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Personality Changes in the Epilepsy Clinic

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Abstract Personality changes (PD) in the clinic of epilepsy are one of the leading symptoms of the disease and are not uncommon in neurological practice, although our experience shows that neurologists often fail to record and treat them. Traditionally, the literature describes the classical type of these changes, the psychopathological phenomena that develop in epilepsy due to organic lesions of various parts of the brain . At the same time, IL in observed patients play a large role in the clinical picture of the disease, are considered as a mental defect and often disorganize the patient more than seizures. That's why much attention is paid to treatment of these manifestations of the disease in the department of epilepsy of the Institute named after V.M. Bekhterev.

Keywords: personality changes, epilepsy, epileptic seizures.

While the treatment of epileptic seizures provides mainly medication therapy, the treatment of mental defect includes psychosocial and psychotherapeutic interventions in addition to medication. It is now clear that the study of personality and its changes belong to the most pressing problems of our time, being the object of study of many scientific disciplines: philosophy, sociology, psychology, psychiatry, etc. The personality of each patient is unique and determined by different things. Often in practice we encounter a combination of features of different types of personality changes. Their formation is due to both endogenous (genetic, pathogenetic) and exogenous factors (particularities of upbringing, environment, intelligence, etc.). It is well known that epileptoid personality traits helped some people to achieve a high, dominant position, while others harmed them and turned them into bitches, criminals, alcoholics, etc.

1. The main objectives of the study were to identify and systematise different types of seizures in patients with epilepsy and to develop adequate differentiated therapy, taking into account the type of seizures and other features of the disease process. The subjects were 129 patients with epilepsy with IL aged 15 to 49 years with a disease duration of 1 to 33 years, who had different types of epileptic seizures. There were 68 (52.7%) males and 61 (47.3%) females.

2. The research allowed us to distinguish [5], in addition to the "typical" for epilepsy (ILE), 4 other mixed types of personality changes in this disease: epileptoid-hysteroid (ILE), epileptoid-unstable (ILEN), epileptoid-cycloid (ICE) and epileptoid-schizoid (ESS). We shall describe them briefly.

3. (1) Epileptoid type (69 patients, or 53.5%). The main features of this type are stiffness, sluggishness, viscosity, inertness of mental processes and tendency to dysphoria. The patients are flattering, obsequious and at the same time very stubborn, stenotic in attaining their goals, inclined to truth-seeking, chicanery, extremely vindictive, petty, even a minor disturbance of their routine may cause violent affective outbursts. These affective outbursts may be of the "last straw" for any incidental reason and are prolonged; they are very aggressive, violent. They tend to abuse alcohol,

prefer hard drinks (vodka, alcohol) in large quantities to achieve high intoxication. Alcohol tolerance is generally high. Alcohol intake may provoke the development of dysphoria.

4. (2) Epileptoid-hysteroid type (27 patients, or 20.9%). More often observed in women (81.5%). Patients are ingratiating, sweet-tongued, sneaky, trying to make the best impression, to present themselves in a more favorable light, to show how much they are loved by others, how many good deeds they have done. At the same time, selfish, pretentious, prone to demonstrative behavior, stenichny, tend to subjugate people around them, tend to simulate seizures to achieve their goals, especially in the family. Playing the role of the sufferer, may cry for hours "for the attending physician", complain a lot about pain and discomfort in various parts of the body, which is sometimes mistakenly interpreted as asthenoneurotic syndrome. Pitying patients, many doctors make the typical mistake of starting to comply with all their demands: unnecessarily performing many unnecessary examinations, letting patients go home, etc., which leads to complete decompensation and social disadaptation of these patients. As a result of this "kindness" many able-bodied patients become invalids, despots in the family and in the institutions where they are observed.

5. ***epileptoid-unstable type*** (15 patients, or 12.2%). Most of the patients (73.3%) were male. We named this type of ID by analogy with the unstable type of psychopathies [8, 9J. The patients are euphoric, their judgments are light-hearted, they sort of "go with the flow", joining the more active persons. They often change places of study, work, as they quickly become disillusioned with their choices. They have an increased tendency towards amusement, idleness and idleness. They easily accept without hesitation offers from others to commit any asocial act: petty theft, taking drugs, etc. While in hospital, these patients often violate the regime, then apologise, outwardly giving the impression of being deeply repentant, and then immediately commit antisocial acts again. Very often these patients become alcoholics and drug addicts.

6. Epileptoid-cycloid type (12 patients, or 9.8%). Cycloidism often refers to relatively mild cases of manic depressive psychosis, questioning the existence of such mental changes within other diseases. There is a view that depressive states in patients with epilepsy are usually of psychogenic origin, expressed in mild form and occur only in connection with strong affective influences (1). However, our observations have shown that a number of epileptic patients have unwarranted cyclical changes in emotional background both at the non-psychotic level of subdepression or hypomanic states, and reaching the degree of severe mental disorders: depressive states with elements of vitriolic longing, expressed apathy, delusions of self-blame with the appearance of true suicidal thoughts and intentions, with depersonalization phenomena, asthenodepressive states and others.

7. Epileptoid-schizoid type (6 patients, or 4.7%). Patients of this type spend most of their time reading books or in bed, pretending to be asleep to be "left alone". They read a lot about their disease and usually have their own concept of its development, resonating about it; they are extremely stubborn, always "sticking to their opinion". Outwardly, they give the impression of being odd, strange and infantile. They do not usually seek contact with others, but can suddenly show extreme obnoxiousness and tactlessness in defending their opinions. The lack of communication is compensated for by hobbies in which they sometimes show amazing stenicism (yoga, karate, cultural tourism, parapsychology, special diets, fasting), many discover extrasensory abilities, etc. A favourite hobby may occupy all their free time and they may be extremely punctual and meticulous.

