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1. Introduction

Patients suffering (according to the *International Classification of Diseases, 10th Revision*) from motor and convulsive dissociative disorders (also called nonepileptic attacks) or conversion disorders [functional neurological symptom disorder; according to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5)] frequently present to neurologists as up to 30% of new neurology outpatients present with some functional symptoms [1], about 8% can be diagnosed with

conversion disorder [2] and 10%–20% of patients with intractable epilepsy suffer from nonepileptic attacks (NEAs) [3]. They represent a therapeutic challenge and are considered to be more difficult to help than patients with better characterized organic neurological diseases [4]. The prognosis is globally unfavorable, with long-lasting symptoms as shown by a recent review (globally only 50% improving) [5–7] leading to early work retirement (30% do not work anymore at an average age of 44) [6]. A number of treatment strategies have been proposed ranging from psychologically derived hypothesis using hypnosis [8], abreaction [9], cognitive-behavioral approaches [10–12] to more physically based approaches using physiotherapy [13], transcranial magnetic stimulation [14] or drugs (antidepressants) [15]. A recent Cochrane review of treatments for nonepileptic attacks concluded that the evidence was scarce for any psychological or behavioral intervention and that there is a lack of randomized controlled trials [16]. In the same year, a randomized controlled trial (not included in the Cochrane review) showed that patients included in the cognitive-behavioral therapy informed psychotherapy (CBTit) arm had a 51% seizure reduction, whereas another arm combining CBTit and sertraline had a 59% seizure reduction, which was significant compared to both the treatment-as-usual arm (follow-up by neurologist only) and the sertraline arm [17]. This argues for a systematic implementation of psychotherapy in the care of NEA patients. For conversion disorder (all symptoms, not only

[☆] Author contribution: The study design and concept were elaborated by B.A., V.F., A.S. and H.M. Patients were enrolled and assigned by H.M., A.S., M.G.E. and C.O. R.A.O. made the NEA diagnoses. The psychotherapeutic intervention was conducted by H.M., M.G.E. and C.O.; the neurological intervention was conducted by A.S. The outcome measures were evaluated by H.M., M.G.E., C.O. and A.S. Data were collected by H.M., M.G.E., C.O. and A.S. and computerized by H.M. Statistical analysis was done by G.M. Critical analysis of data was done by H.M., A.S. and B.A. The first draft of the manuscript was written by H.M. and reviewed by A.S., B.A., V.F., C.O., R.A.O., M.G.E. and GM.

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NEA), the current trend and preferred therapeutic option, based on expert opinion [18], are a multidisciplinary approach, the first step being a careful diagnostic evaluation and clear explanation to the patient by the neurologist. A second key milestone in the care of these patients is the involvement of psychiatrists [19]. Indeed, after a long-lasting separation between neurology and psychiatry over the last century, there has been a recent new collaboration between the two specialties in particular around this paradigmatic “neuropsychiatric” disorder [20]. The newly released DSM-5 classification does not consider the presence of associated psychological factors as a required diagnostic criterion but as an additional suggestive feature; however, literature does suggest a role for psychiatric stressors and/or comorbidities as either triggering or maintaining factors [21,22]. A joint psychiatric–neurological consultation for patients presenting with conversion symptoms was created in our tertiary center in 2005. The evidence of an association between childhood trauma and conversion disorder being meanwhile strong [23,24], we integrated basic psychotraumatology principles in our psychotherapeutic intervention, hoping to increase patients’ treatment adherence. A retrospective study showed that such early intervention involving both neurologists and psychiatrists was effective in reducing physical symptoms, sick leave and health care use [25]. There are only very few published data on the efficacy of therapeutic interventions for conversion disorders [26]. We present here the results of a pilot prospective randomized controlled trial to compare the effect of our brief interdisciplinary psychotherapeutic intervention (IPI) to standard care (SC) as treatments for patients recently diagnosed with severe motor conversion disorder or NEA.

2. Material and methods

We conducted a parallel, randomized, controlled trial with an allocation ratio of 1:1. No changes were made to methods after the trial started.

2.1. Standard protocol approvals, registrations and patient consents

This trial was approved and registered by the Ethics Committee of Canton de Vaud, Switzerland, under Protocol 174/09. Patients received written information and gave written informed consent. We followed CONSORT reporting guidelines [27].

