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Group psychotherapy format guided self-help for patients with FNSD awaiting inpatient multidisciplinary treatment: A pilot study

Vasile Boico[1] | **Susan Humblestone**[2] | **Michael Moutoussis**[2,3,4] | **Caroline Selai**[1,2]

[1]Department of Clinical and Movement Neuroscience, UCL Queen Square Institute of Neurology, London, UK

[2]Neuropsychiatry Department, National Hospital for Neurology and Neurosurgery, London, UK

[3]Wellcome Centre for Human Neuroimaging, University College London, London, UK

[4]Max Planck–University College London Centre for Computational Psychiatry and Ageing Research, London, UK

Correspondence
Caroline Selai, Department of Clinical and Movement Neuroscience, UCL Queen Square Institute of Neurology, London, WC1N 3BG, UK.
Email: c.selai@ucl.ac.uk

Abstract

Background: We describe our experience of developing Guided Self Help for patients with Functional Neurological Symptom Disorder as group therapy, delivered remotely, via Zoom.

Aims: The aims of the current study are (a) to describe how the original Queen Square Guided Self-Help (QGSH) was adapted for group therapy, and (b) to present a service evaluation of the first 8 months of running QGSH therapy groups remotely.

Methods: We carried out a review after 8 months, from 11 May 2021 until 31 January 2022.

Results: A total of 16 patients were treated in three groups. Assessing our outcomes in terms of Yalom's framework for group psychotherapy, we found that the group provided 10/11 of Yalom's therapeutic factors. Patient satisfaction was high.

Discussion: We outline for plans for further devaluation and development, including the development of a stand-alone group.

Conclusion: The group therapy format is a promising addition to our service.

KEYWORDS
client experiences, cognitive behavioural therapy, group therapy, psychotherapy

1 | INTRODUCTION

Functional neurological disorders (FND) are characterised by disabling neurologic symptoms without a macrostructural cause, which are not explained by other neurological or neuropsychiatric disorders. Nonepileptic or dissociative seizures and functional movement disorders (FMD) are the most common phenotypes (American Psychiatric Association, 2013; Carson & Lehn, 2017). Previous terminologies have included 'psychogenic disorders', 'hysteria', 'somatization' and 'conversion disorders', associated with stigma and burden that the condition has borne (Keynejad et al., 2017). The currently preferred term 'functional' is causally neutral and more acceptable to patients (Levenson & Sharpe, 2016).

There is a vast and varied collection of symptoms that can range in duration from brief to persistent episodes (Petrochilos et al., 2020), including motor (e.g., jerks, weakness and tremor) and sensory symptoms (e.g., pins and needles) to impaired vision and/or speech, dissociative events, seizures and cognitive dysfunction

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Joint senior authors: Caroline Selai and Michael Moutoussis.

(Bennett et al., 2021). With an estimated yearly incidence of 12 per 100,000 people (Stone & Carson, 2015) and a prevalence of 50 per 100,000 people (Carson & Lehn, 2017), FND is a significant cause of disability that accounts for around 10% of cases in neurological practice (Bennett et al., 2021). FND can affect individuals of all ages, being more common in women than in men (74.6% versus 25.4%), and is associated with high rates of unemployment (Hendrickson et al., 2014). Evidence indicates that FND is also correlated with reduced quality of life (Jones et al., 2015), elevated healthcare costs (Stephen et al., 2021) and increased mortality rates (Nightscales et al., 2020). Additionally, it is accompanied by high levels of psychological comorbidity, namely depression (Carson et al., 2011), anxiety (Feinstein et al., 2001) and panic symptoms (Dimaro et al., 2014), as well as personality disorders (Hovorka et al., 2007).

Treatment modalities include psychotherapy, physiotherapy, speech or occupational therapy, or multidisciplinary treatment (MDT) (Aybek et al., 2013; Goldstein et al., 2010; LaFrance et al., 2014; Nielsen et al., 2016). Indeed, psychotherapy has been found to lead to reduced seizure frequency and severity, and improved overall quality of life (Goldstein et al., 2010). One of the main approaches to therapy is cognitive behavioural therapy (CBT), which challenges the maladaptive beliefs and behaviours assumed to underpin the development of FND (Lin & Espay, 2021). In a randomised controlled trial (RCT) of 66 patients, Goldstein et al. (2010) compared CBT with standard medical care (SMC) and found that CBT conferred a higher reduction in seizure frequency than SMC. More recently, a meta-analysis of 16 studies by Carlson and Nicholson Perry (2017) indicates that CBT is favourable for psychogenic nonepileptic seizures (a subtype of FND), with 82% of participants having had reductions in seizure frequency by 50% or more. Patients presenting with more complex symptoms and high levels of comorbidity and/or disability may benefit from an inpatient MDT programme (NHS Scotland, 2012). Focussed MDT interventions, delivered by healthcare professionals from diverse backgrounds (i.e., psychologists, neurologists, and occupational/speech therapists), have the potential to maximise recovery by helping patients to identify triggers and enabling behavioural changes (LaFaver et al., 2020). For instance, Saifee et al. (2012) reported that 58% of patients rated their symptoms as improved at the end of an MDT programme and at a 2-year follow-up.

