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CASE REPORT

Diagnostic Challenges of Bipolar Affective Disorder and Borderline Personality Disorder in a Patient with Epilepsy and a Reported History of Status Epilepticus

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ABSTRACT

Background: The coexistence of bipolar affective disorder, borderline personality disorder (BPD), dissociative disorder, and epilepsy presents diagnostic challenges due to overlapping clinical manifestations, including mood instability, emotional dysregulation, and seizure-like episodes. **Objective:** To describe the diagnostic challenges and multidisciplinary management of a patient with coexisting bipolar affective disorder, BPD, dissociative disorder, and epilepsy, with a reported history of status epilepticus. **Case:** We report a patient with documented bipolar affective disorder, BPD, dissociative disorder, and epilepsy, with a reported history of status epilepticus. The clinical presentation included emotional dysregulation, interpersonal difficulties, and recurrent seizure episodes, some reportedly associated with emotional stress or interpersonal conflict. Brain magnetic resonance imaging showed no significant structural abnormalities, while routine electroencephalography (EEG) revealed no epileptiform discharges or abnormal slowing. Treatment included phenytoin, levetiracetam, and valproic acid for seizure management, alongside escitalopram, lorazepam, and quetiapine for psychiatric management. **Conclusion:** This case highlights the diagnostic challenges associated with the coexistence of epilepsy, bipolar affective disorder, borderline personality disorder, and a documented dissociative disorder. The classification of recurrent seizure-like events, including the reported history of status epilepticus and the possibility of functional seizures, remains uncertain. Normal routine EEG and brain MRI findings alone are insufficient to exclude epilepsy or establish a diagnosis of functional seizures. Integrated neurological and psychiatric reassessment is essential for diagnostic clarification, individualized management, and addressing psychosocial needs and suicide risk.

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Highlights

1. The coexistence of bipolar affective disorder, borderline personality disorder, and epilepsy presents complex diagnostic challenges due to overlapping clinical manifestations.
2. A normal routine electroencephalogram (EEG) does not exclude epilepsy, emphasizing the importance of comprehensive neurological and psychiatric assessment.
3. Multidisciplinary management is essential to address the complex neurological and psychiatric needs of patients with multiple comorbidities.

BACKGROUND

Bipolar affective disorder and borderline personality disorder (BPD) are psychiatric conditions that may present with overlapping clinical features, including mood instability, emotional dysregulation, impulsivity, and interpersonal difficulties. However, distinguishing episodic mood changes associated with bipolar affective disorder from the affective instability commonly observed in BPD is essential for accurate diagnosis and appropriate management. Bipolar episodes are generally characterized by distinct periods of mood disturbance, whereas BPD-related affective instability is often associated with interpersonal stressors and heightened emotional reactivity. Nevertheless, these clinical features may overlap, requiring careful assessment of symptom duration, temporal patterns, associated features, and longitudinal psychiatric history.

Epilepsy is associated with an increased burden of psychiatric comorbidities, which may adversely affect psychosocial functioning and quality of life. The coexistence of epilepsy and psychiatric disorders can complicate clinical assessment, particularly when patients present with recurrent seizure-like episodes alongside emotional and behavioural disturbances. Differentiating epileptic seizures from functional seizures, also known as psychogenic nonepileptic seizures (PNES), remains an important diagnostic challenge. Dissociative symptoms and a previously documented dissociative disorder may be relevant to this assessment; however, their presence alone does not establish a functional seizure diagnosis. Emotional stress and interpersonal conflict may coincide with seizure-like episodes, but such associations do not independently demonstrate a functional or dissociative ethology. Furthermore, normal findings on routine electroencephalography (EEG) and brain magnetic resonance imaging (MRI) do not independently exclude epilepsy or establish a diagnosis of functional seizures. Therefore, careful clinical characterization, appropriate neurological investigations, and longitudinal psychiatric assessment are essential for diagnostic clarification.

The present case illustrates the diagnostic complexity of a patient with previously documented epilepsy, bipolar affective disorder, BPD, and dissociative disorder, together with a reported history of status epilepticus. Its distinctive clinical contribution lies in the coexistence of multiple neurological and psychiatric diagnoses, creating two interconnected diagnostic challenges: distinguishing bipolar episodes from BPD-related affective instability and differentiating epileptic seizures from potentially functional seizure-like events. The classification of the recurrent seizure-like episodes and the diagnostic basis of the reported history of status epilepticus require careful consideration. This case report aims to describe these diagnostic challenges and the multidisciplinary clinical management of the patient, emphasizing the importance of comprehensive neurological and longitudinal psychiatric reassessment to guide individualized care.

OBJECTIVE

To describe the diagnostic challenges and clinical management of a patient with coexisting epilepsy, bipolar affective disorder, borderline personality disorder, and dissociative disorder, focusing on the

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differentiation of bipolar episodes from BPD-related affective instability and epileptic seizures from potentially functional events.

CASE

1. Patient Information

A 19-year-old female patient was admitted to RSUD Bhakti Dharma Husada with recurrent seizure episodes. The primary complaints during the most recent admission included multiple episodes of tonic-clonic seizures, accompanied by fever, nausea, vomiting, cough, and rhinorrhoea.

The patient's neurological history began in 2022, when she experienced her first seizure episode at approximately 15 years of age and was evaluated at RSUD Bhakti Dharma Husada. In 2024, she underwent neurological and psychiatric evaluations at RS William Booth. The diagnoses documented at that time included bipolar affective disorder, schizophrenia, and chronic cephalgia. However, she subsequently discontinued psychiatric medication and follow-up visits because she felt that the treatment was unsuitable.

On February 20, 2025, the patient was reevaluated at RSUD Bhakti Dharma Husada following an episode of convulsions. The psychiatric assessment documented emotionally unstable personality disorder, with diagnostic codes F60.3 and F60.31.

The patient's psychiatric history was characterized by emotional instability, irritability, interpersonal difficulties, and impaired impulse control. She also reported a history of childhood sexual abuse and physical violence. These experiences represented relevant psychosocial factors in her psychiatric history and warranted consideration during the overall clinical assessment.

Regarding her sleep pattern, the patient reported longstanding sleep disturbances since junior high school, characterized by a habitual sleep schedule of approximately 6:00 AM to 12:00 PM. She had reportedly used sleep medication regularly for approximately three years.

