

Epilepsy and Depression

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Like it or not . . . if you have epilepsy . . . there's a pretty good chance you have or have had an episode of *clinical depression*.

Let's put that into perspective.

Take a group of 100 people randomly selected from the general population: one in every 20, or 5%, is likely to have had an episode of clinical depression. If you take 100 patients from a general practitioner's office, roughly 10% will have had an episode of clinical depression. And, if you consider 100 patients with epilepsy, 33% have, have had, or will have an episode of clinical depression.

So, like it or not . . . if you have epilepsy . . . you have a one in three chance of also having clinical depression. (Now, you can turn that into good news by pointing out that two of every three patients with epilepsy do NOT have clinical depression!).

I am a psychiatrist – also known as a behavioral healthcare specialist – with an interest in epilepsy and the behavioral problems commonly associated with epilepsy. The statistics I just mentioned have been confirmed repeatedly in our and other epilepsy centers around the world.

Why should clinical depression be so common in patients with epilepsy? Some might say that anyone with epilepsy would be expected to suffer from depression, because things that others take for granted are not so easy for patients with epilepsy to do: like working full-time, driving, finding new friends, or even going out in public. Who wouldn't be depressed??

Another important reason depression is common in epilepsy is that epilepsy is a brain disorder. It turns out that depression occurs more frequently not only in epilepsy but other brain disorders as well, such as stroke, dementia, multiple sclerosis, Parkinson's disease, and others. The higher

rate of depression in these disorders may be due both to the physical disability they cause and also to the disruption of normal activity in that part of the brain that regulates our emotions.

It's also important to remember that the medications used to treat epilepsy can sometimes trigger depression, or more commonly, produce side effects that resemble depression, like sluggishness or trouble thinking clearly.

Knowing these facts may help one accept that depression is an important and legitimate clinical disorder. But, in my experience, few patients easily accept the diagnosis of clinical depression. Some are offended even if asked about it. For them, I suspect that depression means, “weakness”, “not trying hard enough” or “not carrying their weight”.

Having clinical depression also can feel like losing self-control. Epilepsy itself suddenly and with little or no warning causes loss of self-control. It's this loss of self-control, I believe, that contributes to the stigma of both these illnesses, because losing self-control can be embarrassing, humiliating, even frightening. And, for those known as Control Freaks (. . . you know who you are!), losing control is especially upsetting.

To make things worse, individuals with depression often cannot find a good enough reason to be depressed. They look at their lives and think, “I have no reason to be depressed, or I shouldn't be depressed. Not having a good explanation contributes to loss of self-confidence and feelings of worthlessness.

Finally, adding all this uncertainty, there are no laboratory tests or procedures available to substantiate the diagnosis of clinical depression.

So, after all this discussion about clinical depression, what is it? How does one make the diagnosis of clinical depression, technically referred to as MDD, or major depressive disorder? In fact, the diagnosis is based exclusively on what the patient reports about the way they have been feeling and behaving. (The screening questionnaire – you may already have completed one

– is one method used to assist in diagnosis, but it also relies on the patient’s report of symptoms and behaviors).

Being in a “bad mood” is a cardinal feature of clinical depression; but, being in a bad mood – feeling sad and blue, or being irritable and angry, or just feeling blah – by itself is not enough. To qualify for a diagnosis of clinical depression, or MDD, a person must also have four or more of the following symptoms:

- Insomnia (Trouble falling or staying asleep)
- Loss of usual enjoyment, enthusiasm or motivation
- Feeling unusually bad about oneself, or guilty
- Lack of energy
- Trouble paying attention or making decisions
- Poor appetite (or eating more than usual)
- Moving or thinking more slowly than usual (or feeling restless and agitated)
- Feeling hopeless, or as if life just isn’t worth living.

Most of us have had one or more of these symptoms here and there, but the depressed patient has a majority of these symptoms most everyday for at least two weeks or more. Other symptoms that commonly accompany clinical depression include:

- Tearfulness (“crying at the drop of a hat”)
- Nervousness or even anxiety attacks (panic attacks)
- Unusual irritability or temper tantrums

Another very important feature of clinical depression is that it or other problems – like anxiety disorders and chemical dependency – often run in the family.

When the symptoms will not let up; when everyday activities become less enjoyable; when it’s harder and harder to get things done; and especially when life feels like it’s no longer worth living – it’s time to get treated. I tell patients that the purpose of treatment is to get them back to their full potential and to function like they normally do, at their best. The goal is not to take so-called “happy pills” that turn them into something they are not. Antidepressant treatment is meant to help restore normal sleep, energy, attention, motivation, and a realistic outlook on life.

How is depression treated? I won't go into all the details, but it's commonly said that there is no single best treatment, and that combining antidepressant medication with other therapies achieves the best results. Important therapies other than medication include:

- Regular exercise (walking is the best, but yoga is good too)
- Cognitive-behavioral therapy (talk therapy focused on learning to view the glass as half full rather than half-empty)
- Light therapy (for seasonal depression)
- Relaxation therapies (for those with a lot of tension and high anxiety)

How do I go about getting these treatments? The first place to start might be with the specialist that manages your epilepsy, or your primary care doctor. The Epilepsy Foundation in your area may be able to offer helpful advice. If you know your community's mental health resources, go there. A physician or nurse practitioner can prescribe the medication you need or, if necessary, refer you to behavioral health specialist that can prescribe antidepressant medication and the non-medication therapies previously mentioned.

The good news about antidepressant medications is that they are safe and do not interfere with treatment of epilepsy. Like antiepileptic drugs, though, antidepressants don't always work on the first try. It's important to inform your doctor about your response so that the two of you can decide whether or not to try something else. I advise all my patients never to give-up. Keep trying because the right medication is usually found in at most 2 or 3 tries.