

Anxiety & depression

Treating anxiety and depression in their own right can improve quality of life for people with epilepsy, says Dr Michael Salzberg.

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As recently as the 1950s, epilepsy textbooks made little or no mention of anxiety and depression. Today, both are recognised as common problems for people with epilepsy. Depressive symptoms have been linked to antiepileptic medication side-effects, neurobiological and psychosocial factors, and life challenges such as the inability to drive or work because of epilepsy. While patients feel more able to talk about these feelings, diagnosis and treatment has improved. But barriers still remain. There is a lack of available psychological and psychiatric services in hospitals, combined with a widely held attitude that it's normal to feel anxious or depressed.

In fact, ongoing anxiety and depression cause distress for many people with epilepsy, undermining their ability to cope with life. These emotional problems deserve treatment in their own right. Psychological treatments and medications can help to safely and effectively reduce the symptoms, in turn preventing a string of other consequences.

What's at stake?

1. Anxiety and depression can add to

disability Epilepsy patients often struggle to cope with their condition, the activities of daily life, the social limitations and stigma imposed by epilepsy and with other challenges that life inevitably throws up. It is even harder to cope when in the grip of a chronic anxiety or depressive disorder. It can be more difficult to think clearly. Meanwhile motivation, energy and sleep are impaired, particularly when a person experiences depression.

These emotional disorders can undermine already shaky confidence. They cause people to withdraw socially, further reducing capacity to cope and aggravating the anxiety and depression in a vicious cycle.

2. The lives of some patients with epilepsy end in suicide It's likely that for the few who do take their own lives, depression – a very treatable illness – has played a large part.

3. Increased health costs can result Health planners in government have realised that depression raises healthcare utilisation and costs. Depression combined with other medical conditions such as epilepsy can increase a patient's rate of hospital admissions, complications and length-of-stay, while reducing their level of recovery.

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as occasionally anxiety and depression stem from a physical illness like thyroid disease.

- The possibility that some antiepileptic medications could be contributing to negative mood changes.

At the end of this data gathering, psychiatrists and psychologists will:

- **Make a diagnosis** e.g. Panic Disorder, Major Depression.
- **Devise a ‘formulation’** or summary of how a particular patient became ill in this particular way at this particular time. This is an important step as 10 people with Panic Disorder may have arrived at their illness via 10 different life-paths, early life factors, personalities and recent stresses. These differences shape the approach to treatment, recovery, repairing relationships, and to preventing future relapses.

From treatment to prevention

The stereotyped idea of treatment for depression is this: “Here, take this tablet for a few weeks, then come back and see me and you’ll be okay.” This is far from ideal.

Ideally, there are three main phases:

1. Achieving relief from symptoms

Mild anxiety or depressive disorders can be relieved by psychotherapy – also called “talk therapy” as it is often based on conversations with a trained therapist. A specific example of this is cognitive behavioural therapy (CBT) which can be effective to assist people to change negative patterns of thinking and behaviour. For moderately severe symptoms, typically a combination of medication and psychotherapy is required. For more severe anxiety or depressive illness, medication alone may be necessary – the patient may be too distressed or agitated to engage in psychotherapy. When symptoms have reduced to more moderate levels after days or weeks, psychotherapy can begin.

The recommended evidence-based medication at present for both types of disorder is SSRIs (serotonin specific reuptake inhibitors) and related drugs. These take several weeks to achieve maximum effect. Fortunately these have virtually no tendency to aggravate seizures, unlike earlier generation drugs (such as tricyclics). Indeed recent evidence suggests they may improve seizure control.

Typically, treatment of the first phase should continue for 6-12 months, although patients usually feel better in days to weeks.

About a third of patients will not respond well to the first medication and may need a higher dose or transfer to a different medication. Only a tiny percentage of people need hospitalisation.

2. Recovery and rehabilitation It’s one thing to control symptoms, and another to rebuild a life after weeks, months or years of emotional disorder. This may involve re-establishing or repairing relationships or forming new ones, returning to work, and recommencing lapsed leisure activities. It may mean resuming one’s roles in life – as parent, spouse, family member, worker, friend. It includes deciding what to say to people about your problems. How much to say (if anything), and how to say it.

