

When Epilepsy Presents as Behavioral or Psychiatric Change

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Abstract

Seizures are not always dramatic convulsions. Focal seizures may involve altered awareness, behavioral arrest, automatisms, fear, unusual sensory experiences or transient confusion. Psychiatric changes can occur before, during or after seizure activity. Distinguishing these patterns from panic, dissociation, delirium and primary psychosis is a problem of timing, semiology and neurological evidence—not a simple choice between biological and psychological labels.

Time structure matters

An abrupt stereotyped episode lasting seconds or minutes differs from persistent hallucinations lasting days, though exceptions occur. Focal seizures involving temporal or related networks may produce sudden fear, déjà vu, unusual odors, visceral sensations or impaired awareness. Postictal states can include confusion, agitation or less commonly psychotic phenomena. Recurrent stereotyped events, nocturnal episodes, witnessed automatisms or new focal neurological findings make neurological evaluation more relevant.

EEG and its limitations

Electroencephalography can provide crucial evidence, but a normal routine study does not exclude epilepsy. The probability of detection depends on seizure frequency, event timing and recording duration. Brain imaging and neurological examination may be appropriate according to presentation. Conversely, an incidental EEG abnormality cannot automatically explain every psychiatric symptom, and psychogenic nonepileptic seizures require careful, non-stigmatizing differential assessment rather than dismissal.

Why medication interpretation matters

Antiseizure drugs can influence mood and cognition. Psychiatric medications can affect seizure threshold under some conditions. Drug changes, sleep loss, intoxication or withdrawal may alter the clinical picture. Treatment of an actual epileptic disorder and management of coexisting psychiatric illness can proceed together, but each requires its own diagnostic reasoning.

A bridge to inflammatory and metabolic disease

Autoimmune encephalitis, electrolyte disorders, toxic exposures and structural brain lesions may produce both seizures and psychiatric manifestations. The coexistence of two syndromes should prompt consideration of a unifying cause when the pattern warrants it, but it is also possible for them to be independent. This distinction safeguards against casually reclassifying all panic attacks as occult seizures.

Conclusion

Epilepsy offers a precise illustration of how a neural circuit event can appear behavioral. The most useful clues are temporal pattern, stereotypy, awareness, neurological signs and appropriate testing, not the mere strangeness of a reported experience.

Selected readings

- Dalmau et al., Anti-NMDA encephalitis and seizures
- Pollak et al., Neurological evaluation in atypical psychosis