To clarify the question of a possible pathogenetic link between the seizure and the developing IL, we conducted a correlation analysis.

It should also be noted that 5 (18.5%) patients with ILEI had diencephalic paroxysms, while the other groups did not. Thus, generalized seizures were more often associated with the presence of IL than other seizure types (68.1 to 91.7%), and the same correlation was found for complex partial (temporal) seizures (85.7%).

EEG examination of patients with IL showed that clear paroxysmal brain activity was detected in them more frequently (in 93.9%) than in all epileptic patients. In 81 (62.8%) patients the emphasis of paroxysmal changes was in one of the brain hemispheres, and in 48 (37.2%) generalized bilateral-synchronous flashes of activity were registered.

The treatment of different forms of epilepsy has been extensively reported in the literature, but it is mainly the use of different antiepileptic drugs and their combinations that has been covered in detail. Drug correction of psychiatric disorders in this disease is mentioned only in passing, mostly in the management of psychotic states. When formulating a specific therapeutic programme for an epileptic patient, the physician must know not only the exact nosological diagnosis, the type and frequency of seizures, but also the characteristics of the patient's personality [2].

It is now generally accepted that drug therapy for epilepsy should be comprehensive. The main role in this is given to anticonvulsant therapy, which is prescribed according to the type of paroxysms [3]. We present this information on the basis of our generalised experience in treating patients with epilepsy with domestic and foreign drugs in Table 1.

Table 1.

Effectiveness of antiepileptic drugs (in descending order) for different types of seizures

Type of seizures	Drug of choice
Partial (simple, complex) Secondary-generated	- Carbamazepine
Primary-generated (tonic, clonic, tonic-clonic, atonic)	- Hexamidine
Absences (typical, atypical)	- Benzonal
Myoclonic	- Valproate sodium

Traditionally, most authors suggest that aminazin should be widely used in the treatment of dysphoric states in epilepsy, but in our opinion, its use should be approached very differentiatedly. It is inadvisable to use it in treatment of patients with severe lethargy, rigidity and a significant decrease of intellectual and mental functions, as well as in complex therapy of patients with ILEC and ILES, because it has depressogenic effect and can promote development of so called drug apatoabolic syndrome. Thus, the use of the drug may lead to a worsening of the patient's mental state. The use of the drug in standard doses is only possible in the treatment of dysphoria in patients with ILEI and ILEH.

For the prevention of dysphoria, carbamazepine (finlepsin, tegretol) 0.4-1.2 mg/day is much more effective, which is known to have normotensive effects and rarely causes side effects. In patients with severe hydrocephalus and headaches, it is advisable to prescribe diuretics 1-2 times a week for the same purpose.

We also recommend that carbamazepine (finlepsin, tegretol) is widely used for the prevention of depression. The antidepressant effect of carbamazepine, even in high doses, is very weak in epilepsy, so we usually use other drugs to relieve depression: amitriptyline 0.05-0.3 mg/day, melipramine 0.05-0.2 mg/day, azaphene 0.05-0.2 mg/day. In depressive states with depersonalization phenomena and self-blame delusions, low-dose neuroleptics with a stimulant effect - frenol 0.015-0.03 mg/day, sonapax 0.03-0.05 mg/day, eglonil 0.05-0.075 mg/day, and in anxious-depressive states - phenazepam 0.0015-0.003 mg/day, tizercine 0.025-0.05 mg/day. In asthenodepressive states, the combination of phenazepam 0.015-0.03 mg/day with sidnocarb 0.01-0.03 mg/day has the greatest effect.

During treatment of patients with ILES, in our opinion, the greatest effect is achieved by such drugs as frenolone 0.015-0.06 mg/day, sonapax 0.03-0.075 mg/day, haloperidol 0.009-0.015 mg/day, tizercine 0.0125-0.05 mg/day, phenazepam 0.0015-0.003 mg/day. With prolonged treatment, a positive dynamic is observed: patients become more active and their family and work relationships improve. The greatest difficulties arise in the treatment of patients with IPEI and IPEN. Typically, patients with IPEI are used to being 'sufferers'; they fake epileptic seizures in appropriate situations and take advantage of them: they are cared for, relieved of daily chores, etc. The explanation of the doctor that these seizures are not epileptic and that they can easily be self-limited often leads to protest because it removes the person's halo of a severely ill person. Sometimes, such explanations lead to a sharp deterioration. A great deal of tact and patience is required in psychologically correcting these patients, but it is never appropriate to indulge them. As patients are not stenic, psychotherapeutic conversations are best conducted after the use of sedatives: frenolone, sonapax, neuleptil in small doses. Most patients with IDEI are amenable to hypnosis and this can be used extensively when working with them.

Patients with ILEN are the least effective in treatment. They are seldom adherents to advice, and are prone to alcohol and drug use. Conducting psychotherapeutic interviews is totally ineffective. Therefore, it is advisable to prescribe neuroleptics from the first days of admission: aminazin, tizerzip, haloperidol, neuleptil. In some cases pyrogenal has a positive effect (starting with 25 MPD, gradually increasing the dose, for a course of 15-20 injections). Pyrogenal can also be widely used to overcome drug resistance and to relieve dysphoric states.

In conclusion, it should be noted that epileptic seizure with its disintegrating effect on brain activity seems to underlie the development of IL occurring in patients with epilepsy. Therefore, therapy for IP should be primarily aimed at eliminating seizures and then (or simultaneously) at the resulting mental defect. The therapy package for IP should include both medication and nonmedication - psychotherapeutic and psychosocial measures. Experience with patients with epilepsy shows that IP begins to regress approximately 2-3 years after seizures have been completely controlled.

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