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## **EPILEPSY!! MALINGERING! DISSOCIATIVE CONVULSIONS?**

### **A CASE STUDY**

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#### **Abstract**

Dissociative convulsions, a prominent form of dissociative (conversion) disorder, formerly known as hysteria, are a common and elusive differential diagnosis of epilepsy. The aim of the present case report is to present the difficulties of differential diagnosis between epilepsy, malingering and pseudoseizures. This case study was explored from the psychosocial stressors and based upon patients' disposition, characteristic expressions, the homoeopathic medication *calcarea sulphurica* was given. Patient was followed nearly for 2 years, the given homoeopathic remedy brought improvement at the disorder level, and patient was able to lead a normal life and delivered a healthy baby. This case report emphasizes the role of homoeopathy in treating psychiatric illnesses, especially dissociative convulsions. It also demonstrates the importance of characteristic mental state and expressions when selecting a similimum using Kent's approach.

**Keywords:** Dissociative convulsions, epilepsy, malingering, psychogenic non-epileptic seizures, pseudoseizures, homoeopathy.

## INTRODUCTION

Dissociative disorders are commonly diagnosed in inpatient and as well as outpatient settings in India, dissociative motor disorders and dissociative convulsions are the most common disorders. Unlike in the West, dissociative identity disorders were rarely diagnosed; instead, possession states were commonly seen in the Indian population which indicates the cross-cultural disparity. <sup>[1]</sup> A recent study carried out in a tertiary care hospital suggested that the prevalence of dissociative convulsion (DC) type is high in patients suffering from dissociative disorders. <sup>[2]</sup> Up to one in 5 patients, who referred to the neurologist found to have no organic causes for their seizures. <sup>[3]</sup> It is found to be more frequent among females, women as a gender are over stressed with entwined religious rituals & hence more prone to dissociative disorders. <sup>[4]</sup> Dissociative convulsions also known as Psychogenic Non-Epileptic Seizures (PNES) was originally thought of as a form of hysteria. PNES are categorized as Dissociative (International Classification of Diseases; ICD-10) or Conversion disorder (Diagnostic and Statistical Manual of Mental Disorders; DSM-V). The psychiatric comorbidities in dissociative convulsions are somatoform, depressive, anxiety, post-traumatic stress, and personality disorders. <sup>[5,6]</sup>

Dissociative convulsions (pseudoseizures) may mimic epileptic seizures (ES) closely in terms of movements, but tongue-biting, bruising due to falling, and incontinence of urine are rare in dissociative convulsion, and loss of consciousness is absent or replaced by a state of stupor or trance. <sup>[7]</sup> Dissociative convulsions have close resemblance to ES these patients inevitably wander between neurologists and psychiatrists for definite diagnosis. According to current literature its diagnosis is delayed by an average of 7 years. <sup>[8]</sup> PNES often appear behaviourally similar and commonly leads to a mistaken diagnosis of ES, because the prevalence is much higher than that of PNES. <sup>[9]</sup>

Studies of psychiatric diagnoses in patients with dissociative convulsions have reported a broad range of prevalence figures. Increased rates of depression, anxiety disorder, personality disorder and posttraumatic disorder have been reported. A history of previous

medically unexplained symptoms is very common and an important pointer to the diagnosis.<sup>[10]</sup>

A three-pronged approach comprising adequate EEG, a description of pre-ictal, ictal, and post-ictal events, and proper clinical history taking is the best strategy in the first instance. The absence of ictal EEG discharges characteristic of epilepsy is an important sign that an attack is non-epileptic in nature although this may not be correct for some partial seizures, particularly those originating in the frontal lobes. Most striking about dissociative symptoms is their apparent similarity to those found in many neurological conditions and it is often extremely difficult to distinguish between the two.<sup>[11]</sup>

**Table 1: Signs to differentiate between PNES and epileptic seizures <sup>[12]</sup>**

Variable	PNES	ES
Length	>2 minutes	< 2minutes
Onset	gradual	sudden
Asynchronous movement of limbs	Common	Rare
Side to side head movements	Common	Rare
Side tongue bite	Rare	Common
Scream	Common	Only at the beginning
Cyanosis	Rare	Common
Postictal confusion	Rare	Common
Eyelid closure	Very common	Rare
Eyelid opening resistance	Very common	Rare
Hurt	Rare	Common

