ABSTRACT: Epilepsy directly affects 50 million people worldwide. Most can achieve excellent seizure control; however, people living with epilepsy continue to suffer from enacted or perceived stigma that is based on myths, misconceptions and misunderstandings that have persisted for thousands of years. This paper reviews the frequency and nature of stigma toward epilepsy. Significant negative attitudes prevail in the adolescent and adult public worldwide leading to loneliness and social avoidance both in school and in the workplace. People with epilepsy are often wrongly viewed as having mental health and antisocial issues and as being potentially violent toward others. Twenty-five percent of adults having epilepsy describe social stigma as a result of their epilepsy. They fear rejection and often feel shame or loneliness from this diagnosis. The psychosocial and social impact of epilepsy is significant. Yet few specific interventions have been demonstrated to alter this perception. The effect on public education is primarily short-term, while change over the long-term in attitudes and inaccurate beliefs have not presently been proven effective. School education programming demonstrates improved knowledge and attitude a month after a classroom intervention, but persisting change over a longer period of time has not been evaluated. In-depth adult psycho-educational programs for adults with epilepsy improves knowledge, coping skills and level of felt stigma. However these gains have not demonstrated persistence over time. Myths, misconceptions and misunderstandings about epilepsy continue and programs aimed at increasing knowledge and reducing negative public attitudes should be enhanced.


Stigma of Epilepsy
Nancy F. Bandstra, Carol S. Camfield, Peter R. Camfield

Epilepsy affects approximately 50 million people worldwide with a current prevalence in Canada of 5-10 per 1000.1,2 Despite effective treatments to control seizures, in the majority of people with epilepsy (PWE) there continues to be significant stigma associated with the diagnosis. Kale summarized the history of epilepsy as “4,000 years of ignorance, superstition, and stigma followed by 100 years of knowledge, superstition, and stigma”.3 Fortunately, demonic possession is no longer the proposed pathophysiology of epilepsy, as it was in Biblical times and the Middle Ages; however, currently stigmatization continues to persist in our society.

Sociologist Erving Goffman described stigma as a process where the negative reactions of others “serve to spoil one’s own social identity”.4 He argued that stigmatized individuals are seen as “not quite human” and thereby “rightful” targets for discrimination and prejudice. Accordingly, stigmatized individuals have an undesired characteristic that separates them...
from the general population. This “undesired differentness” is conceptualized as a loss of status and power for the stigmatized individual in the community.

Seizures associated with epilepsy are unpredictable and often quite dramatic; the public finds them frightening. The Epilepsy Foundation summarizes this aspect of living with epilepsy in its Recipe for Stigma: “Take one cup of ignorance and blend in a heaping teaspoon of fear. Let the ingredients stand for about 5,000 years and then wait for discrimination to rise”.5

How much stigma exists?

In 2001 a questionnaire developed by the Epilepsy Foundation of America was distributed to 19,441 American high school students by 20 Epilepsy Foundation affiliates.6 Surprisingly, 19% of the respondents reported that epilepsy was a form of mental illness and another 30% were unsure. Only 27% were sure that epilepsy was not a mental illness. More than 50% were uncertain if PWE could drive cars, could work or should have children. Although 51% thought that people died from seizures, only 33% thought they would know what to do if someone had a seizure. Only 50% confidently believed epilepsy was not contagious. One third (31%) indicated that they would not date a person with epilepsy and 63% believed that youth with epilepsy were or might be more likely to get bullied or picked on than others. In fact, more than 50% thought it was possible to tell if someone had epilepsy by looking at her or him. Unfortunately, the reasons for these inaccurate beliefs and negative attitudes about epilepsy were not explored.

A recent community-based survey conducted by the UK Office of National Statistics (1600 randomly selected adults, response rate 62%) identified important negative attitudes toward PWE thought to contribute to continued stigmatization.7 Despite familiarity with epilepsy (25% reported knowing someone with epilepsy), respondents ranked working alongside someone with the disorder as causing the second highest concern (the highest was a person with stress or depression). Twenty-two percent endorsed the statement that PWE suffered from more personality problems than those without the disorder. This unfavorable perception is further supported by other large-scale community-based surveys8,9 suggesting that PWE are often characterized as retarded, frail, antisocial, hostile and potentially violent.9,10 We disagree with Reis who argues that this stereotype may be more prevalent than enacted stigma and is troubling for the individual even if it does not arise from a social interaction or accurately reflect the evaluative views of others. A UK cohort of 607 PWE in remission highlights this possibility. Although only a small percentage of this large sample attributed specific work-related difficulties to their diagnosis, approximately a third of respondents reported that they perceived that their diagnosis of epilepsy had made it difficult for them to secure a job.15

PWE are viewed as violent

The PWE are often characterized as aggressive and potentially violent.9,10 We disagree with Reis who argues that this classic stereotype no longer has an important impact.10 In Nova Scotia, we assessed the public’s perceptions of PWE as violent in 1981 and again in 2006 using a series of vignettes depicting hypothetical PWE responding aggressively or violently to a variety of situations.16 Two examples of these vignettes are shown here:

“Jane accidentally bumped into John, who has epilepsy, in the cafeteria. John became very angry and stabbed Jane repeatedly with a fork. He explained that he was not to be blamed because he was suffering from an epilepsy seizure.”

