INTERNATIONAL JOURNAL OF SOCIAL SCIENCES BULLETIN
ISSN: (E) 3007-1917 (P) 3007-1909

Volume 4, Issue 3, 2026

A COMPARATIVE QUALITATIVE STUDY: LIVED EXPERIENCES OF INDIVIDUAL'S WITH EPILEPTIC AND NON-EPILEPTIC SEIZURES

Hafiz Muhammad Younas[1], Zartashia Kynat Javaid[*2], Usman Ali[3], Muhammad Abaid Ullah[4]

[1]*PhD Scholar Department of Applied Psychology Government College University Faisalabad*
[*2]*Assistant Professor Department of Applied Psychology Government College University Faisalabad*
[3]*PhD Scholar Department of Applied Psychology Government College University Faisalabad*
[4]*PhD Scholar Department of Applied Psychology Government College University Faisalabad*

[1]younasriaz@gcuf.edu.pk, [*2]zartashiakynat@gcuf.edu.pk, [3]ranausman70000@gmail.com, [4]abaidkamoka@gmail.com

ORCID: [1]https://orcid.org/0009-0008-5768-397X, [*2]https://orcid.org/0009-0003-4377-3476

Corresponding Author: *
Dr. Zartashia Kynat Javaid
DOI: https://doi.org/10.5281/zenodo.22721131

Received	Accepted	Published
30 January 2026	15 March 2026	21 March 2026

ABSTRACT

Psychogenic non-epileptic seizures (PNES) and epileptic seizures (ES) often existing with similar symptoms, making accurate diagnosis challenging. Misdiagnosis may lead to inappropriate treatment and delayed mental health intervention. This qualitative study explored the physical, cognitive, emotional, and psychosocial experiences of individuals with seizure-like episodes. In current study phenomenological research design was used. Semi-structured interviews were conducted with 10 participants (aged 20-45 years) selected through purposive sampling. The sample included equal numbers of males and females from both rural and urban backgrounds. Data were examined using thematic analysis. Results reveled five major themes: 1. Peri-ictal physical experiences 2. Cognitive difficulties 3. Emotional and psychological distress 4. Social and occupational Impacts 5. Healthcare experiences. The symptoms reported by the participants are body jerks, altered awareness, anxiety, fear, memory problems, social stigma, occupational difficulties, and dissatisfaction with healthcare services. The findings highlight the multidimensional nature of seizure experiences and provide qualitative support for developing a culturally appropriate screening scale to improve the diagnostic differentiation of psychogenic non-epileptic seizures (PNES) and epileptic seizures (ES) and facilitate suitable intervention.

Keywords: *Psychogenic Non-Epileptic Seizures, Epileptic Seizures, Qualitative Research, Emotional Distress, Cognitive Difficulties, Dissociation, Thematic Analysis,*

INTRODUCTION

The psychogenic non-epileptic seizures are the behavioral actions that resemble epileptic seizure but these are not associated with abnormal cortical epileptic form activity (American psychological association, 2013), these seizures accounts for up to 20-30 percent of referrals to specialized epileptic centers and is frequently misdiagnosed as epileptic seizures (Reuber & Elger, 2003; Kanemoto et al., 2017). Misdiagnoses not only delays the suitable psychological intervention but also exposes patients to unnecessarily antiepileptic treatment

that associated with side effects and healthcare expenses.

Furthermore, video-electroencephalography remains the gold standard for differentiating the psychogenic non-epileptic seizures from the epileptic seizures, video-electroencephalography is an expensive, may fail to capture the typical episodes and also limited in availability (Widyadharma et al., 2021). Additionally, the retrospective clinical and witness reports frequently dearth and compromise reliability (Benbadis & Hauser, 2000). These limitations demand various psychometrically sound measure that combine peri-ictal behavioral indicators, cognitive features and effective states to clear differential diagnosis.

Mislabeling between the psychogenic non-epileptic seizures and epileptic seizures is common, about 25-30 percent of individuals with seizures on long term antiepileptic therapy are misdiagnosed and later identifies as having the psychogenic non-epileptic seizures (Benbadis & Hauser, 2000; LaFrance et al., 2013). The video-electroencephalography increase diagnostic sureness but remain limited the outside tertiary care centers (Kanner, 2021). The clinically reliable measure such as the Non-epileptic Seizure Recognition Checklist (Duncan et al., 2011), have improved the categorization but lack of multidimensional behavioral and affective integration.

The psychogenic non-epileptic seizure episode often has asynchronous motor activity, longer duration and fluctuation in responsiveness (Kerr et al., 2019; Reuber et al., 2002). The autonomic response like the heart rate varies in PNES and ES (Benbadis et al., 2006). So far, patients feature alone lack sufficient sensitivity and specificity for impartial diagnostic use. The cognitive patterns specifically memory, executive functioning and attention differ between psychogenic non-epileptic seizures and epileptic seizures, actually reflecting underlying functional neurocircuitry differences and psychopathology (Karaaslan & Hamamcı, 2020; Kausar et al., 2021). Sentimental symptoms such as depression, anxiety, and detachment are prominently higher in psychogenic non-epileptic seizure's patients as compare to epileptic seizures' patients, cognitive- affective signs may augment behavioral observations in differential diagnoses (Hopp et al., 2022; Bewley et al., 2005; Brown et al., 2010).

