Epilepsy in mind – anxiety and depression

This guide is for healthcare professionals.

Epilepsy is the most common serious neurological condition in the UK. Some studies suggest that about 30% of people with epilepsy may also have anxiety or a depressive disorder, compared to 20% in the general population, with a potentially higher rate of people with epilepsy having atypical mood symptoms that do not meet a diagnostic classification.

Anxiety and depression in someone with epilepsy does not necessarily mean epilepsy is the cause. Anxiety or depression may have a greater effect on a person’s quality of life than their epilepsy does. It may also affect how they relate to, and work with, their doctors and other professionals, and their ability to discuss, or even recognise, their mood difficulties.

These factors present both a challenge, and a compelling reason, to identify and treat anxiety or depression early.

Individualised approaches

Engaging the individual may help to ensure positive and accurate communication about any mood problems:

- Ask them how they feel and what they would like to get from their clinic appointment.
- Encourage self-awareness and discussion about mood, and how epilepsy may or may not relate to any mood problems.

See our factsheet Your appointment.

See our booklets The Bigger Picture and Epilepsy: how I feel (easy read).

Mood disorder

The spectrum of epilepsy includes different types and severities of seizures, underlying causes and a genetic predisposition, as well as individual responses to medication and the psychosocial impact of epilepsy on quality of life. The following issues can mask or mimic a mood disorder in someone with epilepsy, or be part of an existing mood problem:

- anger, fear, loss or other feelings about having epilepsy;
- unpredictability or fear of seizures, leading to isolation and social restriction, which may be self-imposed or from carers;
- real or perceived stigma of epilepsy;
- an avoidance of exercise or activity, which may stem from the disruptive effects of seizures, a fear of triggering seizures through exertion or a fear of injury;
- a loss of freedom, independence and self-confidence, from not driving, unemployment, or the impact of a protective approach from other people;
- effects of seizures on memory and thinking;
- side effects of anti-epileptic drugs (AEDs) on mood, memory and thinking, or anxiety about the possibility of side effects;
- mood changes before, during, or after a seizure;
- or predisposition to, or family history of, anxiety or depression.

Any additional learning disabilities may complicate the identification of mood disorders.

Identifying anxiety and depression

Self-referral

Self-referral is an important route for people with mood disorders. Someone may state that they are unhappy, or they feel they’ve lost a great deal, rather than use terms such as ‘depressed’. Non-verbal signs of low mood include being unforthcoming, avoiding eye contact, or being tearful. Following up such signs with sensitive questioning may help to identify what the person is struggling with.

Presenting with physical symptoms

Physical symptoms include frequent headaches, tiredness, or generally feeling unwell. These may not be recognised by the person as symptoms of a mood disorder. They may more readily blame these symptoms on their epilepsy or AEDs, than be able to recognise the more complex underlying issues around their mental health.

Role of family or carers

Family or carers may report changes in the person, for example irrational or irritable behaviour. Also, tension between a person and their family may indicate strain caused by changed mood or behaviour.

Questionnaires and scales

Clinically validated scales for anxiety and depression include the Beck Depression Inventory (BDI), the Hospital Anxiety and Depression Scale (HADS) and the Neurological Disorders Depression Inventory for Epilepsy (NDDI-E).

It is important to identify whether depressive episodes are part of a seizure pattern, as treatment may differ for interictal (unrelated to seizure occurrence) and peri-ictal (related to seizure occurrence) depressive episodes. Extreme mood swings of emotional highs and lows should prompt specialist referral as psychiatric review is indicated.

Diagnostic criteria for anxiety disorders and clinical depression vary depending on the specific disorder. The NICE guidelines for generalised anxiety disorder and depression in adults emphasise the following key symptoms.

Generalised anxiety disorder – key identifiers

- excessive worry about a number of events or activities; and
- difficulty controlling the worry.

The worry occurs on most days for at least six months. The focus of the worry is not solely based on another anxiety or depressive disorder (for example, it is separate from worry about having a panic attack, social phobia, or fears of contamination).

Depression – key identifiers

- persistent sadness or low mood; and/or
- marked loss of interests or pleasure.