Before the most recent hospitalization, the patient had a previously documented diagnosis of epilepsy and a reported history of status epilepticus. She had been receiving oral phenytoin at a dose of one tablet three times daily (3×100 mg). The tablet strength was not specified in the available clinical history.

During the most recent hospitalization, the psychiatric diagnoses documented by the psychiatry team included bipolar affective disorder, dissociative disorder, and borderline personality disorder (BPD). The history of status epilepticus was considered a previous neurological event rather than an acute diagnosis during the current hospitalization. Regarding family history, no relevant family history of neurological or psychiatric disorders was reported.

The patient had previously received neurological and psychiatric treatment. However, she had discontinued psychiatric medication and follow-up in 2024 because she perceived the treatment as unsuitable. Further details regarding her previous psychiatric medication regimens and treatment outcomes were unavailable in the clinical history.

2. Clinical Findings

During the most recent hospitalization, the 19-year-old patient experienced five seizure episodes, three of which occurred at home and two in the emergency department. The episodes were clinically described as *tonic-clonic seizures*, each lasting less than one minute, followed by recovery of consciousness after each episode. The patient also presented with fluctuating fever for approximately

Surabaya Medical Journal (SMJ IDI SBY)
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seven days, accompanied by nausea, vomiting, cough, and rhinorrhoea. Additional complaints included one episode of hematemesis and oral ulcers that had been present for approximately three days.

On physical examination, the patient was conscious and responsive, with a Glasgow Coma Scale (GCS) score of E4V5M6. Vital signs included a blood pressure of 104/66 mmHg, heart rate of 116 beats/min, respiratory rate of 20 breaths/min, oxygen saturation of 99% on room air, and body temperature of 36.8°C. Neurological examination revealed no focal neurological deficits. The pupils were isochoric, measuring 3 mm bilaterally, with preserved pupillary light reflexes. Cranial nerve examination was within normal limits. Motor strength was 5/5 in all extremities, and physiological deep tendon reflexes were preserved. Pathological reflexes, including Babinski and Chaddock signs, were absent. No signs of meningeal irritation were identified. Psychiatric examination revealed affective lability, irritability, and impaired impulse control. The patient's level of insight was assessed as level 5. The patient also had a history of self-harm involving cutting the right hand during periods of emotional distress, accompanied by suicidal thoughts. The most recent episode occurred approximately one month before the current hospitalization. However, at the time of the latest psychiatric assessment, the patient denied current suicidal ideation.

Overall, the clinical findings demonstrated the coexistence of recurrent seizure episodes and psychiatric manifestations, including affective instability, impaired impulse control, and a history of self-harm accompanied by suicidal thoughts. These findings highlighted the complexity of the patient's clinical presentation and the need for comprehensive multidisciplinary neurological and psychiatric assessment and management.

3. Clinical History and Timeline

The patient had a history of recurrent seizures and psychiatric symptoms, with previous neurological and psychiatric evaluations at several healthcare facilities.

Table 1. Clinical Timeline of the Patient

Time	Clinical Events and Findings
2022 (age 16)	First documented hospitalization at Bhakti Dharma Husada Regional General Hospital for headache.
During adolescence (Senior High School)	According to the patient, the first seizure episode occurred while living in an orphanage. The patient reported that seizures could be triggered by being startled by peers.
Subsequent years	Recurrent seizure episodes were reported, initially occurring approximately five times per week and subsequently decreasing in frequency to once every two weeks.
2024	Hospitalization at William Booth Hospital for neurological and psychiatric evaluations. Diagnoses reported included bipolar disorder, schizophrenia, and chronic cephalgia. The patient subsequently discontinued psychiatric medication and follow-up because of perceived treatment dissatisfaction.
February 20, 2025	Hospitalization at Bhakti Dharma Husada Regional General Hospital for convulsions, followed by psychiatric assessment. Documented psychiatric diagnoses included emotionally unstable personality disorder, borderline type (ICD-10 F60.31), and bipolar affective disorder, current episode severe depression without psychotic symptoms (ICD-10 F31.4).
Within the year preceding the most recent admission	An episode of status epilepticus required several days of intensive care unit (ICU) admission. The patient reported that the episode occurred following an emotionally distressing interpersonal incident.
Approximately one month before the most recent admission	The patient reported an episode of self-harm involving cutting the right hand during emotional distress, accompanied by suicidal thoughts.
Approximately seven days before the most recent admission	Onset of intermittent fever accompanied by nausea, vomiting, cough, rhinorrhea, and one episode of hematemesis.

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Approximately four days before the most recent admission	Two separate seizure episodes were reported, one occurring in the bathroom and accompanied by loss of consciousness, and another at church, followed by spontaneous recovery of consciousness.
September 30, 2026 (most recent admission)	The patient experienced five additional seizure episodes, three at home and two in the emergency department. One episode in the emergency department was treated with intravenous diazepam

4. Diagnostic Assessment

Diagnostic Methods

The diagnostic assessment was conducted through clinical history-taking, physical examination, neurological examination, psychiatric evaluation, and supporting investigations. The neurological examination revealed no focal neurological deficits. Brain magnetic resonance imaging (MRI) showed no significant structural abnormalities, while routine electroencephalography (EEG) demonstrated no epileptiform discharges or abnormal background slowing.

The psychiatric assessment included an evaluation of mood symptoms, emotional regulation, interpersonal functioning, impulse control, and dissociative symptoms. The patient's history of recurrent seizures, previous psychiatric diagnoses, medication discontinuation, and reported childhood trauma was also considered in the diagnostic process.

