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Short Communication

Necessary Psychological and Psychiatric Attention in the Patient with Epilepsy

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In this context I will try to review the psychological and psychiatric disorders that may occur in patients with epilepsy, which are not taken into account in the management of the patient and therefore with unsatisfactory results [1]. Epilepsy is a global health problem that requires attention, since approximately between 50 and 69 million inhabitants suffer from it and throughout history, they have been discriminated against in many areas of life, being associated with psychiatric comorbidities, with social, psychobiological and economic consequences [2].

It was not until 1860 that Falret and Morel made the first descriptions of psychiatric disorders in people with epilepsy and later Kraepelin used the terms "periodic dysphoria", which represented the most common psychiatric disorders in people with epilepsy [3].

Since 1984, Hermann., *et al.* have been grouping the main causes of psychiatric disorders in epilepsy into three large groups: biological, psychosocial, drug and socio-demographic factors [4].

However, the association between epilepsy and psychiatry can be considered to have a long history; The traditional approach to epilepsy care has been directed at seizures and their treatment, however, this only occupies a small proportion in affecting the patient with epilepsy and their quality of life. Sackellares and Berent (2000) (cited by Bender) considered that adequate care of patients with epilepsy requires "attention to the psychological and social consequences as well as seizure control" [5]. What is worrying is that this is not taken into account by health professionals.

Most authors consider that the incidence of neurobehavioral disorders is higher in patients with epilepsy and a relationship can be established between these disorders and especially in focal epilepsy of the temporal and frontal lobe and in patients with epilepsy refractory to treatment and that existence of comorbid psychiatric disorders has a significant impact on the treatment of epilepsy [6].

The prevalence of psychiatric disorders in patients with epilepsy is high, 5.9 - 55.5% among adults, with a maximum of 80% in some patients with temporal lobe epilepsy (TLE) [6-8] and 24 - 37% among children.

Other authors estimate that between 20 and 30% of patients with epilepsy have psychiatric disorders (Vuilleumier, Jallon 1998) and that the most common psychiatric conditions in patients with epilepsy are depression, anxiety and psychosis (Téllez-Zenteno., *et al*. 2007; Ettinger., *et al*. 2004; Kobau., *et al*. 2006; Barry., *et al*. 2007; Jobe., *et al*. 1999; Jobe 2003) (Cited by Bender) [5].

Kanner's studies suggested that 24 to 66% of patients with drug-resistant or refractory epilepsy have mood disorders; Among these, the most common is depression [9]. Mood disorders, anxiety, psychosis, attention deficit hyperactivity disorder (ADHD) and autism have also been considered to be relatively common diseases in patients with epilepsy [10,11].

Anxiety is considered a common comorbidity in patients with epilepsy, with a frequency that varies between 14 and 15% [12].

Anxiety and depression associated with epilepsy increase the risk of suicide, this justifies close surveillance and optimal management [13].

Psychosis is a frequent complication of epilepsy whose prevalence has been estimated at 5 - 30%. A study in the Mexican population estimates it at 8.3%. Patients with epilepsy have an eight times greater risk than the general population of developing psychosis [14].

The presentation of psychosis, bipolar affective disorders, depression, mania, suicidal behavior, and anxiety and personality disorders has been described in patients with epilepsy. All this is feasible to present in patients with refractory epilepsy with surgery criteria or not [15].

The prevalence of personality disorders is 5 - 18% in patients with epilepsy. Personality disorders can be divided into three subgroups of the DSM-5-TR: Cluster C personality disorders are the most common personality disorders in patients with epilepsy: avoidant, dependent, obsessive-compulsive [16].

In 2008, the Food and Drug Administration (FDA) introduced a warning suggesting that "all" anticonvulsant drugs (ACMs) have the potential risk of causing suicidal ideation and suicidal behaviors which led to the inclusion of a warning in the information of all the MACs.

Although the validity of this statement has been questioned due to methodological problems, the warning remains. The main consideration is that epilepsy itself can cause mood and anxiety disorders; additionally, some CAM can worsen symptoms, so an evaluation of suicidal risk and suicidal ideation should always be done in patients with epilepsy [17,18].

In the comprehensive management of the patient with epilepsy, attention to the psychological and psychiatric aspects must be taken into account as part of the treatment, since otherwise, the results would not be encouraging, in a pathology considered complex, with social and psychobiological and economic consequences [19].

It can significantly compromise the quality of life of those who suffer from it, since in many cases it affects, although in a variable way; emotional, behavioral, social and cognitive state. There is a general consensus that the incidence of neurobehavioral disorders is higher in patients with epilepsy than in the general population [20].

The incidence of psychiatric pathology in these patients implies the need to take this aspect into account [21].

However, these disorders go unnoticed in the majority of patients with epileptic seizures, since their control becomes the main focus of attention and, many times, doctors are not aware that psychiatric disorders can occur. in patients with epilepsy [22].

The final message to convey is that psychiatric disorders lead to a poor response to treatment, affect the patient's quality of life and increase the risk of premature death due to suicide or accidents.

Therefore, it is important to keep them in mind and attend to them [23].

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