However, the efficacy of MDT programmes can be suboptimal because patients spend a substantial amount of time getting acquainted with the rehabilitative approach and gaining an understanding of their FND diagnosis (Demartini et al., 2014). Preparatory therapy programmes, which include psychoeducation and an introduction to the CBT approach, can provide effective guidance for patients embarking on an MDT programme journey, allowing them to maximise the benefits of hands-on rehabilitation. Humblestone et al. (2022) developed such an intervention, called the Queen Square Guided Self-Help (QGSH), which was delivered as individual therapy to 122 patients. The original format QGSH, delivered by one therapist to an individual patient, yielded positive results, and a number of factors led to a natural evolution and the development of a group therapy format. First, patient groups bring additional therapeutic benefit compared with individual psychoeducation, facilitating crucial peer support and helping motivation. Second, with the imposition of the first COVID-19 pandemic lockdown in the UK (March 2020), the guided self-help (GSH) team sought to conduct their clinical activities remotely, as did many clinicians and therapists worldwide. Online delivery of therapy has become increasingly used and can increase access to treatment by removing constraints such as location, commuting time and therapists' availability (Lin & Espay, 2021). This study extends the work of Humblestone et al. (2022) to group-based, online therapy, which has considerable advantages—as well as limitations. We outline the process of adapting the QGSH therapy for patients with FND who are being prepared for an inpatient MDT programme, including the experiences of the team and feedback from our patients.

Implications for Practice and Policy

- We describe the development and piloting of a group therapy intervention for patients with functional neurological symptom disorder (FNSD).
- Estimates of the prevalence of FNSD vary, but it is acknowledged to be a significant problem. It is estimated that up to 52% of patients presenting to hospital clinics fulfil criteria for medically unexplained symptoms (MUS). These patients make high demands on healthcare services, with requests for multiple consultations and a high annual cost to the NHS.
- There is significant waiting time for patients referred for psychotherapy. A remotely delivered group therapy intervention could reduce waiting times with implications for saving scarce healthcare resources.

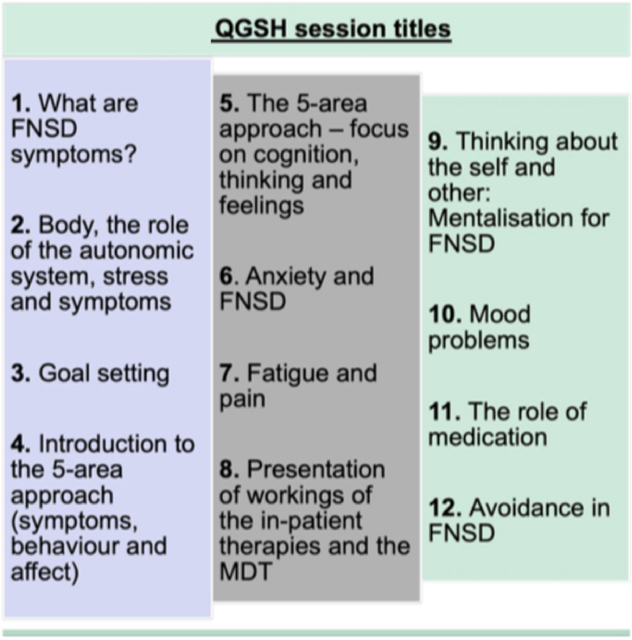
1.1 | The Queen Square Guided Self-Help (QGSH) model

In the previous work, we developed and implemented a CBT-informed therapeutic intervention (Humblestone et al., 2022), based on psychoeducation, homework tasks and goal-setting, introduced so that patients preparing to undergo an inpatient MDT programme can make the best use of their treatment. Designed as a short-term, preparatory therapy before admission to the MDT programme, the intervention aims to equip patients with an understanding of their FND diagnosis, the five-area CBT model (centred on the work of Williams et al., 2011), and the importance of goal-setting during rehabilitation. Most importantly, however, the aim of the QGSH is to establish a collaborative approach to treatment between patients and MDT staff.

The QGSH is a structured, internet-based GSH model that combines the use of patient worksheets, original videos and relevant published resources (e.g., Overcoming FNS by Williams et al., 2011), with guidance from therapists. Delivered in the format of individual therapy sessions for up to 12 weeks, the intervention includes 12 thematic modules, each supported by a set of associated worksheets and bespoke video sessions on YouTube that patients get access to at intervals determined by the therapist and patient working collaboratively. In addition, the patients are offered telephone appointments approximately every 2 weeks with senior clinicians in the QGSH team (an occupational therapist, a consultant medical psychotherapist and a psychologist). The delivery of the therapy is specifically tailored to the needs of each patient (e.g., the order of the modules might be changed and information might be sent by post instead of electronically).