**Table 2: Specific procedure for distinguishing among Neurological illness, Hysteria, and Malingering <sup>[13]</sup>**

<b>Nature of disturbances</b>	<b>Neurological illness (Epilepsy)</b>	<b>Dissociative convulsions</b>	<b>Malingering</b>
Cause	Disturbance in the electrical activity of brain.	By mental or emotional processes, rather than by a physical cause.	Resulting in alterations in behaviour to gain something, to get an external secondary gain.
Clinical features	Temporary confusion, a staring spell, uncontrollable jerking movements of the arms and legs, loss of consciousness or awareness. Psychic symptoms such as fear, anxiety or déjà vu.	Loss of awareness, loss of sensation, loss of control of bodily movement, palpitations, sweating, dry mouth, hyper-ventilation.	People simulate illness for some obvious practical gain.
EEG interpretation	Has disrupted brain activity in EEG.	No changes in brain activity in EEG	No changes in brain activity in EEG
Video telemetry: Involves EEG and being filmed at the same time.	Brain activity present during seizure.	Brain activity doesn't match with the seizures.	No brain activity and seizures.
Anti-epileptic drugs (AED)	Can be controlled by AED.	Cannot be controlled by AED.	Cannot be controlled by AED.
Psychotherapy	It will not help in Epilepsy.	It will help in dissociative convulsions.	It will not help in malingering.
<b>I.Special Senses</b>  Sight:  Total blindness	Atrophy of optic disc, absent/feeble papillary response to light, opto-kinetic nystagmus, absent	Normal fundus & papillary responses, no opto-kinetic nystagmus, positive visual evoked	Same as hysteria may draw up forehead to inhibit papillary reflex to sudden

	visual evoked.	response.	light.
Ptosis	Eyebrow generally higher than on unaffected side with secondary contraction of frontalis.	Eye brow generally lower than on unaffected side without secondary compensatory contraction of frontalis.	Same as hysteria
Hearing	Auditory averaged evoked responses should be present	Evoked responses should be present	Evoked responses should be present
Smell	Can identify stringent stimuli (e.g., ammonia) which excite cranial nerves I and V, but cannot name.	Denies smell	No clinical data
<b>II Motor power all muscle groups</b>	Erben test- is based on physiological principle, during fine movements agonists and contracting antagonists act in synergy so that movements can be executed with precision during gross movements, agonists alone contract and antagonist became relaxed, thereby making action of agonist more effective, muscle groups are evaluated by requesting patient to move part against resistance, slow course tremor may appear.	Antagonist muscle contract when patient told to move part. No tremor.	Same as hysteria
<b>Paresis/ Paralysis</b>	Characteristic physiological and compensation responses, such as circumduction of affected leg, wide gait, consistent weakness pattern.	Astasia-abasia with flailing legs and no falling, may be able to run but not walk, can move legs while in recumbent position,	Indicates cannot stand or walk or move legs in recumbent position with when requested

	Reduced or exaggerated deep tendon reflexes	no circumduction of paretic leg from hip, can maintain spasms, contractures.  Normal reflexes	to walk on or not simulated lame gait may forget to limp support self on good leg when getting up from kneeling position.  Normal reflexes
<b>Aphonia</b>	Paralysis of vocal cords with inability to perform normal speech movements	Can whisper with formal movement of lips, tongue, pharynx, and vocal cords during respiration, can cough on request, indicating intact vocal nerves, may have absent or reduced pharyngeal reflex and hypesthesia of larynx.	
<b>Analgesia deficits</b>	Conforms to anatomical principles (hemianesthesia and hemianalgesias uncommon)  Japanese illusion Test-cross both hands, palm to palm, interlock fingers, and invert consistent responses to testing of anesthetic hand.  stocking-glove anesthesia rare.	Non-anatomical distribution with midline or sharp demarcation, often associated with other complaints, such as paralysis, usually annular or total, impossible claim of deficits in all sensations.  Response may be consistent or inconsistent.  Stoking – glove anesthesia-may move	Rare complaints        Inconsistent responses more probable.   Rare complaints

<p><b>Pain</b></p>	<p>Vibratory sense loss at mid-ulna or mid-tibia is a physiological impossibility since solid structures vibrate as a whole. Vibratory sense will be transmitted by solid structures to abnormal side whichever side of sternum or frontal bone tested.</p> <p>Distal deficits more severe than proximal.</p> <p>No pain response to intradermal histamine.</p> <p>Pressure over or movement of painful part may lead to temporary increase of pulse rate from 10-30 beats per minute (Mannkopf's sign), and also pupil dilation, sudden flushing and sweating</p>	<p>up limb with repeated testing and suggestibility.</p> <p>Will deny perception of vibration on anesthetic side when affected bone tested but will acknowledge perception when this is done over normal side. Cornea not insensitive on hemi anesthetic side.</p> <p>Proximal deficits may be more severe than distal.</p> <p>Pain in response to intradermal histamine over anaesthetic area.</p> <p>No clinical data</p>	<p>No clinical data</p> <p>No increase in pulse rate or dilatation of pupils</p>
<p><b>Coordination</b></p> <p>-Ataxia</p> <p>-Romberg Test</p>	<p>Worse with eyes closed, when patient lying on back, ataxic limb will not be lifted straight and steadily in vertical plane- it is abducted or adducted, rotated inwards or outwards, oscillates, and does not come down vertically.</p> <p>Makes every effort to maintain equilibrium and keep from falling, tendency</p>	<p>Different pattern from true ataxia</p> <p>Pattern probably</p>	<p>As severe with eyes closed, different pattern from true ataxia.</p> <p>Starts to fall before eyes closed and makes little effort to maintain</p>

