



Review

Psychiatric comorbidities go untreated in patients with epilepsy: Ignorance or denial?

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ABSTRACT

Psychiatric comorbidities are common in patients with epilepsy (PWE). Depression and anxiety are the most prevalent of these comorbidities and are associated with worse quality of life. Several screening tools are available to identify and follow up these conditions. However, time constraints in outpatient clinic visits and limited access to mental healthcare professionals discourage clinicians to use them. This paper discusses the advantage and limitations of screening tools and makes a compelling argument for neurologists to take an active role in the diagnosis and treatment of common psychiatric comorbidities in PWE.

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People living with epilepsy are more likely to suffer psychiatric illness than the general population. Population-based studies have shown a higher lifetime prevalence of anxiety, depressive disorders, and suicidal ideation [1] in patients with epilepsy (PWE). Depression affects 20–55% [2] and anxiety 12–22% [3] of PWE. These prevalent psychiatric comorbidities are known to have a significant impact in quality of life. Together with toxicity to antiepileptic drugs (AEDs), comorbid depression and/or anxiety disorders has been found to predict a poor quality of life in patients with treatment-resistant focal epilepsy to a greater extent than seizure frequency [4–6]. If left undiagnosed and untreated, depression and anxiety would limit the ability of our patients to fulfill their life goals, even when seizures are under control.

The coexistence of these two psychiatric comorbidities in PWE is not a coincidence; they are caused by common and interdependent neurophysiologic and neurochemical mechanisms [7,8]. Depression and anxiety are another clinical manifestation of the seizure disorder, which can also be associated with cognitive deficits in some of patients. Some studies have suggested an interdependent relation between depression control/management and seizure control [9,10].

Death by suicide accounts for approximately 12% of all deaths in PWE, being ten times more frequent than in the general population [11]. Psychiatric comorbidities have been associated with an increased risk of premature mortality related to external causes, with depression and substance misuse being the two comorbidities most frequently

associated with premature death [12]. Furthermore, as of 2008, clinicians that prescribe AEDs are expected to monitor for suicidal ideation and behavior (and the comorbid psychiatric conditions that increase such risk), following the Food and Drug Administration's mandated inclusion in the package insert of all AEDs of a warning suggesting that this class of drugs is associated with an increased suicidal risk.

Neurologists and epilepsy specialists devote our efforts to the treatment of epileptic seizures and are good at following, recording, and controlling seizures. We miss, however, the ultimate goal that is improving the quality of life of our patients. We do not do a good job if we ignore psychiatric comorbidities or if we outsource our patient's mental healthcare to mental healthcare providers whom the patient may not be able to see for months or may have no access altogether. In such cases, neurologists and epileptologists need to take an active role in the diagnosis and (if possible) in the treatment of depression and anxiety disorders. The challenge is — How to do it within the scope and limitations of the neurology visit?

In 2016, the American Epilepsy Society (AES) sought to better understand the level of awareness, practices, and limitations in the identification and care of depression and anxiety of PWE among the members of the society [13]. Sixty percent of the targeted members completed an online survey that asked specifically to describe their practices regarding the diagnosis and treatment of these psychiatric comorbidities in the clinic.

Seventy percent of the responders were likely to conduct further screening when presented with a patient with major depressive disorder, and 60% indicated that they would start antidepressant treatment. Nonetheless, most of them (90%) still recommended a referral to a

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mental healthcare provider. Of note, these same responders were less likely to screen (53.9%) and treat (33.7%) a patient with symptoms of anxiety.

A significant percentage of these epilepsy care providers admitted to only inquiring about these symptoms (15.7% for depression and 34.7% for anxiety) when they are brought up during the visit by the patient or a family member. This approach places the responsibility on the patient and/or their family to identify and report these symptoms as being relevant to their seizure disorder and/or to the reason for their visit. The providers expressed two main limitations to a more proactive approach: 1) lack of clinic time and 2) lack of mental healthcare resources.

The systematic use of screening tools can help to identify patients at risk for major depression and anxiety disorders and can assist in addressing these very real limitations.

There are several validated screening tools available for use in the clinical setting. These screening instruments do not make the diagnosis of depression or anxiety disorders but help identify patients at risk while also allowing for the follow-up of their symptoms in subsequent visits.

Some of the scales have been validated in different languages and specifically in PWE [14]. The Neurological Disorders Depression Inventory for Epilepsy (NDDI-E) is the most frequently used self-rating scale for identifying patients with possible major depressive episode (MDE). This scale has a sensitivity of 80.5% and specificity of 86.2% with a total cutoff point >15, as reported in a recent systematic review [15]. It has been translated and validated to Spanish, French, German, Arabic, Chinese, and Portuguese and has been selected by the International League Against Epilepsy (ILAE) as the instrument to identify patients with possible MDE. This scale is free for the public to use.