Surabaya Medical Journal (SMJ IDI SBY)
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[redacted] DOKUMEN RAHASIA

No. Laboratorium : [redacted]
No. RM : [redacted]
No. Order : [redacted]
Ruang : [redacted]

Nama Pasien : [redacted]
Tanggal Lahir : [redacted]
Jenis Kelamin : [redacted]
Alamat : [redacted]
Dokter Pengirim : [redacted]
Tgl. Periksa : 30-09-2026 00:56
Tgl. Selesai : 30-09-2026 01:32

PEMERIKSAAN	HASIL	SATUAN	NILAI RUJUKAN
HEMATOLOGI			
DL (Darah Lengkap)			
Hemoglobin	**L 11.3**	g/dL	11.7 - 15.5
PCV/Hematocrit	35.6	%	35.0 - 47.0
Eritrosit	4.30	10^6/uL	3.80 - 5.20
MCV	82.8	fL	81.0 - 96.0
MCH	**L 26.3**	pg	27.0 - 36.0
MCHC	31.7	g/L	31.0 - 37.0
RDW-CV	14.2	%	10.0 - 15.0
Trombosit	296	10^3/ul	154 - 386
Leukosit	7.09	10^3/ul	3.60 - 11.00
Hitung Jenis (Diff Count)			
Eosinofil	2.1	%	2.0 - 5.0
Basofil	0.3	%	0 - 1
Neutrofil	58.9	%	50 - 70
Limfosit	29.3	%	25.0 - 40.0
Monosit	**H 9.4**	%	2.0 - 8.0
KIMIA DARAH			
BUN	11.3	mg/dL	8 - 18
SGOT	21	U/L	< 35
SGPT	10	U/L	< 35
Creatinin	0.78	mg/dL	< 0.9
Kalium Darah	4.0	mmol/L	3.5 - 5.0
Natrium Darah	143	mmol/L	136 - 146
Glukosa Darah Acak	90	mg/dL	< 200

Figure 1. Laboratory Findings

Brain magnetic resonance imaging (MRI) revealed Brain magnetic resonance imaging (MRI) showed no significant structural abnormalities. Routine electroencephalography (EEG) revealed no epileptiform discharges or abnormal slowing. These findings were interpreted alongside the clinical history and neurological assessment.

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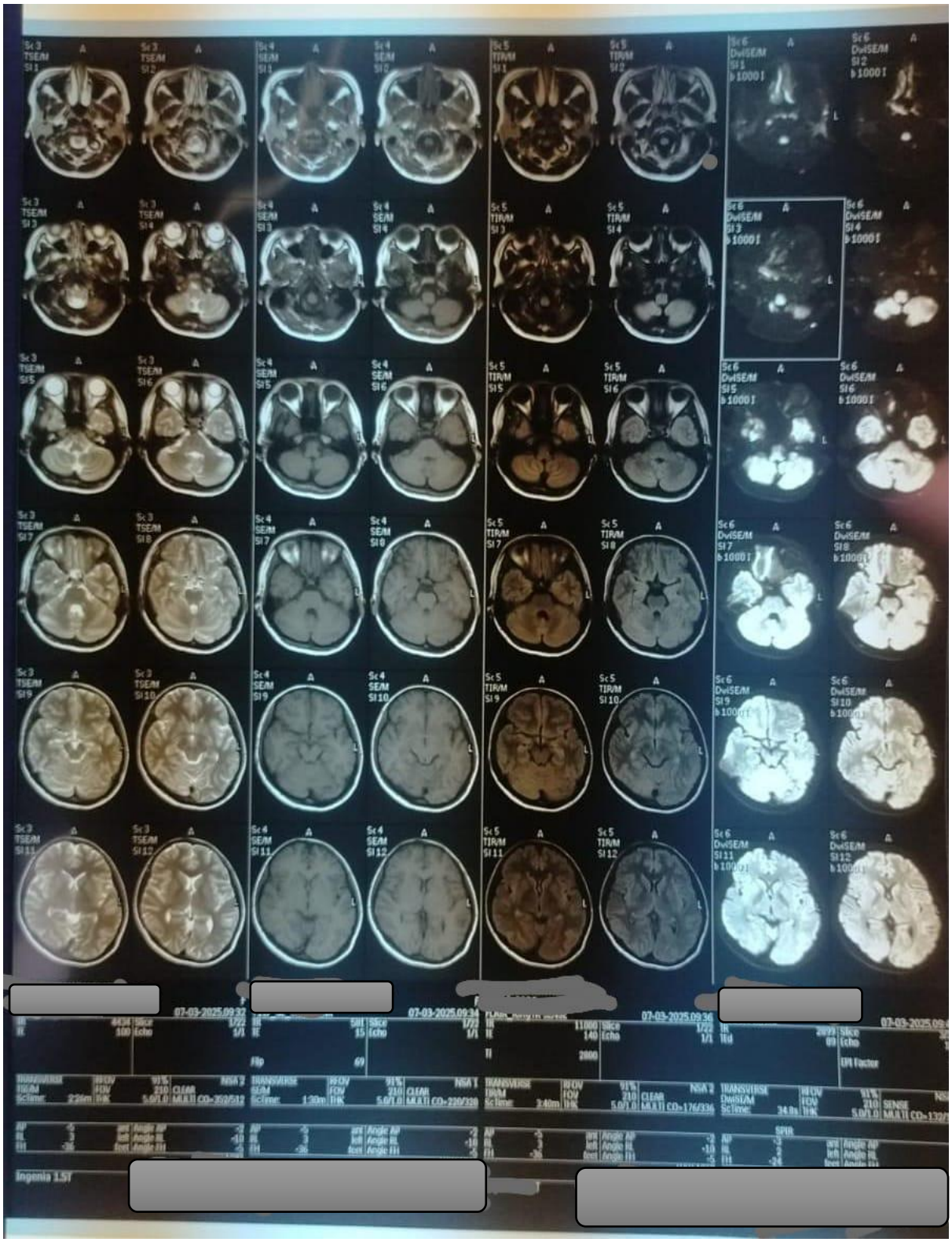
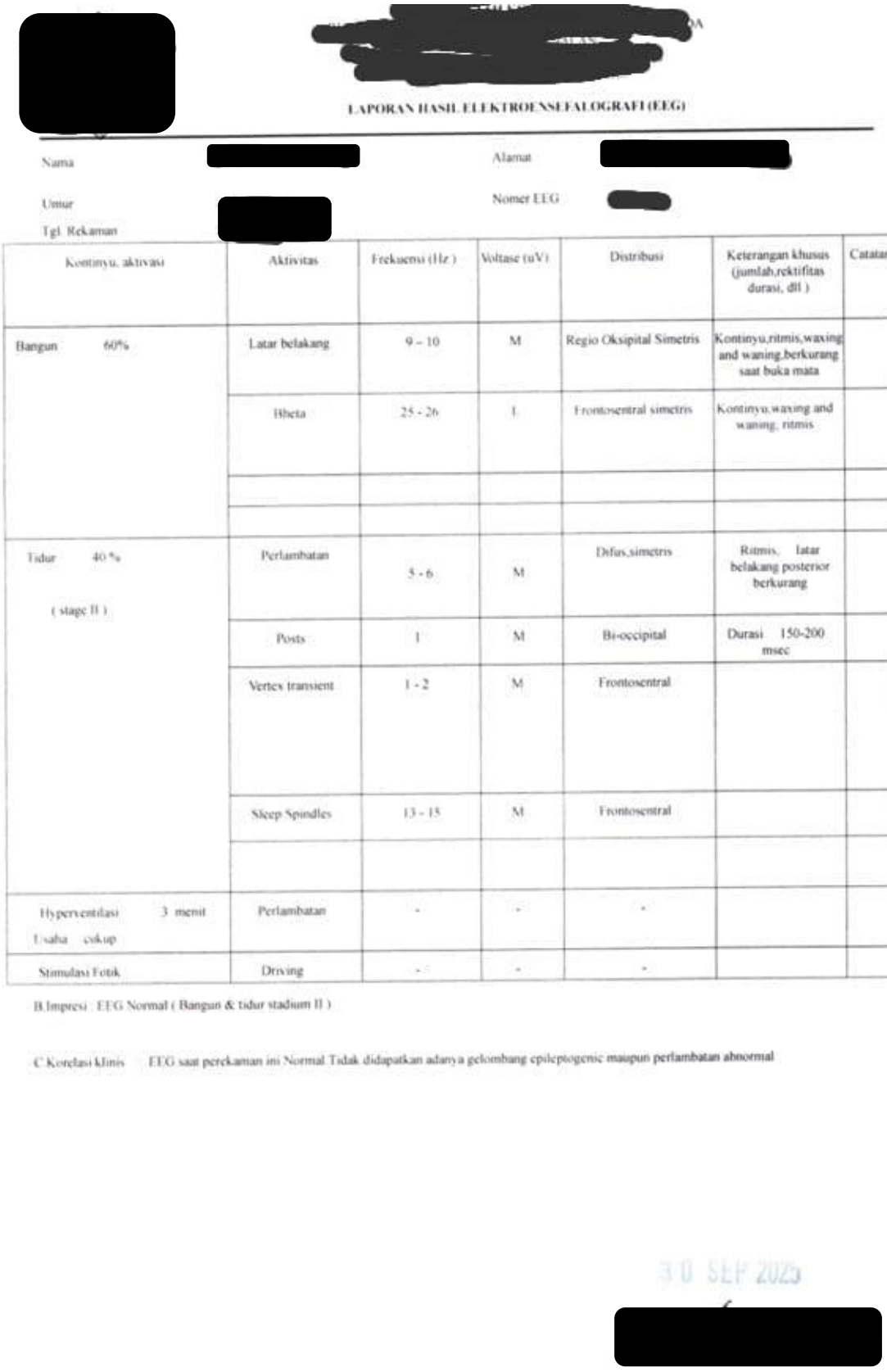


