PSYCHOPATHOLOGICAL PROFILE OF PATIENTS WITH EPILEPSY THAT OCCURRED AT AN EARLY AGE

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Abstract. *The article deals with the study mental disorders that arise in the initial period of epilepsy. The results obtained indicate a high incidence of epileptic disease in childhood and adolescence, often leading to mental retardation and maladjustment. Studying the frequency and types of seizures, age of onset of epilepsy, the mental disorders and social problems can be important factors in predicting the development of disease and determining the need of individualized approach to treatment and support for the patient.*

Keywords: *epilepsy, mental disorders, childhood, prognostic factors.*

Introduction. Epilepsy, as is known, is one of the most important problems that are the focus of attention of psychiatrists and neurologists. The problem of epilepsy attracts the attention of specialists both because of the high prevalence of this disease among the population (0.5-1%), and because of the frequency of unfavorable variants of the course and outcomes of the disease with irreversible mental disorders [1, 2, 4, 8], because this disease develops mainly at a young age, often leads to disability [9, 11]. In this regard, a very pressing issue in modern psychiatry is the problem of prognosis of mental disorders caused by epilepsy, since in most cases it is these disorders that largely determine the social and labor maladjustment of patients [3, 5, 6].

Purpose of the study. Education about medical disorders at the onset of epilepsy in childhood and adolescence.

Material and research methods. Clinical-catamnestic and clinical-psychopathological methods were used to examine 65 patients (24 women, 41 men) aged from 16 to 54 years, who were hospitalized at the Tashkent City Clinical Psychiatric Hospital. The study included patients whose diagnosis was qualified by the categories F02.8-Dementia due to epilepsy and F07.02-Personality disorder due to epilepsy according to ICD-10.

Results and discussion. In more than half of the cases, the disease began in childhood and adolescence. In 35 (53.8%) patients, the disease began before the age of 11 years, and in 10 (15.4%) patients between the ages of 12 and 15 years. Between the ages of 16 and 21 years, 9 (13.8%) patients became ill, and there were 11 (16.9%) cases of onset of the disease at the age of 22 years or older. The duration of the disease at the time of examination varied from 7 to 43 years. Since the incidence of onset of epilepsy clearly predominated in childhood and adolescence, it was interesting to look at the incidence rates of certain age periods considered critical for children and adolescents, i.e. identified by the authors according to the maximum risk of onset of epilepsy [7, 10]. The peak incidence was observed at the age of up to 2 years (13 patients - 20%), and in second place was the age period from 11 to 14 years (11 patients - 16.9%). At the age of 3-4 years, the disease began in 7 (10.8%) cases, and the smallest number of cases occurred at the age of 8 years (3 patients -4.6%).

In the initial period of epilepsy, in the vast majority of patients (61(93.8%)), the disease began predominantly with generalized seizures, which most often manifested themselves in the

form of generalized tonic-clonic seizures. Partial seizures without generalization were observed less frequently, in only 4 patients (6.2%).

However, this distribution of types and forms of seizures related only to the initial period of the disease. Subsequently, the paroxysmal syndrome observed in each patient often showed both a modification of seizures and the emergence of new types, as well as a complication of the structure of seizures observed in the initial period of the disease. In some patients, one seizure was replaced by another. The uniformity of seizures and the constancy of the seizure structure throughout the entire period of the disease was observed mainly due to generalized tonic-clonic seizures.

In the examined patients, a large variability in the frequency of seizures was noted, but it was possible to identify certain types of seizure frequency. Seizures that occurred daily and up to several times a week were classified as frequent seizures. Occurrence of seizures every week or 3–5 times per month was classified as weekly seizure frequency. Occurrence of seizures every month and up to 15 times per year was classified as monthly seizure frequency type. In addition, there were patients who had only a few seizures (up to 7) in the first year of the disease. These cases were classified as rare seizure frequency type.

Increased seizures were the most common reason for hospitalization at the clinically advanced stage of the disease, and patients were characterized by extremely pronounced cases of increased frequency and series of seizures. The causes of such decompensations were mainly interruptions of anticonvulsant therapy. Therapy was often interrupted arbitrarily, by the patient himself, for various reasons. Among the latter, there were conflicts between patients and relatives, which were typical for almost all patients with an unfavorable course of epilepsy. In a conflict situation, refusal of treatment took on the meaning of protest. In addition, arbitrary refusal of treatment occurred in conditions with a depressive mood background and in dysphoria, and sometimes due to the patient’s conclusion that therapy was useless and the disease was incurable. A special place was occupied by violations of the treatment regimen during the development of psychotic symptoms, when the motivation for refusing treatment was determined by corresponding psychotic experiences. In the earlier stages of the disease, the most common cases were refusal of treatment due to non-recognition of one’s own illness. It should be noted that there were many cases of forced interruption of treatment due to lack of drugs, poor drug supply or lack of funds to purchase drugs in patients from families with low material income. In addition to interruption of treatment, the cause of increased frequency of seizures in a number of cases was the patient’s alcoholism, unfavorable background state of physical health, overwork, intense life activity, etc. However, these reasons caused a less pronounced increase in seizures, which, in cases of hospitalization of the patient, were relatively easier to treat therapeutically.

