

15 - Psychiatric comorbidities in epilepsy

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Drug treatment of psychiatric symptoms in the context of other conditions CHAPTER 10 Epilepsy

Psychiatric comorbidities in epilepsy People with epilepsy (PWE) have an elevated prevalence of several psychiatric disorders including depression (13–37%), anxiety (20%) and psychosis (5%).^{1,2} Suicide is threefold higher in PWE compared with the general population³ and is an important cause of premature mortality.⁴ The link between epilepsy and mental illness is bidirectional as patients with depression, anxiety and psychosis have an increased risk of developing new-onset epilepsy.^{5,6} Suicide attempts are also associated with the development of epilepsy.⁷ This bidirectional relationship might be explained by a common underlying pathology between mental illness and epilepsy. Disturbances in neurotransmission, neuroinflammation and the hypothalamic–pituitary–adrenal (HPA) axis have all been suggested⁸ to be the shared pathology. Interictal psychiatric disorders (with symptoms occurring independently of seizures) are likely to require treatment with psychotropics.^{9–11} When prescribing psychotropics to people with epilepsy, the following general principles^{12,13} should be adhered to: ■ ■First, rule out other possible causes of psychiatric symptoms (both peri-ictal and iatrogenic – Table 10.3). ■ ■Optimise the treatment of epilepsy (ideally before prescribing psychotropics). ■ ■Consider using psychotropics with known antiseizure properties (e.g. antiseizure medications in bipolar disorder). ■ ■Check for interactions with antiseizure medications. ■ ■Start with a low dose and titrate according to tolerability and response (proconvulsive effects are dose-related). ■ ■If seizures do occur, consider changing the psychotropic drug or optimising the antiseizure medication. Table 10.3

Possible causes of psychiatric symptoms in people with epilepsy (PWE) and their management.⁵

Cause of symptoms	Description	Management
Interictal psychiatric disorders	Symptoms occurring independently of seizures. Although common in PWE, other causes and relatedness to seizures should be ruled out first. Likely to require treatment with psychotropics. See Table 10.5 for more information about the use of specific psychotropics in PWE.	
Peri-ictal symptoms	PWE may experience psychiatric symptoms that are temporally related to seizures. All peri-ictal psychiatric symptoms (pre-ictal, postictal and ictal) are initially treated by optimising antiseizure medications. ¹² Peri-ictal depressive symptoms do not appear to respond to treatment with antidepressants. ^{14,15} Postictal psychosis can remit spontaneously or respond to treatment with low doses of antipsychotics. ¹⁶ Short-term symptomatic treatment with a benzodiazepine or	

antipsychotic is recommended for up to 3 months.¹⁷ Taper off carefully after symptom resolution.¹⁵ There is no evidence that psychotropics can prevent ictal symptoms.¹⁸ Pre-ictal symptoms Typically presents as a dysphoric mood preceding a seizure by a period of 30 minutes to hours to 2 or 3 days. Postictal symptoms Typically presents between several hours to 7 days following a seizure (depression, anxiety, suicidal ideation and psychosis reported) PWE and interictal psychiatric disorders may experience worsening of symptoms previously in remission (breakthrough symptoms). Ictal symptoms May present as ictal fear/panic (most commonly), depressive symptoms or, rarely, psychosis. (Continued)

Revision #1

Created 2026-01-04 20:17:41 UTC by Omar Ayman

Updated 2026-01-04 20:17:41 UTC by Omar Ayman