Figure 2. Brain Magnetic Resonance Imaging Findings

Surabaya Medical Journal (SMJ IDI SBY)
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LAPORAN HASIL ELEKTROENSEFALOGRAFI (EEG)

Nama [redacted] Alamat [redacted]

Umur [redacted] Nomer EEG [redacted]

Tgl Rekaman

Kontinyu, aktivasi	Aktivitas	Frekuensi (Hz)	Voltase (uV)	Distribusi	Keterangan khusus (jumlah,rektifitas durasi, dll)	Catatan
Bangun 60%	Latar belakang	9 - 10	M	Regio Oksipital Simetris	Kontinyu,ritmis,waxing and waning,berkurang saat buka mata	
	Bbeta	25 - 26	1	Frontosentral simetris	Kontinyu,waxing and waning, ritmis	
Tidur 40 % (stage II)	Perlambatan	5 - 6	M	Difus,simetris	Ritmis, latar belakang posterior berkurang	
	Posts	1	M	Bi-occipital	Durasi 150-200 msec	
	Vertex transient	1 - 2	M	Frontosentral		
	Sleep Spindles	13 - 15	M	Frontosentral		
Hyperventilasi 3 menit Usaha cukup	Perlambatan	-	-	-		
Stimulasi Fotik	Driving	-	-	-		

B.Impresi : EEG Normal (Bangun & tidur stadium II)

C.Korelasi klinis : EEG saat perekaman ini Normal Tidak didapatkan adanya gelombang epileptogenic maupun perlambatan abnormal

30 SEP 2023

[redacted]

Figure 3. Electroencephalography (EEG) Findings

Surabaya Medical Journal (SMJ IDI SBY)
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Diagnostic Challenges

The coexistence of neurological and psychiatric disorders presented a diagnostic challenge in this case. The patient had a previously established diagnosis of epilepsy and a reported history of status epilepticus. During the most recent admission, the patient experienced *tonic-clonic seizure* episodes, each lasting less than one minute and followed by recovery of consciousness. These characteristics required careful evaluation of the current seizure episodes in the context of the patient's established epilepsy diagnosis and previous history of status epilepticus. The brief duration of each episode and recovery of consciousness between episodes did not independently support a diagnosis of status epilepticus during the current hospitalization.

Normal findings on routine electroencephalography (EEG) and brain magnetic resonance imaging (MRI) also presented a diagnostic consideration. The absence of epileptiform discharges or abnormal slowing on routine EEG does not exclude epilepsy, as epileptic abnormalities may not be captured during a routine recording. Similarly, the absence of significant structural abnormalities on brain MRI does not rule out epilepsy. Therefore, these findings should be interpreted in conjunction with the patient's clinical history and seizure characteristics.

Another diagnostic challenge involved differentiating epileptic seizures from possible functional seizures, also known as psychogenic nonepileptic seizures (PNES). The patient's documented dissociative disorder, emotional dysregulation, and history of psychological distress warranted consideration of functional seizures in the differential diagnosis. However, psychiatric comorbidities, dissociative symptoms, or a history of psychological trauma alone cannot establish the diagnosis of functional seizures. Epilepsy and functional seizures may also coexist in the same patient. Further evaluation through detailed seizure semiology and video-electroencephalography (video-EEG) monitoring, when clinically indicated, would be necessary to clarify the nature of the episodes.