A retrospective analysis showed that in patients with the onset of clinical manifestations of the disease in early childhood, mental changes were primarily expressed by more or less noticeable signs of mental retardation (in 12 - 18.5% of the number of patients in the group). These disorders were more aggravated in cases accompanied by relatively frequent seizures than in patients with petit mal seizures. In these cases, the process of acquiring socially adaptive skills was significantly hampered. Disadaptation in this regard was already evident in the process of joining children's groups of preschools, school institutions and immediate environment. Parents of patients who had previously less objectively noted the characteristics of their child due to the understandable “protective” guardianship of the child, immediately encountered a lot of problems arising from the

weakened adaptive qualities of the child's psyche. The process of preschool learning became more difficult; in the general background of the child's mood, the emotional tension and irritability of the child often increased, often causing corresponding behavioral reactions - conflict with peers and disobedience of adults. Some children were distinguished by motor disinhibition and instability of attention; in other children, the protective-adaptive reaction in the form of tearfulness of a hysterical nature intensified. Patients with mental retardation from the beginning of school poorly mastered educational material or failed to cope with the school education program. Less than half of patients with early onset epilepsy (45%) were able to obtain incomplete secondary education in a regular or auxiliary school. At the onset of the disease at school age, patients also quickly experienced a decline in academic performance, studying became more difficult, intelligence deteriorated, memory weakened, attention became unstable, and the ability to acquire new knowledge and skills decreased.

At the onset of the disease in older ages, active complaints indicating exhaustion of attention and direct complaints about memory impairment came to the fore, although some patients did not express their own subjective assessments of these functions. As epileptic dementia deepened, in the structure of the latter, in most patients, the rigidity and inertia of thinking increased, it became extremely viscous, which could be seen in the speech of the patients, and in some cases acquired an object-specific character. In these cases, the memory processes noticeably suffered and oligophasia manifested itself. Dementia developed in varying degrees of severity in all patients, and in most patients, an intellectual-mnestic decline or defect was detected without special research methods. With the severity of these disorders, the social and labor adaptation of patients was persistently disrupted, and the corresponding attitudes were lost.

Both at the onset of the disease at school age and at a later onset of the disease, the decrease in educational performance and work adaptation of patients most likely had other reasons than the increasing intellectual-mnestic decline. With unfavorable trends in the course of the disease, educational and work processes requiring a certain psychophysical stress served as a natural tool for early detection of signs of progression of the process, both in terms of the development of paroxysmal syndrome, including an increase in the frequency of paroxysms, and in terms of the deepening of mental disorders.

In general, the patients were characterized by the severity and rapid rate of development of mental disorders and personality changes. Some patients experienced an increase in emotional tension with outbursts of affect and manifestations of dysphoria with anger and anger. In other observations, patients were characterized by increased irritability and sensitivity, showing extreme impatience with stimuli and situations that cause dissatisfaction or internal tension. Both patients exhibited strong temperament on minor occasions and an inability to suppress emotions and avoid conflict situations. The patients were characterized by a tendency to violent reactions, resulting in increased conflict, pugnacity, a tendency to aggressive and sometimes out-aggressive actions, and were characterized by being stuck on unpleasant experiences, touchiness and vindictiveness. The increase in character changes contributed to the development of appropriate behavioral reactions and stereotypes that meet the egocentric needs of patients. Demand towards guardians and loved ones increased, reaching despotic qualities. Often, ingratiating and calculating treatment of officials, who did not condone the antics of the sick, was combined with ruthless treatment of members of their own family. Putting ultimatum demands on loved ones, simulating a seizure, threatening conscious aggression, demonstrating suicide, and refusing to take medications turned