	of plantar surfaces of feet to grip floor. When sitting in bed, will show less sway with upper torso because of broader base for balance	between organic and malingering responses.	equilibrium or grasp floor. May fall backward when sitting, no change in sway from standing.
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## CASE REPORT

A 21 year old female was brought by relatives in a wheelchair at National Homoeopathy Research Institute in Mental Health (NHRIMH) OPD on 9<sup>th</sup> December 2019 with complaints of sleeplessness since 9 days, multiple episodes of pseudoseizures, each episode lasts for few seconds with stiffness of body, frothing+, eyes open, self-talking, getting angered easily towards family members, fear of darkness, claims she can see her dead mother. All her complaints started in the last 9 days.

Patient was apparently healthy before 10days and her complaints started when she saw an image like her dead mother during bathing and she got fainted. Her mother died before 2 weeks by suicide (hanging) and when she heard the news, had a fainting spell and was fine within one hour. She was normal during the rituals of her mother and she left for studies after the rituals and there were no behavioral changes in her. On the 16<sup>th</sup> day of her mother's death, she woke up early and went for bathing and there she saw some images of her dead mother and got scared and had seizures like movements. She was taken to temple for faith healing and religious treatments. There she became unconscious and had vomiting several times. Then she was taken to allopathic hospital and got admitted there for 4 days. There she had multiple episodes of pseudoseizures, started allopathic medicines there and got relieved and took back home. Again after 2 days, she showed symptoms of self talking, getting angered easily towards family members, fear of darkness, recurrent tendency to faint with consciousness, says that her died mother will come and attack and always controlling her, says that she can see the god in front of her and also had sleeplessness.



P/H: Epileptic seizures at the age of 8 years took allopathic treatment till 11 years of age and recovered.

F/H: Mother - Depression died by suicide, Father: Obsessive Compulsive disorder, Grandfather - Psychiatric illness, Sister - Cluster B Personality Trait.

Patient was homemaker; she was married since 9 months.

Physical generals: desires - sweets+, ice cream+++, chocolate++, spicy foods, appetite increased, thirst increased, perspiration scanty. Menses - regular cycles, lower abdominal pain and vomiting during menses. Thermal state - Hot.

Clinical examination: O/e patient is conscious, oriented. No post ictal confusion, no loss of power or weakness in any limbs, no tongue bites/involuntary urination.

**Mental status examination:** appearance and behavior -the patient was conscious and cooperative with poor personal care, attention seeking with recurrent tendency to faint and fall on contradiction, psychomotor activity: increased, frequent seizure like movements. Eye to eye contact was poor. Interpersonal relationship - Poor. Speech: increased rate with normal volume, tone and reaction time. Mood: anxious, affect: inappropriate, reactive, labile, and incongruent. Thought flow: increased; with delusion of persecution - says that died mother will kill her. Transient auditory & visual hallucinations - hearing voices of died mother commanding her to give the property to her sister; says that she saw her died mother in the bathroom and tried to choke her. Memory: immediate, recent and remote: average. Attention, concentration and insight was poor.

**Diagnosis:** the patient was diagnosed by the psychiatrist - **Dissociative Convulsion (F44.5)** according to the ICD-10. [7]