The psychiatric diagnostic process also required consideration of overlapping clinical manifestations among bipolar affective disorder, borderline personality disorder (BPD), and dissociative disorder. Emotional instability, irritability, impulsivity, and interpersonal difficulties may occur across these conditions, making diagnostic differentiation challenging. Therefore, the patient's longitudinal psychiatric history and previously documented diagnoses were considered important in the overall diagnostic assessment.

The diagnoses documented during the most recent hospitalization included epilepsy by the neurology team and bipolar affective disorder, dissociative disorder, and BPD by the psychiatry team. The reported history of status epilepticus was considered separately from the current seizure episodes. This distinction was maintained to ensure diagnostic accuracy and avoid attributing the current clinical presentation to status epilepticus without sufficient supporting evidence.

Diagnosis and Differential Diagnosis

Based on the clinical documentation, the patient had a previously established diagnosis of epilepsy and a reported history of status epilepticus. During the most recent hospitalization, the neurology team documented epilepsy, while the psychiatry team documented bipolar affective disorder, borderline personality disorder (BPD), and dissociative disorder. Status epilepticus was considered part of the patient's previous medical history and was not established as an acute diagnosis during the most recent hospitalization.

Surabaya Medical Journal (SMJ IDI SBY)
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The differential diagnoses and diagnostic considerations included:

1. Trauma- and Stressor-Related Disorders

The patient had a reported history of childhood sexual abuse and physical violence. This history warranted further evaluation for possible trauma- and stressor-related disorders. Further assessment should explore the presence of intrusive symptoms, avoidance, negative alterations in cognition and mood, and hyperarousal, including symptom duration and associated functional impairment. A history of trauma alone is insufficient to establish a diagnosis of post-traumatic stress disorder (PTSD) or another trauma-related disorder.

2. Psychogenic Nonepileptic Seizures/PNES

Functional seizures were considered as a differential diagnosis because of the patient's documented dissociative disorder, emotional dysregulation, and history of psychological distress. However, these features alone are insufficient to establish a diagnosis of functional seizures. Epilepsy and functional seizures may coexist in the same patient. Further evaluation through detailed seizure semiology and video-electroencephalography (video-EEG) monitoring, when clinically indicated, would be necessary to distinguish epileptic seizures from functional seizures.

3. Dissociative Disorder

Dissociative disorder had been documented by the psychiatry team during the most recent hospitalization. However, further assessment would be necessary to clarify its specific subtype, clinical manifestations, and temporal relationship with the patient's seizure episodes. Although dissociative disorder is relevant to the overall psychiatric assessment, its presence alone should not be interpreted as evidence that the patient's seizure episodes are functional in origin. Differentiating epileptic seizures from functional seizures requires careful clinical evaluation and, when indicated, video-electroencephalography (video-EEG) monitoring.

Prognostic Characteristics

The coexistence of epilepsy and psychiatric comorbidities represented a clinically complex condition requiring multidisciplinary management and longitudinal follow-up. The history of recurrent seizures, previous status epilepticus, psychiatric medication discontinuation, and impaired impulse control were relevant clinical factors that required continued monitoring.

The patient's prognosis depended on seizure control, psychiatric symptom stabilization, treatment adherence, and continuity of neurological and psychiatric follow-up. Further assessment was also necessary to evaluate suicide risk and monitor potential recurrence of neurological and psychiatric symptoms.

5. Therapeutic Intervention

During hospitalization, the patient received multidisciplinary management involving the neurology and psychiatry departments, focusing on seizure control, psychiatric stabilization, and management of associated medical complaints.

Antiseizure therapy consisted of intravenous phenytoin 100 mg three times daily and oral levetiracetam 500 mg twice daily. Intravenous diazepam (5 mg) was administered slowly during seizure recurrence. The psychiatric medication regimen included escitalopram 10 mg orally once daily, lorazepam 2 mg orally once nightly, quetiapine sustained-release (SR) 200 mg orally once nightly, and valproic acid 500 mg orally once nightly. Folic acid 400 micrograms orally once daily was also administered.

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Following the recurrent seizure episode, the patient developed screaming and marked agitation, which was managed with injectable haloperidol. Haloperidol was administered only during hospitalization for acute agitation.

Supportive treatment included oxygen supplementation through a simple face mask at 6 L/min, intravenous 0.9% sodium chloride, and symptomatic medications, including omeprazole, ondansetron, metamizole, sucralfate, and lansoprazole.

6. Follow-up and Outcomes

During hospitalization, the patient experienced one recurrent seizure episode lasting approximately five minutes. Following intravenous diazepam administration, the patient developed screaming and marked agitation, which resolved after injectable haloperidol administration.

No further seizures occurred during the subsequent 48-hour observation period. The patient's clinical condition improved, and the patient was discharged in a stable condition.

At discharge, intravenous phenytoin was switched to oral tablets at a dose of 100 mg three times daily. The discharge neurological regimen included phenytoin 100 mg orally three times daily, levetiracetam 500 mg orally twice daily, and folic acid 400 micrograms orally once daily. Betahistine 6 mg orally twice daily as needed was prescribed for dizziness. Gastrointestinal treatment included sucralfate suspension 1.5 g/15 mL, administered at 15 mL orally three times daily, and lansoprazole 30 mg orally once daily.

The psychiatric discharge regimen consisted of escitalopram 10 mg once daily, lorazepam 2 mg once nightly, quetiapine SR 200 mg once nightly, and valproic acid 500 mg once nightly. Haloperidol was not continued after discharge.

Regular neurological and psychiatric follow-up, psychological intervention, medication adherence monitoring, and suicide risk assessment were recommended, considering the patient's coexisting psychiatric disorders and history of self-harm and suicidal ideation.

This case emphasizes the importance of multidisciplinary management in patients with epilepsy and coexisting psychiatric disorders.