The modules comprise introductory sessions on FND and the five-area model, as well as sessions on goal-setting, fatigue and pain (Figure 1). A key component of the QGSH includes setting 'homework' tasks that encourage the patient to assume control over their self-management and accomplish a set of goals in their rehabilitation. The therapists sought to build rapport with patients from the outset and to make them feel 'heard', whilst explaining the importance of collaborative approaches to MDT programmes. At handover stage, patients were encouraged to play an active role in reflecting on what they have learnt/achieved during therapy, rather than just simply being handed over to the MDT team.

A total of 122 patients took part in the individual QGSH preparatory therapy. Patients stated that the QGSH, particularly the interactions with the therapists, diminished their anxieties and stigma regarding FND treatment. Both qualitative feedback and quantitative data from the specially devised patient-reported outcome measure (PROM) and the clinician-rated outcome measure (CROM) were very positive, indicating that the QGSH is a helpful intervention in preparing patients for the inpatient MDT programme (Humblestone et al., 2022).



QGSH session titles

1. What are FNSD symptoms?

2. Body, the role of the autonomic system, stress and symptoms

3. Goal setting

4. Introduction to the 5-area approach (symptoms, behaviour and affect)

5. The 5-area approach – focus on cognition, thinking and feelings

6. Anxiety and FNSD

7. Fatigue and pain

8. Presentation of workings of the in-patient therapies and the MDT

9. Thinking about the self and other: Mentalisation for FNSD

10. Mood problems

11. The role of medication

12. Avoidance in FNSD

FIGURE 1 Queen Square Guided Self-Help session titles. FNSD, functional neurological symptom disorder; MDT, multidisciplinary treatment.

1.2 | The need for group QGSH

Group therapy provides significant advantages (Yalom, 1995), ranging from opportunities to meet and gain support from other patients with similar symptoms and difficulties to instilling hope and providing an appropriate medium for disseminating information. In addition, online groups can bring together diverse individuals with FND from different geographical areas, increasing their sense of community support. Online group therapy may offer financial savings and be more accessible to individuals than standard treatment modalities (Barry et al., 2008), but the temptation to see them as money-saving devices has to be offset against the challenges experienced by some for patients who find it difficult to make use of groups.

With the emergence of the COVID-19 pandemic and the first lockdown in the UK (March 2020), as well as growing patient waiting lists, we decided to offer the QGSH: (a) remotely via Zoom and (b) to groups of patients instead of individually. The move to a group format required a thorough review of the QGSH, which we detail below.

1.3 | Aims

The aims of this study are (a) to describe how the original QGSH was adapted for a group therapy format and (b) to present a service evaluation of the first 8 months of running QGSH therapy groups remotely on Zoom.

2 | METHODS

We adapted the QGSH for a group therapy format by (a) introducing a number of parameters recommended by the British Psychological Society (BPS, 2021) and (b) collecting qualitative data from those receiving the group intervention to inform service evaluation.

2.1 | Adjustments

The BPS developed a set of guidelines and practice tips for adapting interventions for digital, group delivery (BPS, 2021). The resource summarises practical advice on the delivery of safe and controlled group interventions with the use of videoconferencing tools whilst providing questions to stimulate reflection on and highlighting potential areas of concern. In adapting the QGSH model for group therapy, we made the following adjustments.

2.1.1 | Group orientation and initial contracting

Before the first group therapy session, each patient was invited to an individual telephone or Zoom orientation session to explain the goals of this preparatory group therapy and what the QGSH entails. We also took time to address some common initial concerns and apprehensions from patients regarding groups, and to outline some advantages of participating in group therapy. Some patients said they were anxious about being seen on camera by a group of strangers. This was related to a variety of concerns, including social anxiety, embarrassment about symptoms (e.g., vocal tics), a previous experience of trauma and difficulties related to autism spectrum disorder (ASD). Patients were advised that they could attend the first session 'just for a short while' and/or that they could keep their camera off. Permission was asked for pets to be allowed to join and, during the period under consideration, these included cats, a therapy dog and a cockatiel.

2.1.2 | Group boundaries and expectations

The first group therapy session also started with contracting. We discussed confidentiality in detail, including the need for carers to 'keep an eye' on patients with frequent seizures, and other such concerns. We then established boundaries in relation to the length (12 weeks) and frequency (once a week) of group therapy, patients' environment/setting (private and free of distractions) and the use of camera and the mute button on Zoom. In cases where a family member requested to join the patient for part or all of a session, explicit permission was requested in advance from all group members. Expectations were also set by both therapists and patients regarding communication and the interactive nature of the sessions.

2.1.3 | Interactive group sessions

Each group started with a check-in, with all participants being invited to say how things had gone in the preceding week. We introduced a number of interactive group activities, at least one per group meeting, to invite the participants to discuss a concept (e.g., 'What is FNSD?'), to share experiences, especially regarding their journey to diagnosis and previous treatments and what impact their symptoms are having on their life, as well as to ask questions and to share tips and suggestions with each other.

