



Interdisciplinary Conference of Young Scholars in Social Sciences

DEPRESSIVE AND ANXIETY CONDITIONS IN EPILEPSY

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Epilepsy, like other chronic conditions affecting the brain (multiple sclerosis, stroke, Parkinson's disease, migraine, and dementia), is associated with a higher incidence of mental disorders. Most studies show that up to 50% of patients with epilepsy have psychiatric pathology, mainly in the form of dysthymic, panic and psychotic disorders. The most common mental disorder in epilepsy is depression [6]. However, despite this unequivocal statement, it must be pointed out that the term depression does not fully reflect the current understanding of this condition.

According to the widely used DSM-IV classification of psychiatric disorders, the following depressive disorders (DR) are distinguished: major DR, dysthymic disorder, minor depression, DR due to a somatic disease or the use of any substance, or unidentified DR [5]. In general, depression in the above neurological diseases meets the criteria for DR specified in the classification. However, this does not apply to depression in epilepsy. There is some evidence that depression in epilepsy often does not meet the criteria for standard DR and is not detected by routine depression tests [3]. Some authors distinguish depression in epilepsy as a separate category of DR [1].

The connection between depression and epilepsy has been known since antiquity. Back in 400 BC. Hippocrates, in his book *The Sacred Disease*, questioned the current mystical ideas about epilepsy and suggested its organic nature and connection with the brain [4]. Regarding the mood in epilepsy, he writes: ... melancholics usually become epileptics, and epileptics - melancholics: this is determined by the direction in which the disease develops; if it affects the body - epilepsy develops, if the mind – melancholy.

As you can see, the genius of the ancient doctor consisted not only in indicating melancholy as an integral part of the clinical spectrum of epilepsy, but also in recognizing a two-way connection, to which researchers returned only more than 20 centuries later.

After Hippocrates, this issue was forgotten due to the primitive ideas about epilepsy, which persisted into the Middle Ages, when epileptic phenomena were explained in terms of various mystical, magical and religious concepts.

Interest in the medical side of epilepsy appeared only from the Renaissance, and in the middle of the 19th century. received special development thanks to the work of the neurologist H. Jackson, who is considered the founder of modern epileptology. In 1873, Jackson gave the first precise definition of epilepsy: Epilepsy refers to periodic, sudden, pronounced, rapid, local discharges of gray matter [4]. Epilepsy is becoming the subject of study by psychiatrists. At the beginning of the last century, Kraepelin (1923) described the psychiatric syndrome of epilepsy in his classification of mental disorders.

With the beginning of the use in the 1930s of the EEG for the diagnosis of epilepsy and the introduction of phenobarbital into practice, the interest of psychiatrists in epilepsy fades, since the 40s epilepsy has become a purely neurological disease. Despite the positive side of this change in the development of epileptology, neurologists considered psychiatric disorders to be reactive and did not see the bidirectionality of this relationship, and psychiatric abnormalities in epilepsy were often not assessed and not adequately treated.

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However, psychosis and a high frequency of suicides in patients with epilepsy could not but attract the attention of specialists. Gradually, there was a tendency to actively involve psychiatrists in the process of treating patients with epilepsy and comorbid psychiatric disorders [5].

Currently, the following concept has been adopted on this issue: not only biological factors (etiology, localization of the focus), but also therapy (the number and types of drugs used), as well as psychological and social factors (fear of seizures, stigma) are important aspects of the development of psychiatric problems. and especially depression in epilepsy [2].

Despite differences in research methods on the prevalence of depression in epilepsy, in almost all cases it is shown that depression (or its main symptoms) is the most common comorbid mental disorder.

In the general population, the prevalence of depression is 1-3% in men and 2-9% in women. The lifetime prevalence of major depressive disorder (at least one episode in a lifetime) in the general adult population according to the Epidemiological Catchment Area Study is 5.8% [1]. However, other data suggest a higher prevalence, 26% of women and 12% of men [2].

According to Harden et al. (2002), depression is more common among patients with epilepsy than in the general population [5].

Hermann et al. (2000), guided by the DSM-IV and ICD criteria, in their review of the literature determined that the prevalence of mood disorders among patients with epilepsy ranged from 44 to 63%, and separately for large DR, it averaged 29% [6]. Interestingly, the gender difference found in the general population has not been confirmed in depressed patients with epilepsy.

The O'Donoghue study showed that depression is more pronounced in patients with uncontrolled (resistant, refractory) epilepsy (33%) than in patients with controlled epilepsy (6%) [8].

The tactics of the therapy for epilepsy depends on many reasons - age, gender, comorbid pathology, form of epilepsy, antiepileptic therapy regimens and duration of administration, as well as drug interactions with other drugs, especially with anxiety and depressive disorders.

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