DISCUSSION

1. Epilepsy and Psychiatric Comorbidities

The coexistence of epilepsy and psychiatric disorders represents an important clinical challenge because both conditions may influence clinical presentation, treatment adherence, quality of life, and overall prognosis. Psychiatric comorbidities are frequently reported among individuals with epilepsy and may include mood disorders, anxiety disorders, psychotic disorders, and other psychiatric conditions (Ahlqvist et al., 2024; Gurgu et al., 2021; Mula et al., 2021). A population-based study by Ahlqvist et al. reported a substantial lifetime prevalence of psychiatric comorbidities among individuals with epilepsy, supporting the importance of comprehensive psychiatric assessment in this population (Ahlqvist et al., 2024). Similarly, Mula et al. emphasized that psychiatric disorders in people with epilepsy may be underrecognized and should be routinely assessed as part of epilepsy care (Mula et al., 2021).

The relationship between epilepsy and psychiatric disorders is complex and multifactorial. Potential contributing factors include shared neurobiological mechanisms, psychosocial stressors, the burden of

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recurrent seizures, treatment-related factors, and the impact of chronic illness on daily functioning (Gurgu et al., 2021; Löscher and Stafstrom, 2023). However, the coexistence of epilepsy and psychiatric disorders does not necessarily indicate a direct causal relationship. Ahlqvist et al. highlighted that although epilepsy and psychiatric conditions frequently co-occur, the underlying mechanisms cannot be explained by genetic associations or causal effects alone (Ahlqvist et al., 2024).

In the present case, the patient had a documented history of epilepsy and recurrent seizure episodes, together with established psychiatric diagnoses of bipolar affective disorder, borderline personality disorder (BPD), and dissociative disorder. This combination illustrates the importance of evaluating neurological and psychiatric conditions concurrently rather than assuming that all clinical manifestations arise from a single disorder. The presence of psychiatric comorbidities should not lead clinicians to prematurely attribute seizure-like episodes to a psychiatric cause, particularly in a patient with an established history of epilepsy.

2. Historical and Index Seizure Episodes: Diagnostic Considerations

The interpretation of seizure episodes in this patient requires differentiation between the previous episode of status epilepticus requiring intensive care unit (ICU) admission and the seizure episodes during the current hospitalization. These events represent distinct clinical episodes and should not be interpreted as a single continuous seizure event.

During the admission on September 30, 2026, the patient reportedly experienced five seizure episodes, consisting of three episodes at home and two in the emergency department. Each episode lasted less than one minute and was described as tonic-clonic in nature, with reported recovery of consciousness after each episode. These characteristics do not, by themselves, fulfill the operational criteria for convulsive status epilepticus. According to the International League Against Epilepsy (ILAE), the operational time threshold for bilateral tonic-clonic status epilepticus is five minutes, while recurrent seizures without recovery of consciousness between episodes also raise concern for status epilepticus (Scheffer et al., 2017).

During the subsequent hospitalization, one additional seizure episode lasting approximately five minutes was documented. The episode was treated with intravenous diazepam. This event should be distinguished from the five earlier episodes because its duration reached the operational treatment threshold for convulsive status epilepticus. However, the final classification should also consider the documented clinical characteristics, including the presence of continuous convulsive activity and the patient's level of consciousness.

The previous episode requiring ICU admission was a separate historical event. Its classification as status epilepticus should be interpreted according to the available historical clinical documentation, including seizure duration, recurrence, and recovery of consciousness. If these details cannot be verified, the limitation of the historical records should be acknowledged rather than assuming that the previous episode fulfilled all diagnostic criteria.

This distinction is important because the duration, frequency, semiology, and recovery of consciousness provide essential information for differentiating isolated seizures, seizure clusters, and status epilepticus. The available information also emphasizes the importance of obtaining detailed witness accounts and reviewing previous medical records when reconstructing the clinical course of patients with recurrent seizure episodes (National Institute for Health and Care Excellence, 2022; Scheffer et al., 2017).

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3. Dissociative Disorder and the Diagnostic Challenge of Seizure-Like Episodes

Dissociative disorders may present with disturbances in consciousness, memory, identity, perception, or bodily functioning. In some individuals, dissociative symptoms may include episodes resembling epileptic seizures, commonly referred to as functional or dissociative seizures (FDS). These episodes may resemble epileptic seizures clinically, creating diagnostic difficulties, particularly when neurological and psychiatric conditions coexist (Goldstein et al., 2019; Tolchin et al., 2026; Villagrán et al., 2021).

The distinction between epileptic seizures and FDS is clinically important because the underlying mechanisms and treatment approaches differ. The diagnosis of FDS should be based on a comprehensive assessment of the clinical history, characteristics of the episodes, examination findings, and appropriate investigations. The American Academy of Neurology guideline emphasizes the importance of obtaining detailed descriptions of typical episodes, including witness accounts and available video recordings, and considering video-electroencephalography (video-EEG) when clinically indicated (Tolchin et al., 2026). Goldstein et al. also demonstrated the clinical heterogeneity of dissociative seizures in a large multicentre cohort, highlighting the importance of individualized diagnostic assessment (Goldstein et al., 2019). Population-based findings from Villagrán et al. further demonstrate that dissociative seizures are a clinically relevant condition requiring appropriate recognition and management (Villagrán et al., 2021).
In the present case, dissociative disorder was documented in the patient's psychiatric history. However, the available clinical records do not provide sufficient details regarding the specific dissociative symptoms, their frequency, or their temporal relationship with the seizure episodes. Therefore, the clinical significance of this diagnosis in relation to the recurrent seizure-like events remains uncertain. The presence of a dissociative disorder alone does not establish that the observed episodes were functional or dissociative seizures.

The possibility of coexisting epileptic and functional seizures should nevertheless be considered when clinically appropriate. Epilepsy does not exclude the possibility of additional functional neurological symptoms, and psychiatric comorbidity does not invalidate an established neurological diagnosis. In this patient, the available information is insufficient to determine whether the recurrent episodes were exclusively epileptic, functional/dissociative, or represented more than one type of event. Further assessment of dissociative symptoms and video-EEG monitoring, when clinically indicated, may help clarify the relationship between the patient's neurological and psychiatric manifestations (Goldstein et al., 2019; Tolchin et al., 2026).

4. Interpretation of EEG Findings and Neurodiagnostic Considerations

Electroencephalography (EEG) is an important investigation in the assessment of suspected epilepsy. However, a normal routine EEG does not exclude epilepsy, particularly when the recording does not capture a typical clinical event. The interpretation of EEG findings requires consideration of the patient's clinical history and the limitations of the recording. NICE guideline NG217 recommends that EEG should support, rather than replace, clinical assessment and explicitly advises against using a normal EEG to exclude epilepsy (National Institute for Health and Care Excellence, 2022).