Till now, the differential diagnosis depends on clinical history, neurophysiological data and semiology, (Xiang et al., 2019). Though, peri-ictal behavioral features such as, responsiveness, autonomic signs, cognitive effective gages like anxiety or detachment, and duration of motor activity, show promise as discriminators (Kerr et al., 2019; Hopp et al., 2022). Based on the previous literature, it is concluded that the lack of qualitative studies in Pakistan about the comparison between psychogenic non-epileptic seizures and epileptic seizures that can conceptualize this phenomenon within the context of mental health.

Objectives

1. To explore the multidimensional experiences of individuals who are experiencing seizure and seizure-like episodes.
2. To understand the similarities and differences exist in the lived experiences of patients with psychogenic non-epileptic seizures and epileptic seizures.

Research Questions

1. What peri-ictal, cognitive, and affective experiences do patients with psychogenic non-epileptic seizures and epileptic seizures report?
2. How do patients describe their lived experiences related to seizure episodes, thoughts, emotions, and daily functioning?
3. What similarities and differences exist in the lived experiences of patients with psychogenic non-epileptic seizures and those with epileptic seizures?

Methods

Research Design

The present study employed a qualitative research design to explore the peri-ictal, cognitive, affective and psychological experiences of individuals with seizures episode. A phenomenological approach was implied to understand the lived experiences of the patients about psychogenic non-epileptic

seizures and epileptic seizures. Phenomenology exploration was intended to contribute in the development of a multidimensional tool for differentiating the PNES and ES.

Participants

The study sample comprised of 10 individuals' experiencing seizures or seizure like episodes, participants were selected by using purposive sampling technique from the public hospitals with an age range of 20-45 years and having history of fits for at least six months. The sample includes equal ratio of male and female participants as well as married and unmarried from the urban and rural areas of Faisalabad, Punjab Pakistan to ensure diversity of experiences.

Inclusion Criteria

Participants who were able to understand and answer appropriately to the interview questions were included in the study, individuals who were willingly agreed to participate in the study were included. Participants provided informed consent prior to data collection.

Exclusion Criteria

Individuals with severe cognitive impairment, communication difficulties, or severe psychiatric and neurological conditions that could interfere with the interview process were excluded from the study.

Measures

Demographic Sheet

The demographic data sheet was created using the following information: The age, education, occupation, nature of disease, other physical health issues, and mental health concerns.

Interview Schedule

A semi-structured interview questionnaire was used to collect qualitative data from participants. The interview schedules were created primarily for patients with psychogenic non-epileptic seizures and epileptic seizures. The interview guide consisted of open-ended questions regarding symptoms before seizures, physical experiences during seizures, awareness during episodes, cognitive difficulties, emotional reactions, dissociative experiences, history of trauma, psychosocial functioning and experiences with healthcare professionals.

The interview questions were developed according to the objectives of the study and relevant literature related to ES and PNES. The interview protocol aimed to explore multidimensional experiences associated with seizure disorders.

Data collection and Procedure

The data for the study was collected through semi-structured interviews. Semi-structured interviews allowed participants to freely express their thoughts and feelings while also allowing me to explore into their experiences through targeted inquiry. Permission for data collection was obtained from relevant clinical and rehabilitation settings. Participants fulfilling inclusion criteria were approached individually and informed about the objectives and nature of the study. The interview questions or guideline initially formulated in Urdu language to overcome the language barrier and provide eased of communication to the participants. The interview schedule was specifically planned to keep me focused on the study's questions and objectives. During the interview, the interview schedule was iteratively created.

A semi-structured interview helped to create rapport by allowing participants to think and express themselves during the interview. The interviews varied in length from twenty to twenty-five minutes, with twenty-four minutes being the average. Participants were assured regarding confidentiality and anonymity of their information. Before each interview, a briefing was held to provide the participant with an overview of the context, including a discussion of the interview's objectives and recording approach, as well as the opportunity to ask any questions. This was done to provide situation for those who participated and answer any queries concerning the interview, so fostering a sense of connection. Furthermore, prior to the interview, the participants were agreed to a consent form to sign. They were additionally instructed that at the end of the interview; they would have the opportunity

to ask and debate questions. During the interviews, I diligently documented my ideas and feelings.

Transcription

Transcribing spoken speech to written form. Transcribing audio recordings into textual form may be considered preliminary analysis as it involves arranging material for later investigation. I meticulously recorded and transcribed the interviews for this study using audio equipment. The construction of lived experiences of psychogenic non-epileptic seizures and epileptic seizures.

