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Psychoses in Epileptic Patients: A Clinical Approach Based on a Case Study

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Abstract | **Case Report**

Psychotic disorders are common in individuals with epilepsy, with a prevalence significantly higher than in the general population. These disorders can present in various forms, depending on their timing in relation to seizures and level of consciousness. Despite their clinical specificity, epileptic psychoses are not recognized as distinct entities in current psychiatric classifications, complicating diagnosis and management. This article presents the case of a 23-year-old man with nocturnal seizures and persistent psychotic symptoms (auditory hallucinations and persecutory delusions) unresponsive to antiepileptic treatment. EEG confirmed fronto-temporal epilepsy. The patient was ultimately diagnosed with an interictal schizophrenia-like psychosis associated with epilepsy. Combined treatment with antiepileptic and antipsychotic medication led to clinical improvement. This case highlights the complexity of diagnosing psychosis in epilepsy and underscores the need for close collaboration between neurologists and psychiatrists to ensure appropriate care. A better understanding of this comorbidity is crucial for improving outcomes in affected patients.

Keywords: Epilepsy, Psychotic Disorders, Schizophrenia-like Psychosis, Interictal, Comorbidity.

INTRODUCTION

Epilepsy is a neuropsychiatric disorder [1]. One in three people with epilepsy will develop a psychiatric disorder (depression, anxiety, or psychosis) during their lifetime, due to biological and psychosocial factors. This risk is two to five times higher than in the general population [2].

Psychotic disorders are characterized by symptoms falling into one or more of the following five categories: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, and negative symptoms, all occurring with preserved awareness (DSM-5) [3].

The relationship between epilepsy and psychotic disorders is complex. A seizure may directly induce a psychotic disorder, which can also be a comorbidity of epilepsy. Moreover, both seizures and psychotic disorders may be manifestations of a shared genetic condition. This relationship is also bidirectional: the presence of psychosis increases the risk of developing epilepsy, and epilepsy increases the risk of psychotic disorders [4].

However, epileptic psychoses are not recognized as a distinct entity in the DSM-5. They are classified under "Psychotic Disorder Due to Another Medical Condition" with the specification "epilepsy" and a mental disorder code. The lack of specific recognition of epileptic psychoses in international classifications complicates the management of these conditions, which lie at the intersection of neurology and psychiatry.

CLINICAL CASE

To explore this link, we report the case of a 23-year-old patient with no family history of psychosis or epilepsy, referred to psychiatry by a neurologist due to persistent perceptual disturbances (auditory and visual) unresponsive to antiepileptic treatment.

The patient, a student at a technical institute, single, and living with his father following his parents' divorce, was described by his father as outgoing, diligent, and socially well-adjusted. The onset of symptoms began two years earlier with nocturnal episodes involving sudden awakenings and dystonia of

the lower limbs. These brief, stereotypical episodes were followed by partial amnesia.

Initially, the family underestimated these nocturnal events, attributing them to transient sleep disturbances caused by exam stress. A few months later, distressing and insulting auditory perceptions appeared. The patient described hearing a terrifying voice, with paroxysmal evolution.

He became very anxious, unable to stay alone in his room, and had trouble falling asleep. He seemed absorbed by these strange voices, which affected his concentration and academic performance. He became aggressive, felt persecuted by those around him, and had no memory of his actions afterward.

After consulting a general practitioner, he was referred to a neurologist. Brain MRI was normal, but a wake EEG revealed epileptiform abnormalities (frontal and temporal spike discharges, predominantly on the right). Carbamazepine (600 mg/day) was initiated.

Under treatment, the frequency of nocturnal dystonic seizures and neurovegetative symptoms decreased significantly, and follow-up EEG normalized. However, the auditory hallucinations worsened, becoming constant, and a delusional persecutory theme appeared. These psychotic symptoms occurred without impaired consciousness. At this point, he was referred to psychiatry.

It is worth noting that the patient had febrile seizures requiring prolonged hospitalization at 9 months of age. He was later diagnosed with epilepsy and treated with antiepileptic drugs, but the treatment was discontinued after 12 months by his mother due to concerns about side effects. This medical history was only revealed after several psychiatric consultations.

The clinical picture could not be fully explained by partial epilepsy. A diagnosis of comorbid psychotic disorder—specifically, a schizophrenia-like psychosis related to epilepsy—was made. This justified initiating treatment with an atypical antipsychotic (risperidone 2 mg/day) alongside the antiepileptic regimen. The outcome was favorable, with reduced abnormal perceptions and a decline in delusional convictions.

Discussion

In this patient, seizures that first appeared in infancy reemerged around age 20 with a different clinical presentation. The nocturnal seizures with paroxysmal awakenings and dystonia were consistent with nocturnal frontal lobe epilepsy. This type of epilepsy, often unrecognized by the patient and family, occurs exclusively during sleep and may be confused with paroxysmal motor manifestations of sleep disorders [3]. Meanwhile, the auditory and neurovegetative symptoms, along with early experiential phenomena with paroxysmal evolution, suggested temporal lobe epilepsy.

The overall diagnosis was complex fronto-temporal epilepsy, based on history, clinical signs, and EEG findings (frontal and temporal spike-wave discharges).

However, beyond these stereotyped seizures, the subsequent development of sensory hallucinations (auditory and visual) unrelated to seizures and unrecognized as pathological by the patient, as well as delusional persecutory thoughts and hallucinations occurring without impaired consciousness, pointed toward a psychosis associated with epilepsy. The challenge lies in recognizing this comorbidity, despite the polymorphic presentation of fronto-temporal partial epilepsy and the atypical psychotic features in this case.

Indeed, delusional syndromes are not typically part of partial seizures and should alert neurologists to a possible associated psychotic disorder. The presence of other signs, such as rich hallucinatory syndromes, makes this diagnosis highly likely.

These clinical features overlap with schizophrenia. However, can we speak of schizophrenia in an epileptic patient, and if so, what are the specific characteristics of this form? Literature suggests that patients with epilepsy have a 6 to 12 times higher risk of developing psychosis than the general population [4,5], especially in temporal lobe epilepsy [6].

In our case, the nature of the epileptic psychosis remained to be defined. One classification of epileptic psychoses—based on the duration of the psychotic episode, its timing in relation to seizures, and the level of consciousness—distinguishes three types [2]:

- **Episodic psychoses**, often with altered consciousness (ictal psychosis, postictal confusion, postictal psychosis)
- **Chronic or permanent psychoses**, with preserved consciousness (interictal schizophrenia-like psychoses)
- **Alternative psychoses**, where the level of consciousness varies.

Conclusion

The clinical case and literature review illustrate the wide range of psychotic disorders that can be associated with epilepsy and their specific features. This comorbidity implies a causal relationship between epilepsy and psychosis, although the mechanism remains hypothetical. Despite their distinctive clinical and evolutionary profiles, epileptic psychoses are not yet recognized as separate nosological entities in psychiatric classification systems (DSM-IV, ICD-10), complicating their identification and management. Consequently, close collaboration between neurologists and

psychiatrists is essential to accurately describe both the psychotic disorder and the epilepsy. This is key to better understanding the complex comorbidity, avoiding diagnostic errors, and optimizing treatment.

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