3. Relapse prevention Anxiety and depressive illness has a tendency to recur, especially at times of stress. Patients can be helped to live their lives in such a way as to minimise this risk. We can all learn to be more emotionally intelligent and resilient, so that we handle life’s inevitable challenges more effectively. In addition, patients can learn to recognise early signs of relapse, so new episodes of illness can be nipped in the bud by psychotherapy or medication.

During all three phases, there are two other principles of treatment.

1. Informing and supporting carers who may have been very stressed by the patient’s emotional disorder.

2. Dealing with factors that can aggravate anxiety or depression including alcohol and some antiepileptic medications.

What can neurologists and other health workers do?

Neurologists and other health professionals working with patients who have epilepsy should begin by routinely enquiring about symptoms of anxiety and depression during consultations.

By using a few simple probe questions, many patients with these disorders will be diagnosed and helped who otherwise might not be. This may add a little time to the consultation, which for a busy doctor is not a trivial matter. But it probably saves time in the long run, given the impact of undiagnosed anxiety and depression on healthcare utilisation.

One effective approach is **screening questionnaires**, which can be filled out by patients in the waiting room. An example is the K-10, a 10-item scale (available free



Incidence and types

Anxiety and depression occur when normal feelings like fear are abnormally and chronically over-activated, interfering with a person's ability to function in daily life.

There have been few good-quality mental health surveys of people with epilepsy. In the general adult population, about ¼ have a diagnosable anxiety disorder at any point in time and about 5-10% have a depressive disorder. There is some evidence that these rates are greater in people with epilepsy, and (at least for depression) greater than in people with other chronic medical disorders, such as asthma.

Both anxiety and depression come in several forms. Anxiety disorders may be experienced as:

- Frequent unpleasant emotions of tension or fear.
- Constant worrying thoughts.
- Physical symptoms e.g. muscular tension, knotted up feeling in the abdomen, fatigue, difficulty sleeping.
- Panic attacks which are acute, distressing waves of severe anxiety that can be mistaken for a heart attack, stroke or sometimes a seizure.
- High-level anxiety about specific situations or triggers, e.g. social situations.
- A form of anxiety disorder (post-traumatic stress disorder) developed after traumatic experiences, e.g. assault, car accident.

Similarly, sadness and grief are normal emotions that can be abnormally over-activated and prolonged, leading to several depressive disorders. These include:

- Major depressive disorder
- Depression associated with bipolar disorder

Anxiety and depression often co-exist. Thus patients with major depression frequently experience anxiety. In turn patients with anxiety disorders are at greatly increased risk of developing depression, but may have their anxiety problem (e.g. panic disorder) for some years before developing a first depressive episode.

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4. Patients are less compliant There is some evidence that depressed patients take their medications less reliably (sometimes termed ‘nonadherence to treatment’). The consequence for those with epilepsy is reduced seizure control.

5. Obesity, coronary heart disease and stroke may be more likely Emerging evidence links depression to these three disorders. In addition, many epilepsy patients may have to deal with medication-induced weight gain.

Finally, there is the intriguing possibility that depression may aggravate epilepsy itself. This line of thinking should be seen as speculative, not proven, and it is the focus of active research at present.

The diagnostic approach

Even though it may be easy to tell that a patient is clinically depressed or anxious,

important background information needs to be obtained by the doctor or psychologist to ensure correct diagnosis and the most suitable treatment.

As well as a description of the symptoms and their impact, the professional needs to explore:

- The patient's current life circumstances and recent stresses.
- Earlier episodes.
- Whether others in the family have experienced mental health issues.
- The patient's developmental history including problems with pregnancy and birth, early parenting, experiences of abuse and neglect, medical history, their education, work, leisure and relationships.
- Any drug and alcohol use which itself can cause anxiety and depression.
- The patient's personality.
- Physical examination and medical tests,

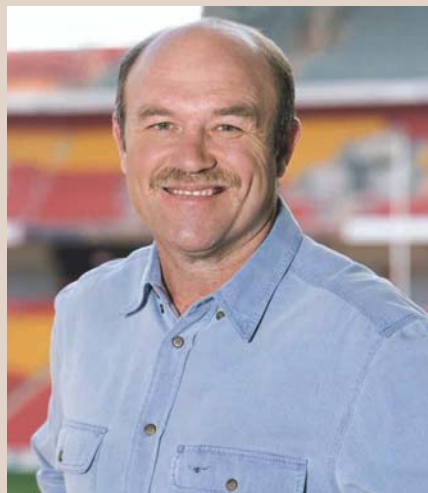
Need help?

