DOI: 10.47407/kr2026.7.3.00787

PTSD-triggered psychogenic non-epileptic seizures in a patient with epilepsy: a case report

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Abstract
Background. Psychogenic non-epileptic seizures (PNES) often coexist with epilepsy and can be difficult to distinguish clinically. Post-traumatic stress disorder (PTSD) is a known risk factor for PNES, yet its role as a precipitating trigger in patients with previously controlled epilepsy is rarely reported.
Case Presentation. We describe a 25-year-old woman with a history of well-controlled epilepsy who presented with recurrent seizure-like episodes after experiencing a violent mugging. Despite antiepileptic treatment, her episodes increased in frequency and displayed features inconsistent with epileptic seizures. Electroencephalography during events showed no epileptiform activity. Further evaluation revealed intrusive memories, hyperarousal, and avoidance behaviors consistent with PTSD. A diagnosis of PNES was made, superimposed on controlled epilepsy. The patient received a multidisciplinary intervention involving psychotherapy, psychoeducation, and optimization of medical care, which led to symptomatic improvement.
Discussion. This case highlights the complex interaction between trauma, psychiatric comorbidity, and seizure disorders. PTSD may act as a powerful trigger for PNES even in individuals with established epilepsy, complicating diagnosis and management. Recognition of the neurobiopsychosocial contributors is essential to avoid unnecessary escalation of antiepileptic therapy and to implement targeted interventions.
Conclusion. Clinicians should maintain a high index of suspicion for PNES in patients with epilepsy who develop atypical seizure patterns following traumatic experiences. Early identification and integrated management addressing both neurological and psychological factors can improve outcomes.
Keywords: psychogenic non-epileptic seizures, PTSD, epilepsy, case report, neurobiopsychosocial.
For citation: Yusrin Aulia, Margarita Maria Maramis, Ersifa Fatimah, Soetjipto. PTSD-triggered psychogenic non-epileptic seizures in a patient with epilepsy: a case report. *Clinical review for general practice*. 2026; 7 (3): 20–22. DOI: 10.47407/kr2026.7.3.00787

Вызванные посттравматическим стрессовым расстройством психогенные неэпилептические приступы у пациентки с эпилепсией: клинический случай

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Аннотация
Введение. Психогенные неэпилептические приступы (ПНЭП) часто сосуществуют с эпилепсией, и разграничение их по клиническим признакам может быть затруднено. Посттравматическое стрессовое расстройство (ПТСР) – хорошо известный фактор риска ПНЭП, однако о его роли как провоцирующего фактора у пациентов с ранее диагностированной контролируемой эпилепсией пишут редко.
Клинический случай. Представлен случай 25-летней женщины с хорошо контролируемой эпилепсией в анамнезе, которая обратилась с жалобами на повторяющиеся напоминающие припадки эпизоды, возникшие после ограбления с применением насилия. Несмотря на противоэпилептическую терапию, частота эпизодов увеличивалась, при этом они имели признаки, не свойственные эпилептическим приступам. Электроэнцефалография, проведенная во время приступов, продемонстрировала отсутствие эпилептиформной активности. Дальнейшее обследование выявило наличие навязчивых воспоминаний, перевозбуждения и избегающего поведения, характерных для ПТСР. Диагностированы ПНЭП, наложившиеся на контролируемую эпилепсию. Пациентке назначено комплексное лечение, включающее психотерапию, психиатрическое просвещение и оптимизацию лечения, что привело к улучшению, облегчив симптомы.
Обсуждение. Представленный случай демонстрирует сложную взаимосвязь между травмой, сопутствующим психическим заболеванием и судорожными расстройствами. ПТСР может стать мощным триггером ПНЭП даже у лиц с установленным диагнозом «эпилепсия», осложнив диагностику и лечение. Распознавание нейробиопсихосоциальных факторов важно с точки зрения предотвращения ненужной эскалации противоэпилептической терапии и осуществления целенаправленных вмешательств.
Заключение. Клиницистам следует сохранять высокий уровень настороженности в отношении ПНЭП у пациентов с эпилепсией, у которых после травматических событий возникают атипичные приступы. Раннее выявление и комплексное лечение, воздействующее как на неврологические, так и на психологические факторы, могут улучшить исход.
Ключевые слова: психогенные неэпилептические приступы, посттравматическое стрессовое расстройство, эпилепсия, клинический случай, нейробиопсихосоциальный.
Для цитирования: Юсрин Аулия, Маргарита Мария Марамис, Эрсифа Фатима, Соетджипто. Вызванные посттравматическим стрессовым расстройством психогенные неэпилептические приступы у пациентки с эпилепсией: клинический случай. *Клинический разбор в общей медицине*. 2026; 7 (3): 20–22. DOI: 10.47407/kr2026.7.3.00787