There are other self-rating scales that have been used for the identification of symptoms of depression and anxiety. These include the Beck Depression Inventory-II (BDI-II) and the Hospital Anxiety and Depression Scale (HADS) [16]. Of the three, the NDDI-E is preferred for being shorter and more widely utilized; however, it only identifies patients at risk for MDE. The BDI-II and HADS may take a slightly longer period of time to complete and score, but can be used to identify and follow specific symptoms of depression and anxiety and their severity between visits.

To screen for symptoms of anxiety, the Generalized Anxiety Disorders-7 (GAD-7) is a self-report instrument, which has also been validated in diverse populations, including PWE, and is available in different languages [17,18]. It consists of seven items scored on a Likert scale, which take less than 2 or 3 min for patients to complete; cutoff scores of 10 and above are suggestive of a generalized anxiety disorder, and it is recommended that patients complete it together with the NDDI-E and/or the BDI-II, as the comorbidity of both conditions is relatively frequent in PWE and has been associated with a worse quality of life than that identified with isolated depression or anxiety episodes [6]. Recognition of their comorbid occurrence is essential in the choice of psychotropic medications that can target both psychiatric disorders and thus minimize their recurrence.

These scales have multiple advantages: 1) They are short, self-administered instruments, which patients can complete in the waiting room. 2) Scoring of these instruments is simple and takes no time. 3) Clinicians can follow the course of psychiatric symptoms from one visit to the next. Yet, it is not enough to establish if the total scores of the instrument are above the cutoff point in a given visit; in fact, clinicians must review with the patients the reasons for which they endorsed the presence of specific symptoms. Only then can physicians decide if there is need to spend further time addressing a psychiatric problem or move on to other issues.

Tracking the instruments' total scores and individual psychiatric symptoms from visit to visit can also help identify possible emerging psychiatric depressive and/or anxiety disorders that may not have been present in the last consultation. Furthermore, the routine completion

of these scales at each visit in the outpatient clinic helps educate patients and family members to better recognize psychiatric symptoms and bring them to the attention of their clinician, as well as to identify their persistence and/or remission after the start of therapy. The manuscript by Kanner et al., in this issue illustrates the improvement of psychiatric symptoms when neurologists administer and act upon the findings of these scales.

Yet, despite the widespread availability of several screening instruments to identify potential patients with depression and anxiety disorders, their use is still not a common practice in most epilepsy and neurology clinics. Accordingly, these common psychiatric comorbidities of epilepsy continue to be underreported, underrecognized, and untreated, which continue to negatively impact our patients' life at several levels.

The lack of mental healthcare professionals available to see patients in the clinic was the second reason that the survey responders cited as a reason for failing to screen mood and anxiety disorders in PWE. This reasoning is rather bizarre, and creates an ethical dilemma; it portrays a strategy of "burying our heads in the sand" rather than addressing the problem and trying to find a solution. If we have very limited access to psychiatry and psychotherapy services, the thinking process goes, we do not have to identify comorbid psychiatric disorders since there is nothing that we will be able to do and therefore we do not have to deal with the problem. This strategy at best constitutes denial and at worse, negligence.

Whether we like it or not, we need to become more actively involved in the recognition and, when possible, the management of the common types of depression and anxiety disorders associated with epilepsy. Indeed, these conditions are frequently amenable to treatment with pharmacologic regimens of common psychotropic drugs. Our task is to educate ourselves on the diagnosis and management of the common expressions of depression and anxiety disorders associated with chronic neurologic conditions, including epilepsy. This topic is reviewed in detail in the articles by Cleary and Salpekar and by Dunn in this issue. Even if some neurologists may choose or prefer not to treat their patients' primary psychiatric conditions, we should offer referrals to local mental health clinics, and in the case of hospital and clinics that are part of Universities, referral to outpatient clinics that provide Cognitive Behavior Therapy in their School of Psychology can be a potential solution. These clinics are staffed by psychology students under the supervision of seasoned faculty.

Only a comprehensive approach to mental healthcare will help overcome the current national access crisis. Our communities and our patients cannot wait for payer reform or political change before they have access to appropriate care. There is enough information at our fingertips to claim ignorance regarding this issue. Neurologists should and must face the challenge of dealing with the psychiatric comorbidities of the conditions that they treat. We need to make our own contribution to the overall mental healthcare crisis one patient at a time. The tools are ready for prime time; our patients are in need of our care. It is time to come out of denial.

Declarations of interest

None.

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