epilepsy in mind – anxiety and depression

This guide is for healthcare professionals. It refers to four resources for people with epilepsy: Your appointment, The Bigger Picture, Epilepsy: how I feel and Keystones, all available from Epilepsy Society.

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

mood disorder, or fear, loss and confusion?
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.
- A lack 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 mood, memory and thinking, including mood changes before, during, or after a seizure.
- Side effects of anti-epileptic drugs (AEDs) on mood, memory and thinking, or anxiety about the possibility of side effects.
- 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 not communicating, avoiding eye contact, tearfulness or laboured breathing. 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 their low mood or anxiety 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 per-ictal (related to seizure occurrence) depressive episodes. Bipolar disorder should not be treated with antidepressant medication.

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 for assessment.

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 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.
management and treatment

The NICE guideline on depression7 includes the following.

- 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 www.epilepsysociety.org.uk/mood-and-epilepsy

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 http://selfmanagementuk.org

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

Visit www.epilepsysociety.org.uk/complementary-therapies

For depressive symptoms that do not match 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. These include guided self-help based on cognitive behavioural therapy (CBT) for anxiety or depression, and structured group physical activity for depression.6,7

Medication or psychological therapies

For anxiety 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. The availability of NHS therapists has increased through the Improving Access to Psychological Therapies programme (IAPT).

Visit www.iapt.nhs.uk/services

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.