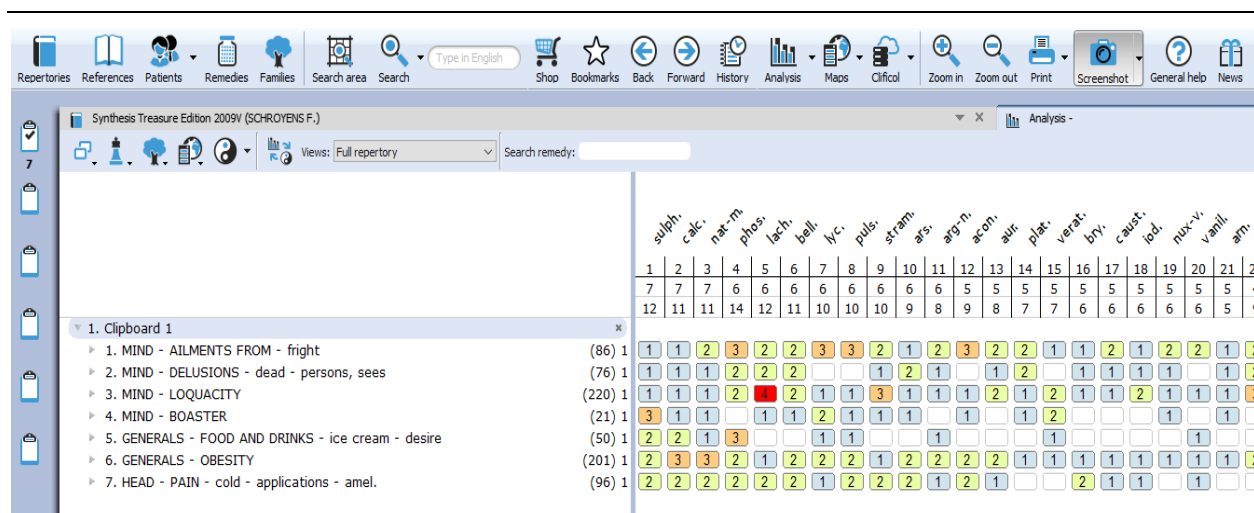
The following fundamental aspects had been considered.

- 1) The symptoms were not intentionally produced or under voluntary control, on the contrary to that which occurs in the factitious disorders and in simulation;
- 2) Temporal relationship between the existence of the stressful psychosocial factor and the appearance of the symptoms;

3) All of the complementary examinations made were normal.

## Results

Patient was hospitalized at NHRIMH Psychiatry ward. Totality was erected and was repertorised by using synthesis repertory (figure no.1). Based on the totality of symptoms sulphur and calcarea carb were came as forefront remedies, a single dose of calcarean sulphurica 200 was prescribed and was followed by Sac lac daily. Calcarea sulphurica 200 one dose was given after 5 days and from the next day patient showed a good improvement in her mental condition, discharged after 2weeks then followed on OPD level. Patient was followed up till her pregnancy which was confirmed on 15/12/2020. Calcarea sulphurica 200 was prescribed when an episode of convulsions occurred again after 1 year. Later the patient was symptomatically better and Sac lac was prescribed till her delivery without any relapse of symptoms. Hamilton Anxiety Scale (HAM-A) was applied before and after the discharge, which showed a remarkable decrease in the score from 46 to 3.



**Figure 1**

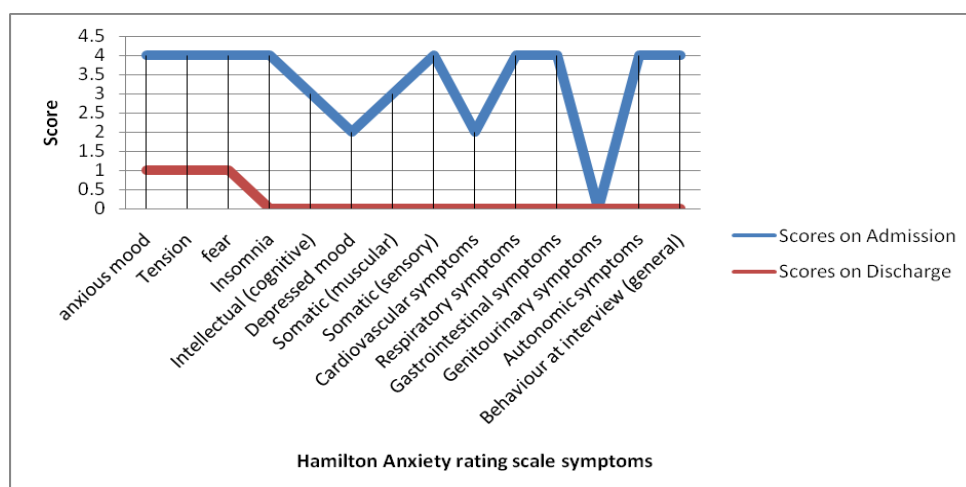
**Table 3: Follow ups**

Date	Follow up of the case in the IPD	Prescription
10/12/2019 To	Head pain on controlling the thoughts > by cold application. MSE: EEC poor, IPR: poor, Speech: Increased, Mood:	Sac lac