2.1.4 | Confidentiality

Patients agreed to keep confidential anything disclosed by group members. In addition, they were informed of any exceptions to confidentiality such as those relating to the responsibility of therapists to keep everyone safe. Various family members sat with group participants to help patients with (to give two examples) cognitive difficulties such as memory deficits and functional aphonia. We sought permission from the group before allowing helpers to join in and reiterated the importance of maintaining confidentiality.

2.1.5 | Risks (e.g., dissociation and/or the possibility that someone becomes distressed)

We undertook a risk assessment taking into account each patient's history, environment and mental state, and created an appropriate risk management plan. For example, we ensured that participants who might be at risk of having a dissociative, nonepileptic seizure had help on hand. We also explored in advance what the follow-up would be should someone become distressed during the group session. Each patient's consent to our plans for risk assessment was sought before joining the group. Patients were told that if they had important mental health concerns, especially about their safety, they could 'stay behind' after group sessions and tell the facilitators, who were trained mental health professionals. They were also informed that the group did not provide emergency care, for which they should still contact emergency and primary care services.

2.1.6 | Factors that may impact a person's ability to join the group

We had explored in advance how we would manage this. Difficulties ranged across:

(i) technical (e.g., a family member or carer was needed to set the patient up on Zoom);
(ii) anxieties about being part of a group (e.g., social anxiety);
(iii) anxieties about being seen on camera (e.g., related to previous trauma);
(iv) communication relating to cognitive difficulties (e.g., brain fog or functional aphonia);
(v) communication relating to mentalisation (e.g., 'Everyone else in the group will not like me / will think I am stupid'; or 'The group and I will not be able to communicate because of my diagnosis of Autism Spectrum Disorder'); and
(vi) self-perception (e.g., 'My symptoms are largely "invisible" so they might think I am "faking" or not sufficiently deserving of treatment').

2.1.7 | Length of sessions

Therapy sessions ran between 60 and 90 min. In consultation with participants, we scheduled at least one comfort break per session.

2.1.8 | Checking in/out

In addition to the routine check-in at the start of each session, to ensure each member felt heard, each member was invited to checkout. Checkouts were focussed, with an emphasis on reflection (e.g., 'What one thing will you take away from today?'). Participants were encouraged to engage with each other and, as the group members gained confidence, the convenors stepped back to allow space for the group members to interact directly with each other.

2.1.9 | Using breakout rooms

We mainly completed the interactive group activities all together in one large group. We experimented with using breakout rooms to facilitate small group discussions, but we found discussions functioned best with the whole group so that nothing was missed by any members.

2.1.10 | Security

The Zoom account used was specifically provided by the Neuropsychiatry Department of UCLH and was approved by the Department in terms of suitability and security. This included the use of codes and password protection, along with the session links that we sent to participants in advance.

2.1.11 | Group members who might be struggling

We had discussed in advance safety measures and the option of involving other services. As per our initial contracting, we contacted (one-to-one) any group members who appeared to be struggling and offered them support. As an example, one participant 'disappeared' from view towards the end of a session, and we phoned to follow up. The patient had experienced a nonepileptic seizure (they had warned us beforehand that this might happen). On this occasion, they were cared for by family members who had been nearby, and the patient had eagerly returned to the group the following week. Another participant who also 'disappeared' from view later reported that they had felt so warm and comfortable during the group they had fallen asleep!

2.1.12 | Preparing handover notes

As each patient came to the end of the preparatory group therapy, one of the group convenors (i.e., one of the therapists) wrote a 'handover' note for the MDT team, outlining the patient's progress throughout the preparatory therapy, how the patient had made use of the group and the QGSH materials (including engagement with the homework tasks), how the patient had interacted with the group leaders and other group members and noting any issues arising that may be of interest to the MDT team (e.g., flagging difficulties engaging with the homework tasks, which might be due to 'perfectionism', low self-esteem or because the word 'homework' evokes memories of bullying at school, can be helpful for the 'receiving' MDT team).

2.2 | Service evaluation: Qualitative data

2.2.1 | Qualitative data (i): Feedback on the materials and the homework tasks

At every session, there was some spontaneous feedback from participants, which prompted us to review and see where improvements could be made. We (staff) met as a team each week for approximately 30 min prior to the start of the group to reflect on the previous week and on our plans for the upcoming session. We also held a 'debriefing' discussion directly after each session, which included task allocation for us (e.g., phone calls, emailing and tailored homework).

2.2.2 | Qualitative data (ii): Experience of the group

In addition to spontaneously offered feedback from the group participants, we elicited qualitative feedback throughout, enquiring at every session how the group members were experiencing the group and whether they had any comments or suggestions. We also asked consolidation and closure questions, inspired by system-centred group therapy.