In this patient, routine EEG performed in April 2025 showed a normal recording, with no epileptiform activity or abnormal slowing. This finding should be interpreted cautiously. It does not rule out epilepsy and does not independently establish a diagnosis of FDS. The findings should be considered alongside the patient's history of recurrent seizure episodes, previous neurological assessments, and clinical presentation. In addition, the interpretation of EEG requires awareness of normal variants and artifacts that may complicate the distinction between physiological and pathological patterns (Amin et al., 2023). Brain MRI was also reported as normal. Nevertheless, a normal structural MRI does not exclude epilepsy because epileptic disorders may occur without identifiable structural abnormalities on

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conventional imaging. Similarly, normal EEG and MRI findings cannot independently confirm functional seizures.

Video-EEG monitoring may be useful when recurrent episodes remain diagnostically uncertain, particularly when differentiation between epileptic seizures and FDS is clinically necessary (Tolchin et al., 2026). In the present case, a typical episode was not documented by video-EEG. Consequently, the available findings are insufficient to determine whether all reported episodes were epileptic, functional/dissociative, or represented more than one type of event. This limitation should be acknowledged, and the normal routine EEG and MRI should not be interpreted as definitive evidence for or against either diagnosis.

5. Neuroimaging Research in Functional/Dissociative Seizures: Clinical Context

Neuroimaging studies have explored structural and functional brain alterations in individuals with FDS, particularly in networks associated with emotional processing, self-awareness, and motor control (Allendorfer et al., 2019; Amiri et al., 2021a; Amiri et al., 2021b; Asadi-Pooya and Homayoun, 2020; Hassan et al., 2024; Homayoun et al., 2026; McSweeney et al., 2017). However, the reported findings remain heterogeneous, and no specific neuroimaging pattern has been established as a diagnostic biomarker for FDS (Hassan et al., 2024; Homayoun et al., 2026; McSweeney et al., 2017). In the present case, no specialized functional neuroimaging was performed. Therefore, these findings are discussed only as background evidence and cannot be considered evidence of specific structural or functional brain abnormalities in this patient.

6. Differential Diagnosis of Bipolar Affective Disorder and Borderline Personality Disorder

The coexistence of bipolar affective disorder and BPD may complicate psychiatric assessment because both conditions can involve affective instability, impulsivity, and difficulties in interpersonal functioning. Nevertheless, they are distinct clinical entities and should be differentiated based on the longitudinal course of symptoms, the pattern of mood changes, and the broader clinical history (Sanches, 2019; Wright et al., 2022).
Bipolar affective disorder is characterized by distinct episodes of mood disturbance, including manic, hypomanic, or depressive episodes, depending on the subtype and clinical course. In contrast, BPD is characterized by a pervasive pattern of instability in interpersonal relationships, self-image, affect regulation, and impulse control. Although mood instability may occur in both conditions, the temporal pattern and clinical context of the symptoms are important in distinguishing them (Sanches, 2019). Wright et al. further emphasized the relevance of self-concept, identity, and self-esteem in the differential diagnosis between BPD and bipolar disorder (Wright et al., 2022).

In the present case, bipolar affective disorder and BPD were documented in previous psychiatric assessments. However, the available clinical history does not fully establish the longitudinal characteristics of manic or hypomanic episodes, including their duration, associated changes in energy and activity, decreased need for sleep, and functional consequences. Similarly, the persistence and pervasiveness of interpersonal instability, impulsivity, and identity disturbance require longitudinal assessment. Therefore, although both diagnoses are retained as documented clinical diagnoses, their respective contributions to the patient's current presentation should be interpreted cautiously.

The presence of epilepsy adds another layer of complexity because neurological symptoms, medication effects, and psychiatric manifestations may overlap. Sleep disturbances, behavioural changes, and emotional dysregulation may arise from different clinical mechanisms and should not automatically be attributed to a single psychiatric diagnosis. A multidisciplinary assessment and longitudinal psychiatric follow-up are therefore important to clarify the contribution of each condition to the patient's clinical presentation and to guide treatment decisions (Mula et al., 2021; Peltola et al., 2024; Sanches, 2019; Wright et al., 2022).

Surabaya Medical Journal (SMJ IDI SBY)
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7. Psychosocial Factors, Self-Harm, and Suicide Risk

Psychosocial adversity may contribute to emotional distress and difficulties in psychological functioning among individuals with chronic neurological and psychiatric conditions. In patients with epilepsy, the burden of recurrent seizures, functional limitations, social stigma, and concerns about the unpredictability of episodes may further affect psychological well-being (Gurgu et al., 2021; Mula et al., 2021; Peltola et al., 2024). In patients with BPD and mood disorders, emotional dysregulation and interpersonal difficulties may also be clinically relevant factors requiring careful assessment (Sanches, 2019; Wright et al., 2022).

In the present case, the patient's psychosocial history and documented psychiatric comorbidities are important considerations in the overall clinical assessment. However, psychosocial adversity should not be assumed to be the direct cause of the patient's seizure episodes. Similarly, emotional distress or interpersonal conflict alone is insufficient to establish a functional or dissociative seizure diagnosis. Such factors should be considered as part of the broader biopsychosocial formulation while maintaining an appropriate neurological differential diagnosis.

The assessment of self-harm and suicide risk is particularly important in patients with coexisting epilepsy and psychiatric disorders. Clinicians should evaluate current suicidal thoughts, previous self-harm behaviour, intent, access to means, protective factors, and available social support. Risk assessment should be repeated when the patient's clinical condition changes and incorporated into an individualized safety and follow-up plan. Particular attention should be given to behavioural changes, impulsivity, depressive symptoms, and possible medication-related adverse effects. The management of psychiatric comorbidities in epilepsy should therefore extend beyond symptom control to include psychosocial support and continuous monitoring of psychological safety (Mula et al., 2021; Peltola et al., 2024).

8. Pharmacological Considerations and Multidisciplinary Management

The coexistence of epilepsy and psychiatric disorders requires careful selection and monitoring of pharmacological treatment. In patients receiving multiple antiseizure and psychotropic medications, potential pharmacokinetic and pharmacodynamic interactions may influence therapeutic effectiveness, tolerability, and clinical outcomes (Johannessen Landmark et al., 2023; Zaccara and Franco, 2023).