Introduction

Psychogenic non-epileptic seizures (PNES) are episodes resembling epileptic seizures but without associated epileptiform activity on electroencephalography. They fall under functional neurological disorders and are strongly linked to psychological stressors and trauma. Recent reviews highlight that psychiatric comorbidities such as anxiety, depression, and post-traumatic stress disorder (PTSD) are highly

prevalent in PNES, complicating diagnosis and management [1].

PTSD has emerged as one of the strongest risk factors for PNES, with traumatic experiences shaping both symptom onset and recurrence. Trauma-related hyperarousal and dissociation may manifest as seizure-like episodes, which can easily be misattributed to poorly controlled epilepsy [2]. When PNES develops in individuals with established epilepsy, diagnostic uncertainty is common, leading to unnecessary escalation of antiepileptic treatment [3].

This case report describes a young woman with previously well-controlled epilepsy who developed PNES triggered by PTSD after a violent assault. The case emphasizes the importance of recognizing trauma as a precipitating factor and adopting a neurobiopsychosocial framework for diagnosis and treatment.

Case presentation

A 25-year-old woman with a known history of generalized tonic-clonic epilepsy, previously well controlled on antiepileptic medication, was referred for evaluation of new recurrent seizure-like episodes. For several years, she had remained stable with no breakthrough seizures.

Three months prior to presentation, the patient was the victim of a violent mugging in which she was physically assaulted and threatened. Following this event, she began experiencing frequent episodes of collapse accompanied by generalized shaking, vocalization, and prolonged unresponsiveness. These episodes differed from her typical epileptic seizures in several ways: they were often precipitated by reminders of the trauma, lasted longer, and were occasionally accompanied by partial awareness, asynchronous limb movements, and eye closure. The frequency of these episodes increased despite adherence to her antiepileptic regimen.

Neurological investigations included repeated electroencephalography (EEG) during the episodes, which showed no epileptiform discharges. Brain magnetic resonance imaging was unremarkable. Given the clinical semiology and negative findings, epileptic seizures were considered unlikely. Further psychiatric evaluation revealed prominent post-traumatic symptoms. The patient described recurrent intrusive memories of the mugging, nightmares, hypervigilance, and avoidance of public spaces where she feared being attacked again. She also reported persistent anxiety, irritability, and sleep disturbance. These symptoms met criteria for post-traumatic stress disorder (PTSD).

The overall clinical picture was consistent with psychogenic non-epileptic seizures (PNES) triggered by PTSD, occurring in the context of controlled epilepsy. The case was managed through a multidisciplinary approach involving neurology, psychiatry, and psychology. The patient received psychoeducation about PNES, trauma-focused psychotherapy, and supportive counseling. Family members were engaged to provide emotional support and to help reduce reinforcement of seizure behaviors. Over subsequent follow-up visits, the patient reported a gradual reduction in PNES frequency, improved coping strategies, and better regulation of mood and sleep, while continuing antiepileptic therapy for her underlying epilepsy.