“As Tom was riding his bicycle to school, he ran over his mother’s favorite tulip plants and continued to pedal toward school. When questioned about this, he said that he was suffering from an attack of epilepsy.”

Participants were asked whether the vignettes were believable. The response choices they were given included “Very
describing high levels of stigmatization. Stigma was closely related to the feelings of stigmatization in respondents (51%) reported feeling stigmatized with 18% feeling uncomfortable because of their diagnosis. About half of the respondents reported that violence was possible and even likely during a seizure. All responded to at least 40% of the vignettes/questions incorrectly (including medical students), except physicians who were incorrect 20% of the time. Sadly, the responses were nearly identical in 1981 and 2006. We concluded that the stereotype of PWE as potentially violent might be an important factor in the continued stigmatization over the 25 year-span of the study.

**Stigma and its interaction with psychosocial problems in PWE**

Although seizures and medication side effects are obviously a burden for PWE, the psychological and social impact of living with epilepsy may be the most troubling. Both adults and children with epilepsy are affected by personal psychosocial difficulties,17-19 which may interact with stigmatization and make coping with it more complex. These problems include poor self-esteem, social isolation, anxiety, improper social skills, loss of a sense of control of their life, depression, emotional distress, and psychosis.17-19 In addition, PWE have reduced marriageability, less years of education, and more unemployment or under-employment than population controls or other chronic diseases.20 It is perhaps understandable that PWE are at an increased risk for suicidal ideation and suicide attempts.21 Stigma may then worsen these psychological problems through obvious routes such as poor living and work conditions, as well as relationship problems with family, friends, and co-workers.

Stigma contributes to what is often characterized as a “hidden burden” that occurs in a variety of chronic disorders and conditions. The shame of such a stigmatizing disorder coupled with the fear of being discriminated against often result in PWE and their parents’ adopting a strict policy of non-disclosure.1 The diagnosis and the effects of the disorder are hidden from acquaintances, co-workers, teachers, close friends, and even some family members.9,15 We suspect that this atmosphere of secrecy can be very socially disabling and isolating.

Psychological health outcomes associated with the stigma of epilepsy were highlighted in a survey of over 5,000 people recruited from epilepsy support groups in 15 different European countries.22 Stigma was assessed using a three-item self-report measure. Participants were asked whether they felt they were ever treated as inferior, avoided by others or made others uncomfortable because of their diagnosis. About half of the respondents (51%) reported feeling stigmatized with 18% describing high levels of stigmatization. Stigma was closely correlated with elevated levels of worry and an overall negative outlook on life. In a separate North American community-based participatory study of 165 PWE, 19% felt that the most common misunderstanding of the public was that “persons with epilepsy should be socially avoided”.19 These studies suggest that high feelings of stigmatization in PWE may exacerbate the psychosocial impact of epilepsy on PWE. However, the results from this study should be interpreted with some caution. The questionnaires were self-report and many of the measures used in Europe were translated into language for which they were never validated. In addition, most of the participants were recruited from epilepsy support groups, which likely attract participants having more serious problems. In the American study, the sample was relatively small and from those attending a single tertiary centre. It is possible that participants provided socially acceptable answers to their medical treatment facility.

**Stigma & Seizure Control**

Baker and colleagues have shown that seizure frequency is a major contributor to an individual’s psychosocial difficulties, decreased quality of life, and perceived stigma.22 Respondents described increased effects of stigma with poor seizure control resulting in frequent seizures. Those with the highest seizure frequency were three times more likely to report elevated feelings of stigmatization as compared to those who were seizure-free. Furthermore, even those on medication with infrequent seizures were more likely to report elevated levels of stigmatization, when compared to those in remission. A separate study from the UK made the same observations.19 In this community-based sample, information was retrospectively collected from medical charts and from self-report questionnaires from 1,341 patients who were currently taking antiepileptic drugs and/or had a recent history of seizures. A clear relationship between seizure frequency and perceived stigma emerged in this sample. Overall, 62% of those with frequent seizures also reported feeling stigmatized by their diagnosis. However, only 40% of those with less frequent seizure felt stigmatized. Each of these studies examining the relationship between seizure control and stigma are co relational in nature. Because they cannot speak to cause and effect, it is possible that perceived level of stigma may simply reflect overall negative feelings about quality of life in those with poor seizure control.