Phenytoin is a potent hepatic enzyme inducer, particularly of CYP3A4 and CYP2C9, and may reduce the plasma concentrations of several psychotropic medications. This interaction is particularly relevant to quetiapine, which is primarily metabolized by CYP3A4. Concomitant administration of phenytoin may substantially increase quetiapine clearance, potentially reduce its systemic exposure and compromise its therapeutic effectiveness. A published case report demonstrated undetectable serum quetiapine concentrations during concomitant phenytoin administration, followed by improved quetiapine exposure and clinical response after phenytoin discontinuation (Thomas et al., 2018; Zaccara and Franco, 2023). The potential interaction between phenytoin and other psychotropic medications, including antidepressants, should also be considered, although its clinical significance depends on the metabolic pathways involved and individual patient characteristics (Zaccara and Franco, 2023).

The combination of phenytoin and valproic acid also warrants careful pharmacokinetic consideration. Both medications are highly bound to plasma proteins, and alterations in protein binding may affect the relationship between total and pharmacologically active free drug concentrations. Phenytoin-induced hepatic enzyme activity may also increase valproic acid clearance, potentially affecting its serum concentration. Therefore, therapeutic drug monitoring may be considered when clinically indicated, particularly when seizure control is inadequate, toxicity is suspected, or changes in medication regimens occur. Measurement of free phenytoin concentrations may be particularly useful when altered protein

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binding is suspected, as total serum concentrations may not accurately reflect pharmacologically active exposure (Johannessen Landmark et al., 2023; Thomas et al., 2018).

Levetiracetam is generally associated with relatively few pharmacokinetic drug interactions. However, behavioural adverse effects, including irritability, agitation, aggression, and mood changes, have been reported. These effects are particularly relevant in patients with pre-existing psychiatric comorbidities because they may complicate the assessment of behavioural and emotional symptoms. Monitoring for new or worsening behavioural disturbances following initiation or dose adjustment is therefore important (Thomas et al., 2018).

The use of escitalopram in patients with bipolar disorder also requires careful consideration. Antidepressant treatment may be associated with treatment-emergent mood switching, including the development of manic or hypomanic symptoms. Although concurrent mood-stabilizing treatment may reduce this risk, it does not eliminate the need for monitoring. Changes in sleep requirements, energy, activity, irritability, impulsivity, and mood should be evaluated during treatment (Keramatian et al., 2023).

In the present case, neurological and psychiatric treatments were administered during hospitalization. An additional seizure episode lasting approximately five minutes was treated with intravenous diazepam. Following this episode, the patient developed marked agitation and screaming, for which injectable haloperidol was administered. These interventions addressed different clinical manifestations: diazepam was administered for the seizure episode, whereas haloperidol was used to manage acute agitation. The patient subsequently remained seizure-free for 48 hours and was discharged in a clinically stable condition.

The patient's maintenance treatment included antiseizure medications and psychiatric medications. Given the potential interactions between phenytoin, valproic acid, levetiracetam, and psychotropic agents, the medication regimen requires regular review by neurology and psychiatry. Treatment decisions should consider seizure control, psychiatric stability, potential adverse effects, drug interactions, and medication adherence rather than evaluating each medication in isolation.

Furthermore, the patient's history of self-harm and documented suicide risk highlights the importance of continuous psychiatric monitoring. Assessment should include suicidal ideation, behavioural changes, mood destabilization, treatment adherence, and possible medication-related psychiatric adverse effects. An individualized safety plan and appropriate outpatient follow-up are essential to support continuity of care and reduce potential risks.

A multidisciplinary approach involving neurology and psychiatry is therefore important to address seizure management, mood stabilization, behavioural symptoms, medication safety, and psychosocial needs. If further seizure-like episodes occur and their nature remains uncertain, additional assessment, including video-EEG monitoring when available and clinically indicated, may help clarify the diagnosis and guide subsequent treatment (Peltola et al., 2024; Tolchin et al., 2026).

Limitations

This case report has several limitations. First, the diagnostic assessment was based on the available clinical history, examination, and routine EEG findings. Although the routine EEG showed no epileptiform activity or abnormal slowing, a normal routine EEG does not exclude epilepsy (National Institute for Health and Care Excellence, 2022). Second, video-EEG monitoring of a typical episode was not performed; therefore, the available information does not allow definitive classification of all seizure-like episodes as epileptic or functional/dissociative. Third, the report relies on previously documented psychiatric diagnoses and the clinical records available during the patient's care. Further

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longitudinal psychiatric assessment may provide additional information regarding the course and interaction of bipolar affective disorder, BPD, and dissociative symptoms.

Finally, as a single case report, these findings cannot be generalized to all patients with epilepsy and psychiatric comorbidities. The neuroimaging studies discussed in this report provide background information from the literature and do not represent investigations performed in this patient. Despite these limitations, the case illustrates the importance of multidisciplinary assessment and careful differentiation between neurological and psychiatric manifestations in patients with complex comorbid conditions.

CONCLUSION

This case highlights the diagnostic challenges associated with the coexistence of epilepsy, bipolar affective disorder, borderline personality disorder (BPD), and a documented dissociative disorder. The overlap of neurological manifestations, emotional dysregulation, interpersonal difficulties, and a history of self-harm underscores the importance of comprehensive clinical assessment to differentiate epileptic seizures from possible functional seizures while recognizing coexisting neurological and psychiatric conditions. Normal routine electroencephalography (EEG) and brain magnetic resonance imaging (MRI) findings alone are insufficient to exclude epilepsy or establish a diagnosis of functional seizures. A multidisciplinary approach involving neurology and psychiatry is essential to support diagnostic clarification, optimize treatment, promote medication adherence, and address psychosocial needs and suicide risk. Further clinical studies are warranted to improve understanding of the interaction between epilepsy and psychiatric comorbidities and to identify effective strategies for individualized, integrated care.

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Conflict of Interest

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Author Contributions

MM: contributed to the conception of the case report, collection and interpretation of clinical data, literature review, and preparation of the manuscript. RL: contributed to clinical supervision, diagnostic interpretation, critical revision of the manuscript, and final approval of the version to be published. Both

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