38 - Phenomenology of epilepsy

Phenomenology of epilepsy:

© SPMM Course Desomatisation refers to depersonalisation that is localised to a body part. Deaffectualisation is an extreme form of anhedonia wherein not only pleasure but also the capacity to feel any emotion is consistently lost. It is not specific to any organic syndrome. It is never reported in mania. Patients score high on neuroticism with introversion being predominant.

Insight: Insight refers to a multidimensional concept which includes 4 A's: Awareness of one's own symptoms (absence - anautognosia) Attribution of symptoms to mental disorder appropriately (absence – dysautognosia) Appraisal or analysis of consequences of such symptoms Acceptance of treatment Insight is not an all or none phenomenon; it fluctuates within an illness for the same patient. More patients with psychoses have poor insight than those with neuroses. Loss of insight is not always related to the presence of delusions; as in manic states even without delusions nearly 50% patients show no insight during the acute episode. This may be different from schizophrenic insight loss that is seen even in the chronic stage. Insight has not been consistently associated with any psychopathology of schizophrenia; some studies show an association with disorganisation symptoms. In depression, insight may be higher than usual, called depressive realism. In acute psychosis presence of insight is associated with more selfharm and suicides. Loss of insight has been compared to anosognosia following stroke. Fronto parietal circuit may play an important role in insight. Levels of insight:

1. Complete denial
2. Slight awareness of being sick but denying it at the same time
3. Awareness of being sick but blaming it on others, on external factors
4. Awareness that illness is caused by something unknown in the patient
5. Intellectual insight: admission that the patient is ill and that symptoms or failures in social adjustment are caused by the patient's own particular irrational feelings or disturbances without applying this knowledge to future experiences
6. True emotional insight: emotional awareness of the motives and feelings of the patient and the important persons in his or her life, which can lead to basic changes in behaviour. Phenomenology of epilepsy: Temporal lobe epilepsy TLE: Autonomic sensations are the most common of auras, causing epigastric aura, salivation, sometimes vertigo, etc. Forced thinking The individual has a compulsion to think on a certain restricted topic.

The evocation of thought: Intrusion of stereotyped words or thoughts.

© SPMM Course Sudden obstruction to thought flow similar to schizophrenic thought block is also reported. Panoramic memory: Here the individual recalls expansive memories in incredible detail as if running a video show of the past. Psychic seizures: Isolated auras with hallucinations, depersonalization, micropsia or macropsia, déjà vu or jamais vu (especially if right sided origin) can occur. Uncinate crises: Hallucinations of taste and smell of uncinate origin associated with dream-like reminiscence and altered consciousness. Strong affective experiences are reported – fear and anxiety being very common. Dostoevsky's epilepsy refers to ecstatic content in the epileptic aura. TLEs are the most common seizures with auras. The term complex partial seizure refers to TLE generally. Parietal lobe epilepsy: Somatosensory seizures: The most common type of seizure in parietal epilepsies - patients describe physical sensations of numbness and tingling, heat, pressure, electricity and/or pain. Some patients describe a typical "Jacksonian march", in which the sensation "marches" in a predictable pattern from the face to the hand up the arm and down the leg. Pain is a rare symptom of seizures as such but is quite common in parietal seizures, occurring in up to 25% of patients. Somatic Illusions: During a somatic illusion patients may feel that their posture is distorted, that their arms or legs are in a weird position or are in motion when they are not (kinaesthetic hallucination), or that a part of their body is missing or feels like it does not belong (body image distortion). Vertigo is also reported. Visual illusions: Patients may experience objects as being too close, too far, too large, too small, slanted, moving or otherwise not right. Frontal lobe seizures: Complex partial seizures of frontal lobe origin are usually quite different from temporal lobe seizures. Frontal lobe seizures tend to be short (less than 1 minute), occur in clusters and during sleep, include strange automatisms such as bicycling movements, screaming, or even sexual activity. Sometimes a person may remain fully aware at the same time having wild movements of the arms and legs. A seizure from the frontal lobe may even involve laughing or crying as the only symptom, the former is called gelastic and the latter dacrystic seizures. These are also noted in temporal lobe seizures. Automatisms: Epileptic automatism is a state of clouding of consciousness which occurs during or immediately after a seizure. The impairment of awareness varies. The individual retains control of posture and muscle tone but performs simple or complex movements without being aware of what is happening. To the onlooker, the patient appears confused, and there is subsequent amnesia for the episode. Simple stereotyped behaviours (gesturing, grasping, lip-smacking and chewing movements) are often exhibited lasting few seconds to minutes. Very occasionally, automatisms are prolonged (fugue