2.2.3 | Quantitative data

We developed a single, streamlined eight-item outcome measure based on the much longer PROM and the CROM, which we had developed and administered during our previous development work (Humblestone et al., 2022). This eight-item outcome measure can be seen in Appendix A.

3 | RESULTS

We carried out a review after the QGSH-based online group therapy had run for 8 months, from 11 May 2021 until 31 January 2022, and a total of 16 patients were treated in three groups. Table 1 contains a summary of demographic information on our sample.

Patients reported a mix of symptoms, with the most common being nonepileptic seizures (NES) and motor and sensory difficulties. Functional neurological disorders also often coexisted with other pathologies, such as anxiety or depression. Of these 16 subjects, only nine have been through an inpatient MDT programme and completed all 4 weeks with positive results.

TABLE 1 Demographic information on patients who completed group therapy.

Group	Total	Female	Male
1	5	5	0
2	6	3	3
3	5	2	3

3.1 | Service evaluation: Qualitative data

3.1.1 | Qualitative data (i): Feedback on the materials and the homework tasks

At every session, there was some spontaneous feedback from participants, which prompted us to improve the materials, including the homework tasks. As a result, improvements were made to all QGSH materials, ranging from simplifying complex slides, changing 'vignettes' to make them more relatable to the members of the group and adding in other interactive tasks to tap into the group members' experiences. Homework instructions were changed to accommodate both patients who were enthusiastic and able to do the homework and patients who could only manage a small amount of between-session work. We were careful to ensure that the group discussion did not re-create the experience of being criticised or judged unfavourably in front of others at school, and to normalise such memories if present.

3.1.2 | Qualitative data (ii): Experience of the group

The feedback received by the patients who engaged with the group was overwhelmingly positive. Patients reported feeling 'understood' by the QGSH therapists and were glad to meet (often for the first time) other patients in the group who also had FND. Many said they were reassured by hearing that other participants had had similar experiences. At the end of the QGSH programme, all patients noted that they had gained a better understanding of their FND diagnosis, the principles of CBT and other aspects of the multidisciplinary approach, and the importance of setting goals during rehabilitation.

Yalom (1995) outlined 11 curative factors that emphasise change within group settings. From the patients' comments, our group intervention has also provided 10 out of 11 of Yalom's therapeutic factors, which are summarised in Table 2.

Below, we explore the 10 curative factors that our group achieved with examples from our participants. The quotes were from patients in this group and are provided as recorded in our notes (the factors were not necessarily acknowledged by the patients).

Instillation of hope

Many FND individuals undergoing treatment felt overwhelmed by their symptoms, which they did not think they could keep under control. Many did not have hope of improvement. During the preparatory group therapy, participants were provided with a sense that change is achievable.

TABLE 2 Yalom's therapeutic factors within the Queen Square Guided Self-Help (QGSH) groups (see text for details).

1.	Installation of hope
2.	Universality
3.	Imparting of information
4.	Altruism
5.	Corrective recapitulation of primary family group
6.	Developing of socialising techniques
7.	Imitative behaviours
8.	Interpersonal learning
9.	Group cohesiveness
10	Catharsis
11.	Existential factors

> 'I found other patients inspirational'.

Universality

Throughout the course of the QGSH group therapy, participants were able to meet others with similar problems, thus becoming aware that they were not alone.

> 'I enjoyed sharing experiences of the impact of FND'.

> 'This is the first time I have met another person with FND'.

> 'It was lovely to be able to share with the group and receive empathy and support'.

Imparting information

Members were able to reflect on their own experiences and hear how others overcome obstacles.

> 'I was really interested to hear how others have coped'.

Altruism

Group members experienced having selflessly helped one or more other group members achieve their change goals.

> 'I was pleased that my suggestion was helpful for xxxx'.

Corrective recapitulation of primary family group

This was not observed during the group experiences that are the focus of this paper.

Developing of socialising techniques

Participants were afforded the opportunity to connect with others in meaningful ways, and overcome their isolation.

> 'It was good to see other patients with FND'.

> 'Good to meet other patients prior to admission to – and stay on – the hospital ward'.

Imitative behaviour

Participants had the opportunity to learn by witnessing how other members successfully dealt with their struggles.

> 'I also have difficulties with some of my family and meeting all their needs. I was interested to hear how XXXX said they were planning to go away for a short break'.

Interpersonal learning

Through interactions with other participants and the QGSH therapists, some members reported learning more about themselves.

> 'I was worried about joining the group. I was sure the group members would reject me'.

> 'I was pretty convinced that you (group convenors) would not like me'.

Group cohesiveness

The group intervention provided many members with a sense of belonging.

> 'It was lovely to be able to share with the group and receive empathy and support'.

> 'Being in the group felt like people putting their arms round us and giving us a big hug'.

Catharsis

A number of patients described a sense of relief during group therapy.

> 'I felt so relieved… to have been able to tell you… I feel so ashamed…'

> 'I felt so warm and comfortable in the last session that I fell asleep'.