Discussion

This case illustrates the complex interaction between trauma, psychiatric comorbidity, and seizure disorders. Psychogenic non-epileptic seizures (PNES) are increasingly recognized as part of the functional neurological disorder spectrum and are often associated with psychological stressors, including post-traumatic stress disorder (PTSD). Recent work confirms that psychiatric comorbidities are highly prevalent in PNES, with PTSD playing a particularly significant role [1].

Diagnosing PNES in individuals with established epilepsy presents a particular challenge. Patients and clinicians may attribute new seizure patterns to poor control or antiepileptic drug resistance, leading to unnecessary medication escalation. However, atypical semiology, such as asynchronous movements, prolonged duration, eye closure during convulsions, or partial awareness, should prompt consideration of PNES, especially when EEG does not show epileptiform activity [3]. In this patient, the onset of recurrent seizures following a violent mugging, combined with trauma-related symptoms, strongly suggested a functional etiology superimposed on controlled epilepsy.

PTSD is one of the most consistent psychological risk factors for PNES. Trauma can activate hyperarousal and dissociative mechanisms, which may manifest as seizure-like episodes. A recent review emphasized the role of traumatic experiences, including assault and abuse, in shaping both the onset and persistence of PNES symptoms [4]. Similarly, a meta-analysis has shown that adverse childhood experiences and traumatic stress significantly increase the risk of developing functional seizures, underscoring the strong link between trauma and PNES [5].

Management of PNES requires a multidisciplinary approach. Psychoeducation helps reduce stigma and fosters patient engagement, while psychotherapy, particularly trauma-focused modalities such as cognitive behavioral therapy or eye movement desensitization and reprocessing, has shown benefit in addressing PTSD-related triggers. Involving family members can also reduce reinforcement of maladaptive behaviors and provide emotional support. In line with recent consensus statements, integrated care across neurology, psychiatry, and psychology is considered best practice to improve outcomes [6]. In this case, such coordinated care led to reduced PNES frequency and improved emotional regulation.

Overall, this case underscores the need for clinicians to consider PNES when atypical seizures develop in patients with epilepsy, particularly following traumatic events. Early recognition, trauma-informed assessment, and integrated management can prevent misdiagnosis, reduce unnecessary pharmacological burden, and promote recovery.

Conclusion

This case highlights how post-traumatic stress disorder can precipitate psychogenic non-epileptic seizures even in

patients with previously controlled epilepsy. The overlap of trauma, psychiatric symptoms, and seizure disorders creates significant diagnostic challenges, often leading to misinterpretation as drug-resistant epilepsy. Recognition of atypical semiology, careful evaluation for trauma-related symptoms, and early psychiatric assessment are crucial in establishing the correct diagnosis. Multidisciplinary, trauma-informed care that integrates neurological and psychological perspectives remains the most effective approach for improving outcomes. Clinicians should maintain a high level of awareness for PNES in patients with epilepsy who present with new or atypical seizure patterns, especially after significant psychological stressors.

Conflict of interests. The authors declare that there is not conflict of interests.
Конфликт интересов. Авторы заявляют об отсутствии конфликта интересов.

Funding. This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.
Финансирование. Это исследование не получало никаких грантов от каких-либо государственных, коммерческих или некоммерческих организаций.
Patient consent. Informed consent has been obtained by authors from the patient and their family prior to submission of the case report.
Согласие пациента. Авторы получили добровольное информированное согласие от пациентки и ее семьи прежде, чем представить описание клинического случая.
Contributors. All authors were involved in the clinical care of the patient and contributed to the conception, drafting, review and revision of the case report.
Вклад авторов. Все авторы участвовали в лечении пациента, а также в разработке концепции, подготовке черновика, редактировании и пересмотре описания клинического случая.

Список литературы доступен на сайте журнала https://klin-razbor.ru/
The list of references is available on the journal's website https://klin-razbor.ru/

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Received: 06.11.2025
Revised: 13.11.2025
Accepted: 20.11.2025

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Поступила в редакцию: 06.11.2025
Поступила после рецензирования: 13.11.2025
Принята к публикации: 20.11.2025