At least one of these on most days, for most of the time, for at least two weeks.
management and treatment

The NICE guideline on depression7 includes the following points:

- Give patients the opportunity to make informed decisions about treatment, according to their needs and preferences.
- If a patient has both anxiety and depression, treat first the condition which is most severe or most likely to respond to treatment first.
- Ask patients with suspected depression directly about suicidal ideas or intent. Arrange any necessary help appropriate to the level of risk, and assess whether they have adequate social support.

Self-help and low-intensity interventions

For some people, prompt diagnosis and supportive communication about mood disorders may reduce symptoms. Information and support around epilepsy may help to avoid confusion about symptoms and combat isolation. Self-help options include keeping a diary of moods and positive steps, regular exercise, a balanced diet and a regular sleep routine.

Visit epilepsysociety.org.uk/mood-problems

If regular exercise or sleep patterns are disrupted by seizures and recovery time, a person could instead try their own, more achievable self-help ideas, which may also help to boost their sense of control. Self Management UK runs free courses promoting self-help and tackling isolation.

Visit selfmanagementuk.org

Complementary therapies may be useful in reducing stress, although some are not recommended for people with epilepsy.

Visit epilepsysociety.org.uk/complementary-therapies

For depressive symptoms that do not meet diagnostic criteria, or mild to moderate anxiety or depression where someone can cope fairly well with daily life, NICE recommends 'low-intensity interventions', based on the person's preference. This includes guided self-help based on cognitive behavioural therapy (CBT) for anxiety or depression, computerised CBT (cCBT) and structured group physical activity for depression.6,7,8 Such interventions can be accessed via local Improving Access to Psychological Therapies (IAPT) services.

Medication or psychological therapies

For anxiety or depression which does not respond to low-intensity options and which is making it hard to function in daily life, NICE suggests either psychological therapies or medication, depending on the patient's history and preference.7 Psychological therapies include counselling, psychotherapy (including CBT) and group therapy. Referral to local IAPT services can be made through the patient's GP or healthcare professional. Alternatively, the patient can self-refer online.

Visit beta.nhs.uk/find-a-psychological-therapies-service

For persistent depression, NICE recommends considering antidepressants. For moderate to severe depression, where coping with daily life is very difficult or impossible, combined antidepressant and psychological therapies may help.7

Medication

Some patients (and physicians) may fear that antidepressants will affect the stability of the epilepsy or AED treatment. AEDs can have positive or negative effects on mood. AEDs with mood-stabilising effects include sodium valproate, lamotrigine, carbamazepine and oxcarbazepine, and any withdrawal of such AEDs in people with mood problems should be monitored carefully.2

Selective serotonin re-uptake inhibitors (SSRIs) are recommended in people with epilepsy as first choice over tricyclic antidepressants (TCAs) due to their better tolerance and safety.7 Studies suggest that the risk of seizures with most antidepressants is low, especially at low doses with gradual titration, and that risks are reduced with SSRIs.5

However, potential for interactions with AEDs needs to be monitored. Enzyme-inducing AEDs may increase the clearance, and so reduce the efficacy, of an antidepressant2, and SSRIs such as fluoxetine, sertraline and fluvoxamine may increase serum concentrations of AEDs such as phenytoin and carbamazepine, increasing the risk of side effects.5 The combination of SSRIs and carbamazepine can potentially increase the risk of hyponatraemia so monitoring of sodium levels is recommended.

Multidisciplinary collaboration

Successful early interventions for anxiety or depression in people with epilepsy may involve referral and consultation between specialists including neurologists, specialist nurses, GPs, psychiatrists or psychologists. Anxiety and depression in people with epilepsy may be underdiagnosed. Greater awareness can help with early interventions for mood disorders, and raise the quality of life for some people.

References

4. Nogueira M. de Oliveira, G. et al. Screening for depression in people with epilepsy: Comparative study among Neurological Disorders Depression Inventory for Epilepsy (NDDI-E), Hospital Anxiety and Depression Scale Depression Subscale (HADS-D), and Beck Depression Inventory (BDI). Epilepsy & Behavior, Volume 34, Pages 50 – 54, 2014.

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