13/12/2019	anxious, Affect: inappropriate, Thought flow: increased, sociable and communicative, Content: delusion of persecution – says that her died mother will attack and kill her, Sleep: disturbed, appetite and thirst increased.	
14/12/2019	All observations – SQ, Sleep: disturbed	Calcarea sulphurica 200 one dose
15/12/2019 to 25/12/2019	Head pain better >, other observations were the same but there was an improvement in sleep noticed, sleep sound without any disturbance at night.	Sac lac
26/12/2019	Patient was discharged on request with improvement and advised to follow up in OPD once in every month.	Sac lac daily
Follow up of the case in the OPD		
13/01/2020	No fainting spells, anger reduced, fear reduced, sleep: good, appetite and thirst normal, sociable and communicative.	Sac lac daily
24/02/2020	No pseudoseizures, patient was feeling better.	Sac lac daily
01/06/2020	Mentally better, generally improved.	Sac lac daily
23/12/2020	Off with the medication for 5months Patient had an episode of pseudoseizures with consciousness for 3 minutes, froth in mouth-nil, gets angered on contradiction, Sleep: reduced, wakes up at 3am and talks about tuition students. Patient confirmed with pregnancy since a week, LMP – 28/11/2020	Calcarea sulphurica 200 2doses, adv. to follow gynaecologist treatment also.
18/01/2021	Reported by her husband – Patient's anger reduced, fear reduced, convulsive like episodes absent, appetite and thirst normal. <b>EEG taken on 06/01/2021 – Normal</b> USG taken on 07/01/2021 – SLIUG - 6 weeks 4 days, FHR – Normal, Fetal pole – Normal.	Calcarea sulphurica 200/ 1 dose
08/03/2021	Reported by husband, all observations were normal	Sac lac

	and patient was mentally better. USG taken on 18/02/2021 – SLIUG – 12.5 weeks, NT scan normal.	
12/05/2021	All observations were normal and patient mentally better, no fainting spells, Sleep good, appetite and thirst normal. USG taken on 02/04/2021 – SLIUG – 20 weeks, cervical length – 3.2cm.	Calcarea sulphurica 200 one dose.
07/07/2021	Reported by husband, patient was mentally better. With 33 weeks of pregnancy.	As patient was nearing to the EDD, no treatment was given.
25/08/2021	Through telephone call – Patient had a FTND on 14/08/2021, male baby with birth weight – 3kg, no complications, feeding well, all parameters were normal, assessed by paediatrician.	

**Figure 2: Patient symptoms assessed by using HAM-A and the scores are:**



## Discussion

There was a possibility of the patient benefiting from these seizure episodes, but as the patient said during interview, she could not control these episodes which created lot of anxiety and if she tries to control her thoughts, she develops headaches. Moreover, she was unable to share details of the episodes even on extensive questioning. There will be full

awareness in Malingering patient about what he is doing and his gains. The main difference between Dissociation and Malingering is that in the case of Dissociation, the motive and mode, both are unconscious in production. Whereas in Malingering, both the motive and mode are conscious in production. These both can be distinguished using Malingering tests given in the table 2. [14]

Kent's approach was used, as the totality of this case was based on the characteristic mental state and its expressions, followed by physical symptoms. Dr. Kent was convinced that if a remedy was to help a patient to any extent, then it has to match closely the mental state which the core of the image, its outline being furnished by the physical generals. [15] Calcarea sulphurica covers the most important core of the mental state i.e. sibling rivalry, patient had a delusion that mother is asking to write her property to the patient's sister. This is reflecting her conflict with the sister which was carrying since childhood and when introduced the remedy calcarean sulphurica showed a good improvement in this case.

Materia medica searched for mental symptoms of calcarean sulphurica- hatred persons of who do not agree with him, jealousy, mood changeable, obstinate, offended easily, delusion imaginations, hallucination, illusion, images, phantom sees frightful, with confusion of mind with mental exertion. [16'17] Nervous attacks analogous to hysteria, with convulsions of face, involuntary laughter & swinging mood or epilepsy. [18]

History taking can reveal significant psychological stresses and a history of psychiatric disorder, although it is important to remember that patients with epilepsy and other types of non-epileptic events may be anxious, depressed and may have been subject to significant traumatic life events. Hence it is important to the homoeopath to be sensitive enough to diagnose and identify the psychological stressors.

## Conclusion

Dissociative convulsions closely resemble the manifestations of epilepsy in the absence of paroxysmal neuronal discharge. Surprisingly, scientific research in homoeopathy on this disorder is very scarce. Therefore, it is strongly suggested that more researches should be dedicated to dissociative convulsions in future, in view of their long diagnostic delays and

the early diagnosis and treatment of PNES may positively influence the patient's outcome and also save the healthcare cost.

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