2.2. Participants

Twenty-three consecutive patients were recruited from our Neurology Department from November 2010 to January 2013, with follow-up ending December 2013. Inclusion criteria were (a) age: 16–65 years and (b) newly diagnosed conversion disorder according to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (DSM-IV-TR) (within 12 months) with motor or NEA symptoms assessed by experienced neurologists. The diagnosis was established after extensive history and clinical examination, including systematic evaluation of “positive signs” of conversion disorder [28]. NEA patients had a video-electroencephalogram (EEG) evaluation with provoking maneuvers (verbal suggestion, hyperventilation, intermittent photic stimulation, positioning of a tuning fork on the forehead and – in selected cases – a NaCl nocebo injection) in order to obtain a typical clinical event; diagnosis was made if this corresponded to the habitual spells, was clinically suggestive of NEA and presented without any pathological EEG alteration in accordance with our practice and recent guidelines [29,30]. Further investigations (computed tomography, magnetic resonance imaging, positron emission tomography scan, electromyographic electrophysiology, transcranial magnetic stimulation) were conducted to confirm diagnosis when necessary. Only patients meeting the international diagnostic criteria for psychogenic movement disorder A: documented, B: clinically established or C: probable were included [31]. An experienced liaison psychiatrist confirmed the diagnosis.

Exclusion criteria were (a) lack of verbal fluency in French; (b) neurological comorbidity with motor or gait symptoms, or concomitant epilepsy diagnosed by an experienced epileptologist; (c) psychiatric comorbidity of psychosis, acute suicidality or current substance abuse; or (d) current psychotherapy at the time of inclusion. All data were prospectively collected in identical settings within the Neurology Department of the Lausanne University Hospital, Switzerland. All patients had been assessed as in-patients in a neurological unit and therefore presented with severe symptoms.

2.3. Randomization

Randomization to IPI or SC was done through 24 identical, nontransparent, sealed envelopes, half containing a paper stipulating “treatment” and the other half “standard.” The envelopes were independently prepared by H.M. and sealed, and then given to a third person unaware of their content to mix. They were numbered consecutively and given in chronological order to patients as written informed consent was signed.

2.4. Treatment

2.4.1. Interdisciplinary psychotherapeutic intervention

This four- to six-session brief psychotherapeutic intervention was based on a psychodynamic interpersonal treatment approach over a 2-month period, analogous to the psychodynamic interpersonal therapy by Guthrie [32]. The majority of patients received five sessions over a period of 2 months, spaced approximately every 10 days according to the therapists’ schedule, but some unstable patients could receive six sessions; so the intervention was tailored to patients. The intervention began by an interdisciplinary session of 2 h and 30 min, divided into a 1-h neurological consultation, followed by a 1-h psychiatric consultation and ending with a joint neurological and psychiatric consultation of 30 min (Fig. 1). During the initial psychiatric–psychotherapeutic session, when the diagnosis was confirmed, focus was primarily on the patient’s reaction with respect to the psychiatric referral, her/his illness beliefs, fears, stress factors, potential conflicts and doubts about the diagnosis. In parallel, the presence of comorbid psychiatric disorders was evaluated and medication was started, if indicated. With care, the potential history of serious trauma (physical and sexual abuse, emotional negligence) was investigated, with respect of potential avoidance and current coping mechanisms. Care was taken to remain within the tolerance window [33] in order to avoid further dissociation. The diagnosis of “functional neurological disorder” was then conveyed to the patient during the joint consultation with the neurologist, allowing for

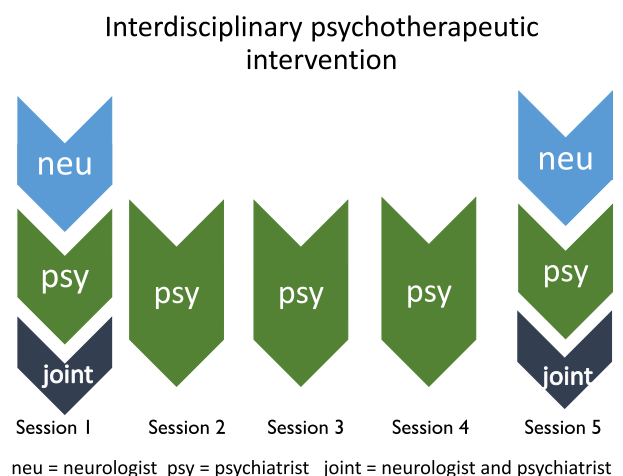


Fig. 1. Interdisciplinary psychotherapeutic intervention.

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