Existential factors

There were some mentions of establishing a life purpose, as well as acceptance of the diagnosis.

> 'I have started to think about what I will do… I would like a different career…'

> 'I am thinking of a career in research. I might do a PhD'.

3.2 | Service evaluation (results)

3.2.1 | Quantitative data

We administered the streamlined eight-item outcome measure (Appendix A), derived from the original PROM and the CROM, which we developed (Humblestone et al., 2022). However, only a small number ($n = 4$) returned the completed questionnaire to us. These data showed that the patients had made good use of the group. The small number of returned questionnaires may be because the questionnaire was sent at the end of the preparatory QGSH group and just before the patient was admitted to hospital. This is a time when the patient is focussed on the multiple practicalities of coming into hospital and the patient is looking forward (usually with some anxiety). No other instructions were given to the participants, and no reminder was sent (we will review this in future). The questionnaire was administered along with other handouts and worksheets, for example, 'What to expect during your stay on the in-patient ward…'. This may have been confusing and/or overwhelming. Importantly, at this transition from preparatory therapy to inpatient treatment, the participants likely felt under pressure to give positive feedback and reluctant to give any comments that might have appeared to be a criticism. Even though patients in the NHS are invited to give feedback and are reminded that any such comments will not affect their clinical care, patients might still imagine that an unfavourable review might have some negative consequences.

4 | DISCUSSION

This study examined the viability of conducting online group therapy with patients with FND.

We report our preliminary experience of moving the QGSH preparatory therapy from an individual, one-to-one format to an online group therapy format, precipitated by the COVID-19 pandemic lockdown.

We were successfully able to adapt the QGSH preparatory therapy to be delivered via an internet group. In doing so, we have made a series of adjustments to the original QGSH model against BPS guidelines for digital group interventions. These included the following: (A) group orientation and initial contracting; (B) group boundaries and expectations; (C) interactive group sessions; (D) confidentiality; (E) risk assessment; (F) assessment of other factors that may impact a patient's ability to join the group; (G) length of sessions; (H) checking in and out; (I) using breakout rooms; (J) security; (K) support for group members who may be struggling; and (L) handover notes.

The intervention was well-received by patients. Qualitative data indicated that the online group offered effective psychoeducation and peer support. There are a number of established advantages to group therapy, including the opportunity to harness the group dynamics to effect therapeutic change, accessibility and cost-effectiveness. Here, the therapy itself and the group setting were reported to affect patients positively, with our group having supplied 10 out 11 of Yalom's curative factors. The online environment created was one in which patients felt comfortable sharing their experiences. Moreover, the CBT framework was vital in facilitating engagement in therapy by fostering a culture of collaboration, interaction, psychoeducation and setting and achieving modest goals.

We attempted a formal service evaluation and, whilst patients readily gave qualitative feedback, we had more difficulties obtaining quantitative feedback (using a specially developed eight-item outcome measure). It may have been that the timing of our administration of the questionnaires, which was just before admission to hospital, was not optimal.

Other possible reasons for the low response rate are as follows: No other instructions were given to respondents (we will review this in future). No reminder was sent (we will review this in future). The questionnaire was administered along with other handouts and worksheets, for example, 'What to expect during your stay on HJ ward…'. This may have been confusing and/or overwhelming. Importantly, the participants, who were about to be admitted to the hospital ward, likely felt under pressure to give positive feedback and may have been reluctant to give any comments that might have appeared a criticism.

We did not attempt formally to compare the outcomes with those of previous patients who had entered the MDT treatment following individual rather than group preparatory treatment because we had significantly reduced the length of the PROM and CROM (Humblestone et al., 2022). The revised PROM can be seen in Appendix A.

In our earlier published study, data were collected on 19 patients using the 31-item PROM and from 29 clinicians using the 15-item CROM. Results for the PROM subsections, (A) knowledge of FNS, (B) experience using the PTP materials, (C) whether PTP helped the patient transition to the inpatient unit and (D) family involvement in FNS, all were rated positively by most patients except Section D, that is, questions about family involvement. Results for the CROM subsections, (i) knowledge of FNS, (ii) engagement during the preparatory treatment, (iii) handover organisation and (iv) overall competence for the inpatient therapy, were positive except for (iii) handover to the inpatient team.

We made changes to address both of these areas: First, discussion of family involvement occurs very early in the group. We start every group with a 'check-in' with all group members, and these weekly updates invariably include references to relationships with friends and family.

Second, we have improved our handover to the inpatient team, and recent feedback from the team is that the handover is no longer an issue. The handover is a collaborative exercise, and we discuss explicitly the handover notes with each patient and invite them to suggest what they would like to be included in these notes (they usually say they are happy to leave this to the group co-conveners). We encourage the patients to bring copies of their worksheets to the ward for ongoing discussions. We developed brief guidelines for our handover notes (Appendix B), and these are now uploaded directly to the patient's notes on the 'EPIC' electronic hospital notes system.