© SPMM Course states), or complex actions are carried out. If violent, these are never premeditated, seldom goal-directed, rarely involve the use of complex tools/weapons and are especially likely if restraining was attempted.

 Andreasen N, Powers P. Overinclusion thinking in mania and schizophrenia. Br J Psychiatry 1974; 125:452456. 24. Andreasen, N. C. (1979) Thought, language, and communication disorders: I. Clinical assessment, definition of terms, and evaluation of their reliability. Archives of General Psychiatry, 36, 1315-1321 Appelbaum, P.S. et al., Persistence and stability of delusions over time, Compr. Psychiatry 45 (2004), pp. 317– Blackwood, N et al. Cognitive Neuropsychiatric Models of Persecutory Delusions. Am J Psychiatry 2001 158: 527-539 Bschor T, et al. Time experience and time judgment in major depression, mania and healthy subjects. A controlled study of 93 subjects. Acta Psychiatr Scand. 2004; 109:222–229. Coltheart, M et al Schizophrenia and Monothematic Delusions. Schizophrenia Bulletin 2007 33(3):642-647 Ghaemi, N. Feeling and Time: The Phenomenology of Mood Disorders, Depressive Realism, and Existential Psychotherapy. Schizophrenia Bulletin, 2007; 33:122–130. Kaplan & Sadock's Synopsis of Psychiatry: Behavioral Sciences/Clinical Psychiatry, 10th Edition. Lippincott Williams & Wilkins 2007 Liddle PF, Crow TJ: Age disorientation in chronic schizophrenia is associated with global intellectual impairment. Br J Psychiatry 1984; 144:193–199 Lincoln, T. Relevant dimensions of delusions: Continuing the continuum versus category debate. Schizophrenia Research 2007, 93, 211-220. Cermolacce, L. Sass, and J. Parnas, “What is Bizarre in Bizarre Delusions? A Critical Review,” Schizophr Bull 36, no. 4 (July 1, 2010): 667-679 Manschreck, T. C. (1995). Pathogenesis of delusions. Psychiatric clinics of North America, 18, 213 Nordgaard, J., et al. The diagnostic status of first rank symptoms. Schizophrenia Bulletin 2008 34(1):137-154 Palaniyappan, L. The Schizophrenic Disguise of Complex Partial Seizures. J Neuropsychiatry Clin Neurosci 2007 19: 479-480. Schiltz, K et al. Neurophysiological Aspects of Synesthetic Experience. J Neuropsychiatry Clin Neurosci 11:58-65, February 1999 Sims, A (2003) Symptom in the Mind, 3rd ed. London: Elsevier Science Swedo SE, et al. Obsessive-Compulsive Disorder in children and adolescents: Clinical phenomenology of 70 consecutive cases. Arch Gen Psychiatry 1989;46:335-41 Taylor M, Fink M. Catatonia in psychiatric classification: a home of its own. Am J Psychiatry 2003; 160:1–9 Scott, A. I. F. (1998). Mental State Examination. In Companion to psychiatric studies (eds E. C Johnstone, C.P.L Freeman, & A.K.Zealley) Chapter 9. Churchill Livingstone, Edinburgh. http://www.med.nyu.edu/cec/epilepsy Levenson, D. Psychiatric issues in surgery. Primary Psychiatry (2007). http://primarypsychiatry.com/psychiatric-issues-in-surgery-a-part-2-specific-topics/

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