Footy great Wally Lewis made headlines this February when he revealed he'd experienced depression because of his epilepsy and had even considered suicide. In a series of candid interviews, Wally said his feelings had ranged from an incapacitating sense of failure, embarrassment and fear of having a seizure in public, to panic and sadness after undergoing brain surgery in February 2007 to treat epilepsy.

Since some degree of anxiety and depression is a natural response to difficult circumstances, it can be hard to know when help is needed – either for you or a person you're close to.

As a general rule of thumb, it's time to get help when these negative feelings are ongoing, and affect a person's ability to function day-to-day. Try these steps:

- 1. Find out about it** Learn more about the signs of depression and anxiety disorders. Excellent information is available at websites such as www.beyondblue.org.au.
- 2. Seek a diagnosis** The best first step is discussing the situation with your treating doctor, who will know your history. This could be your GP, neurologist or paediatrician.
- 3. Get treatment** A range of treatments and services can help with depression, anxiety and related disorders, from cognitive behavioural therapy and medication to alternative options like



“I just hope I can be an inspiration to other people who might be suffering.”

getting more sleep and exercise. For service providers see www.beyondblue.org.au and search for 'services'.

- 4. Stay well** A plan for recovery and teamwork between a person and their close circle can help prevent relapses. Help yourself e.g. by strategies to manage stress and anxiety or reducing drug and alcohol intake. Friends and family can help e.g. by spending time with a person, encouraging them to

talk about their feelings or to look for professional help.

- 5. For urgent help** Speak to your doctor, call the psychiatric team at your nearest hospital, or call Lifeline on 13 1114.
- 6. Prevent it before it happens** If you have epilepsy, particularly if you have just been diagnosed, strategies for self-management and simple lifestyle changes may help you increase seizure control and your sense of control generally. In turn this can help to stave off feelings of anxiety and depression. For more information see the 'Self Management' and 'Seizure Anxiety' fact sheets at Epilepsy Action's website, www.epilepsy.org.au.

Sources: www.beyondblue.org.au and www.epilepsy.org.au

at www.crufad.com), which can be quickly scored and successfully identifies people who may be experiencing anxiety or depressive disorders.

Very good **educational material** on anxiety and depression is available from organisations like SANE (www.sane.org) and beyondblue (www.beyondblue.org.au) and can be given by doctors to patients and their families. Excellent online self-help programs are now available, for example FearFighter for anxiety disorders (www.fearfighter.com), Moodgym for depression (www.moodgym.anu.edu.au) and climate.tv for both (www.climate.tv/). Be aware, however, that these do not replace consultation and advice from a doctor.

From neglect, to treatment, to prevention

Even though the first task is far from complete (comprehensive detection, diagnosis and treatment of anxiety and depression in epilepsy patients), we need to think about the next task: prevention. Many programs are now being developed and tested for the prevention of anxiety and depression in the general population, for example by teaching resilience, emotional intelligence or 'positive psychology' to adolescents.

In this spirit, a first encouraging report was published of a small trial to prevent depression in adolescents with epilepsy. This study involved an at-risk group of newly

diagnosed adolescents. Some were given treatment with counselling as usual, while others received the preventative measure of cognitive behavioural intervention. At follow-up nine months later, there was a significant improvement of depressive symptoms in the teens who'd had intervention.

Given the high prevalence of anxiety and depression in epilepsy patients, it is worthwhile for healthcare professionals to begin considering the development of such programs. These could be designed for children or teenagers with epilepsy, or for patients coming to first-seizure clinics.

Sources available on request