out to be frequent ways of protecting or realizing one's own interests. Teenagers and young men easily acquired the qualities of deviant behavior - they did not obey their parents, missed classes for no reason, wandered, violated the requirements of regimes and routines, became involved in asocial companies, took up smoking, taking alcohol and drugs. Adult patients lost interest in work, stopped fulfilling family and social responsibilities, and adopted a consumerist lifestyle. Gradually losing the sense of distance and tact, they became cheeky and rude, prone to actions without proper consideration of the situation, which indicated a loss of the ability to assess the situation, critically assess their condition and behavior. On top of that, both of them very often interrupted maintenance therapy. Thus, in parallel with intellectual-mnestic disorders, psychopathization of the patient's personality occurred, grossly disrupting the social and labor adaptation of the patients. In some patients, a low mood background with a tendency to depressive and hypochondriacal experiences prevailed; periods of mild mood variability were also noted. Asthenic syndrome, more pronounced in these patients, was characterized by rapid exhaustion, leading to decreased activity and states of general weakness. The character of the patients was characterized by timidity and uncertainty, resentment and suspiciousness. In such cases, an additional maladaptive quality of the patients was their unfavorable position with pronounced lack of initiative and self-sparing behavior, with a desire to separate themselves from an active lifestyle.

As can be seen, the mental characteristics of the patients were largely determined by affective disorders, among which dysphoria should be especially highlighted. Dysphoria was observed in 58 (89%) patients in this group. The duration of the disease at the time of the appearance of dysphoria in the clinical picture of the disease varied widely (from 4 years and later), manifesting itself on average by 10 years of the disease. In more than half of the cases, dysphoria manifested itself in the first 10 years of the disease (36), and up to 15-16 years of age it was observed in almost all patients from the above number (56). It should be noted that we distinguished two types of dysphoria based on the duration of this disorder. All patients were more likely to experience short-term dysphoria, lasting up to several hours. They were often associated with seizures, preceded them or were observed in the post-seizure period, and sometimes they could be considered as seizure equivalents. The emotional state of the patients changed rapidly, acquiring different shades. Patients in this group were distinguished by the predominance of dysphoria variants with a gloomy-angry mood background, with a tendency to excitement and outbursts of effect on minor occasions and without them. Pickiness towards others and dissatisfaction with them, reaching the point of open hostility, often led to aggressive actions of patients towards others, and sometimes towards themselves. Moreover, with the increase in epileptic dementia, dysphoria acquired extremely pronounced elements of rudeness and cynicism. It is interesting that outside of dysphoria, the patients did not have a feeling of regret about what they had done, about the insults inflicted on loved ones. This was explained by a peculiar understanding of justice, which served only the interests of the sick, and a decrease in criticism of one's own condition and behavior.

A special place among affective disorders was occupied by dysphoric states, which, unlike short-term dysphoria, were characterized by a protracted course. These disorders lasted for several days or more. Prolonged dysphoric states, along with short-term dysphoria, were identified in 30 (46%) patients with an unfavorable course of epilepsy. Their origins had some differences. They more often arose both after generalized tonic-clonic seizures and from the influence of psychogenic factors, or it was completely impossible to believe that they were connected with any

factor. These states differed from the above-described asthenic tension of emotions in the sharp onset of disorders, the delineation of episodes, the strength and low exhaustion of the predominant affect, which took on a melancholy, angry or depressive coloring with different accents. In addition, the structure of the disorder often included elements of unreasonable fear, anxiety and agitation, unfounded accusations of loved ones with ideas of attitude, sudden suspiciousness and suspicion towards loved ones. These same signs distinguished prolonged dysphoria from characterological disorders and habitual behavioral characteristics of patients. Thus, the clinical features of prolonged dysphoric states created a picture of acute psychotic states with affective and affective-delusional disorders, often with sensitive ideas of relation.

The frequency of short-term and long-term dysphoria varied individually. Most patients experienced periods of high frequency of short-term dysphoria, alternating with periods of their decrease. In other patients, dysphoria acquired a more stable rhythm, but still had relatively frequent manifestations. Prolonged dysphoria was observed much less frequently, however, it also manifested itself more often in some patients than in others. In general, a relatively high frequency of dysphoria was noted in 34 observations (52% of the number of patients in the group).

Conclusions:

1. At the onset of epilepsy in early childhood, signs of mental retardation were significantly noted in 18.5% of cases.

2. At the onset of the disease in older ages, exhaustion of attention, memory deterioration, and an increase in stiffness and inertia of thinking came to the fore.

3. Both at the onset of the disease at school age and at a later onset of the disease, in parallel with intellectual-mnestic disorders, psychopathization of the patient’s personality occurred, grossly disrupting the social and labor adaptation of the patients.

4. Among affective disorders, dysphoria was observed in 58 (89%) patients.

5. In some patients, a low mood background with a tendency to depressive and hypochondriacal experiences prevailed; periods of mild mood variability were also noted. Asthenic syndrome, more pronounced in these patients, was characterized by rapid exhaustion, leading to decreased activity and states of general weakness.

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