One of the most powerful components of the group is the homework task to write and then share with the group 'My story', which enables the patient to develop a timeline and a narrative of their journey. Each patient can select the time frame to write about, such as their childhood or the period since receiving the diagnosis of FNSD or more recent events. All patients so far have found it helpful to share their stories, hear from other patients and share suggestions for coping strategies. One of the patients in our group said he was so 'inspired' by hearing these stories, and from putting suggestions into practice, that he no longer felt the need to come on the inpatient programme. We have considered ways to adapt the group preparatory therapy as a 'stand-alone' intervention (discussions are ongoing and beyond the scope of this paper).

We took every opportunity to elicit qualitative feedback. This was both in the group setting and individually. An invitation was issued, and there was ample opportunity to contact one of the group convenors for an individual, one-to-one meeting. Patients made good use of this opportunity and contacted us by email and/or phone between the weekly group sessions. One example was a discussion around 'homework'. We invited the patients to tell us what thoughts and feelings were prompted by the word 'homework'. These ranged from unpleasant memories of school-day fears to current social anxiety. We asked whether they were having difficulties with the tasks set and/or difficulties with technology (e.g., sending us an email). Three patients were anxious about joining the group because of their tics, NES or other behaviour. With reassurance, they were all able to join, sometimes with their camera switched off initially until they felt sufficiently held by the group and safe. We noticed that some patients experienced difficulty with goal setting, despite a presentation by us in the group and explicit guidance. We discussed all of these topics in the group, and then we had a discussion about our discussion. This enabled one patient to say that in a previous therapeutic service, she had the experience of therapists setting 'easy' (unchallenging) goals, apparently just to go through the motions and tick boxes. We were mindful of the possibility of negative transference. We were able to facilitate group discussion and use the group dynamics to discuss problems frankly. Whilst it would have been interesting to look for any difference in outcomes between those patients who had immediately taken to the group and those patients who settled into the group more slowly, patient heterogeneity precluded a formal evaluation.

We continue to collect feedback from the wider MDT. Although the original individual preparatory therapy and the group format both received positive feedback from the team, that is, patients coming through both pathways have been prepared for the inpatient treatment, we have not had the opportunity to compare the two pathways, so we cannot at this stage say whether there is a difference (in terms of efficacy) between the individual and group formats.

The patients in each group are not admitted to the inpatient therapy on the ward at the same time. If there are only 1–2 patients left in the group (with some upcoming planned absences due to holiday, etc.), the group might be terminated, and the patients given some homework tasks to do during the time remaining until their admission date and/or are offered a couple of individual preparatory sessions up until their admission date.

The current study builds on our previous work developing the QGSH, a brief internet-based preparatory therapy based on psychoeducation and CBT (Humblestone et al., 2022). In an RCT in two neurology services in the UK, patients with functional symptoms were randomly allocated to usual care (UC) or UC plus GSH (Sharpe et al., 2011). Participants allocated to GSH reported a greater improvement. After 6 months, the treatment effect was no longer statistically significant on the Clinical Global Impression (CGI) scale, but was apparent in symptom improvement and in physical functioning.

In a nonblinded RCT to determine whether the self-rated health of patients with motor FND can be improved by unguided internet-based self-help and education, 186 patients were allocated to either an unguided education and self-help website in addition to UC or UC only (Gelauff et al., 2020). There was no difference in the improvement of self-rated health at the third month or sixth month. Satisfaction was high, with 86% of patients recommending the website to other patients.

In a small study, an information and management intervention within a neuropsychiatry service, which included weekly CBT-based group therapy sessions, was administered to 10 patients with NEAs. The authors concluded that group therapy intervention with a CBT-based approach is a feasible treatment option for the management of NEAs and other FNSs, as shown by significant improvements in emotional domains of quality of life (Conwill et al., 2014).

In a pilot randomised controlled feasibility study with a parallel-group design, a sample of adult outpatients with psychogenic nonepileptic seizures (PNES) was utilised to evaluate a new body-focussed group therapy (CORDIS) versus guided SHGs. Of the 29 patients, 15 completed the body-focussed group therapy programme and 14 completed guided SHG therapy (Senf-Beckenbach et al., 2022). Both groups showed changes in seizure severity and level of dissociation. CORDIS was superior to the SHG for reducing seizure severity 6 months after the treatment.

5 | LIMITATIONS AND STRENGTHS

Our study has several important limitations. The service evaluation only includes qualitative data. We were unable to collect quantitative data on all patients at the end of the group intervention, which could be due to the fact that the questionnaire was administered right before patients were admitted into hospital. We will explore other options for collecting quantitative data. We noted that some patients experienced glitches and latency in their internet connection that made communication somewhat difficult. One of the most frequent challenges, however, was that therapists could not always clearly observe each patient's non-verbal behaviours (e.g., body language).