**Stigma-Mitigating Strategies/Interventions**

**Public Interventions**

Few interventions have specifically addressed the stigma associated with epilepsy, but some strategies have been proposed to counter stigma in other health conditions, such as HIV/AIDS. Weiss and Ramakrishna at the National Institutes of Health’s conference on stigma and global health suggested the use of social marketing campaigns aimed at public education for both members of the public and those with disabling conditions.24 While this approach is aimed to reduce misconceptions and apprehensions and thereby reduce stigma, results using such an approach to reduce the stigma associated with HIV/AIDS have been mixed. Interventions appeared to make gains in public knowledge in the short-term, but attempts to make long-term changes in attitudes and inaccurate beliefs do not appear to be as successful.25

Being familiar with epilepsy may be an important first step in reducing stigma. In the large U.K. study about the public’s knowledge and attitudes about epilepsy, respondents who were familiar with a PWE more often identified signs and causes of seizures and knew that epilepsy could be successfully treated.7 Those having fewer educational qualifications expressed more negative attitudes.

While research aimed to reduce the stigma of epilepsy is limited, there is some evidence to suggest its partial success. For
instance, school children in Grade five (n=783) in Ontario, Canada were randomized to receive or not to receive a 30-minute educational program about epilepsy. The intervention and control group completed a baseline and outcome questionnaire one month later. The intervention group demonstrated improved knowledge and slightly better attitudes toward those with epilepsy.\(^{26}\) However, the long-term effects of such an intervention are unknown as is the validity for other age groups.

Group educational programs for PWE themselves may also limit the effect of stigma. Randomized studies have documented that there is enhanced knowledge, self-esteem, and increased coping with felt and perceived stigma. For example, Ried and colleagues\(^{27,28}\) have created a psycho-educational program for PWE and their families covering five content areas: medical aspects, healthy lifestyle behaviors, family and peer relationships, self-esteem, and stress management techniques. Sessions were one hour long and met weekly for six weeks. Improvements were documented in all areas.\(^{27}\) By inference, those with better knowledge would be expected to deal with stigma more readily, although this specific issue was not addressed.

**Personal Interventions**

A European study randomized 242 PWE aged 16-80 years from 22 epilepsy centers to an intervention or a control group.\(^{28}\) The intervention group (n=113) received the Modular Service Package Epilepsy that addressed nine content areas: epidemiology, basic knowledge, living with epilepsy, diagnostics, therapy, self-control, prognosis, psychosocial aspects, and network epilepsy. The control group (n=129) completed similar baseline and follow-up generic and epilepsy-specific questionnaires at six months. There was no change in the SF-36 (general health related quality of life) and self-esteem items. However, there was an increase in knowledge and coping skills, and fewer participants reported seizures in the intervention group. It seems likely that these improvements might diminish the effects of stigma.

**Conclusion**

Stigma is highly associated with incomplete seizure control and poor psychosocial outcomes for PWE (e.g., depression, anxiety, social isolation). The PWE have reported that stigma is one of their most significant challenges.\(^{15,29}\) Interventions for individuals with epilepsy in a clinical setting are of unproven benefit to overcome stigma. However, increasing knowledge about epilepsy and interventions to improve self-esteem seem likely to be helpful. Misconceptions about epilepsy continue and programs aimed at increasing knowledge and reducing negative public attitudes need to be enhanced. An atmosphere of understanding within educational and industrial settings and the health care system may help PWE feel sufficiently comfortable to disclose their diagnosis to others, which in turn may contribute to increased public understanding.

**Future Directions**

Clearly more research is needed to understand the origins of stigma for people with epilepsy and how to decrease its impact. Education at many levels of society including the public, workplaces, schools, health care and recreational settings is needed. People with epilepsy need to learn about their disorder to explain it appropriately. They also must be able to recognize and deal with stigma when it appears in their personal lives. All of these goals are enormous, but the individual physician can probably help a great deal by considering issues about stigma as they approach each person with epilepsy.

**Acknowledgements**

The authors thank Jeannette McGlone for her comments and suggestions on an earlier version of the manuscript. N.F. Bandstra was supported by a Nova Scotia Health Research Foundation Student Research Award and an honorary Killam Predoctoral Scholarship.

**References**


16. Collins TBK, Camfield PR, Camfield CS, Lee K. People with epilepsy are often perceived as violent. Epilepsy Behav. 2007; 10:69-76.