The strengths of our therapeutic work in the group include input from a multidisciplinary team (a medical psychotherapist, an occupational therapist and a psychologist), achieving online group cohesion and positive outcomes for individual group members. We provided a comprehensive approach to psychoeducation and therapy, offering input across a variety of domains (i.e., emotion regulation, activities of daily living, work and environmental factors). In addition, our preliminary observation was that the barrier imposed by the screen conferred significant advantages to some patients with social anxiety, who were able to open up more because they felt ‘safe’ and ‘protected’. Future studies need to assess whether this therapeutic approach works with larger samples and across different socioeconomic groups. We hope that the experience of the Queen Square team can be used to help patients and clinicians to improve the provision of FNS services. Interested clinicians may contact us at c.selai@ucl.ac.uk to discuss access and use of the materials, with potential for ongoing collaborations.

CONFLICT OF INTEREST STATEMENT

None of the authors has a conflict of interest.

ORCID

Caroline Selai https://orcid.org/0000-0002-9698-3405

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AUTHOR BIOGRAPHIES

Vasile Boico holds a BSc in Psychology and has recently completed his MSc in Clinical Neuroscience. His research project was a systematic literature review: 'The role of hyperscanning in elucidating the neural basis of cooperation in mood disorders and borderline personality disorder'. Vasile's initial involvement in this project began with the preparation of a poster for the British Neuropsychiatry Association's 35th Annual Meeting and Conference.

Sue Humblestone is a senior occupational therapist working as a mental health specialist in a national neuropsychiatry department for 20 years. She has a special interest and experience in the psychiatric presentations of neurological conditions and the treatment of patients with functional neurological symptoms.

Michael Moutoussis is a clinical lecturer in neuroscience and an honorary consultant medical psychotherapist. He has worked for many years in medical psychotherapy. His areas of interest include functional somatic symptoms, psychotic symptoms and the so-called personality disorder. He has a special research interest in stakeholder involvement in research, especially in researching engagement and disengagement with therapy. He holds a PhD in the psychology of paranoid ideation and its relationship to how we value ourselves. He has been a key contributor to the new field of computational psychiatry, wherein he strongly advocates for basic research subserving psychological therapies. He is a member of the UKCP.

Caroline Selai is a psychologist, associate fellow of the British Psychological Society (BPS), member of the Register of Psychologists Specialising in Psychotherapy (ROPSIP) and member of the British Association for Counselling and Psychotherapy (BACP). Currently, she is working as an honorary associate professor at UCL Institute of Neurology and a psychologist at The National Hospital for Neurology and Neurosurgery, working in a liaison role with the neuropsychiatry and uro-neurology departments. Her clinical and research interests include functional neurological symptom disorder, Fowler's syndrome and stakeholder involvement in research.

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APPENDIX A

Patient-reported outcome measure (PROM) (Reduced Version)

Evaluation of preparatory therapy questionnaire—Patient-rated outcome measure

Patient initials (or unique identifier):	Date:	(t = 1/t = 2)

1. How much do you know about the *diagnosis* of functional neurological symptoms?
(Scoring: 0—not at all; 10—a lot)

0 1 2 3 4 5 6 7 8 9 10

2. How much are you aware of how your life situation, practical problems and relationships may affect your functional neurological disorders ?
(Scoring: 0—not at all; 10—a lot)

0 1 2 3 4 5 6 7 8 9 10

3. How much do you know about the multidisciplinary team treatment approach?
(Scoring: 0—not at all; 10—a lot)

0 1 2 3 4 5 6 7 8 9 10

4. How much do you know about what might trigger (exacerbate) your own functional neurological symptoms?

0 1 2 3 4 5 6 7 8 9 10

5. Do you understand the role of goal setting in your rehabilitation?
(Scoring: 0—not at all; 10—a lot)

0 1 2 3 4 5 6 7 8 9 10

6. Do you understand why looking at your story ('history') will help you to understand your current symptoms?
(Scoring: 0—not at all; 10—a lot)

0 1 2 3 4 5 6 7 8 9 10

7. Do you understand how your own thoughts (thinking styles) and your feelings can affect (trigger, exacerbate) your symptoms?

0 1 2 3 4 5 6 7 8 9 10

8. How prepared do you feel to come into Hughlings Jackson Ward for treatment?
(Scoring: 0—not at all; 10—a lot)

0 1 2 3 4 5 6 7 8 9 10

APPENDIX B

Brief guidelines for our Handover notes:

1. What are the main (FNSD) symptoms as indicated by the patient?
2. How has the patient engaged with the group members?
3. How has the patient engaged with the cofacilitators?
4. How has the patient made use of the group?
5. How has the patient engaged with the homework tasks…?

6. Whilst engaging with the preparatory therapy, what were the patient's strengths?
7. Whilst engaging with the preparatory therapy, what challenges did this patient experience?
8. What are the patient's views about ending the preparatory therapy and being admitted to the Ward?
9. Overall impression of the patient
10. Any other reflections you wish to share with the team?