Data Analysis

Table 1 Reflexive Thematic Analysis (RTA) Process Adapted from Braun and Clarke (2019, 2021).

Phases	Process	Description
1. Data Familiarization	Immersion in the data	The transcription process data, reading and rereading it, and taking notes on initial ideas.
2. Generating Initial Codes	Systematic coding	Coding unique characteristics throughout the dataset in a methodical manner.
3. Constructing Initial Themes	Theme development	Collecting codes and pertinent data for each theme.
4. Reviewing and Developing Themes	Theme refinement	Checking whether themes work with coded extracted and the entire dataset.
5. Defining and Naming Themes	Theme clarification	Clarifying theme names and definitions.
6. Producing the Report	Writing and interpretation	Final analysis, choosing vivid examples that relate to the study subject.

The collected qualitative data were analyzed using thematic analysis to explore the lived experiences of participants regarding epileptic seizures and psychogenic non-epileptic seizures. The data were analyzed by using thematic analysis following the Reflexive Thematic Analysis (RTA) as developed by Virginia Braun and Victoria Clarke (2019, 2021). This approach moves beyond the rigid six-phase structure (2006) and adopts a flexible, iterative, and interpretive analytic process. An inductive, data-driven approach was used to ensure that themes emerged directly from participant's narratives. The researcher carefully reviewed the transcripts multiple times to gain familiarity with the data and to understand the depth and meaning of participants' experiences. The initial codes were created from meaningful statements from participants and repeated patterns also were identified from the interview responses. The initial coding focused on the peri-ictal symptoms, cognitive difficulties, emotional reactions, psychological impacts, health related and detachment experiences.

After the initial coding, the similar codes were grouped together under the subthemes to develop the broader themes, the identified themes reflect the similar and shared experience among the participants such as physical symptoms during seizures, cognitive impairment, emotional distress, social difficulties and perception regarding the treatment approaches. The researcher continuously compared themes across participants to ensure consistency and credibility of findings. Thematic analysis enabled an in-depth understanding of seizure-related experiences and assisted in identifying clinically relevant dimensions for the future development of a multidimensional screening scale for differentiating epileptic seizures and psychogenic non-epileptic seizures.

Ethical considerations

Participants were informed that their participation was voluntary, that they could withdraw at any time, and that their confidentiality was guaranteed. Prior to data collection, we got written or verbal consent. To safeguard confidentiality,

pseudonyms were employed during transcribing and reporting.

Findings

The findings of the present qualitative study revealed that participants experiencing seizure or seizure-like episodes reported a wide range of physical, cognitive, emotional, and psychosocial difficulties. Most participants described noticeable physical sensations before the onset of seizures, including dizziness, heaviness in the head, numbness, rapid heartbeat, weakness, and feelings of fear or panic.

Throughout seizure episode, the individuals most commonly reported stiffness, body jerks, trembling, loss of body control, reduce responsiveness and altered awareness. Some reported complete loss of consciousness while others of them stated that they partially remained aware of their surroundings during episodes, differences were also noticed in the duration and intensity of seizure experiences among patients.

The results further shows that the seizure experiences were strongly linked with cognitive difficulties and emotional distress. Most of the individuals described the symptoms of anxiety, sadness, fear memory problem, confusion, and difficulty concentrating before and after seizures. Several patients reported dissociative experiences, including the feelings of detachment toward self and others or surroundings. There are many factors that contribute the severity of the seizure episodes like the family conflicts, psychological stress, financial burden, and the traumatic life experiences. The individuals additionally reported significant social and occupational difficulties, including difficulties in education, employment, social relationships, and daily functioning.

The reflective thematic analysis (RTA) identified five major themes from individual narratives: cognitive difficulties, peri-ictal physical experiences, emotional and psychological distress, social and occupational impacts, and healthcare experiences. The participants also articulated dissatisfaction related to healthcare services, particularly the lack of attention to psychological and emotional aspects of their condition. Most of the participants believed that the healthcare professional focused mainly on the medication and neglecting their emotional suffering and psychosocial needs. Overall, results shed light the multidimensional nature of seizure experiences and highlighted the importance of integrating behavioral, emotional, psychological, and cognitive factors in distinction of psychogenic non-epileptic and epileptic seizures.

Table 2 Main themes, subthemes, and codes related to lived experience of Patients with Epileptic and Non-Epileptic Seizures (N=10)

Main themes	Subthemes	Codes
Peri-Ictal Physical Experiences	Bodily Tremors and Jerking Movements	Uncontrolled jerking movements, body tremors, muscle stiffness, dizziness, numbness, physical rigidity, weakness, warning signs before seizures
	Loss of Awareness and Bodily Control	Reduce responsiveness, loss of consciousness, inability to control body movements, loss of bodily control, altered awareness.
	Post-Seizure Physical Exhaustion	Fatigue, physical weakness, exhaustion, excessive sleepiness, reduced energy, recovery difficulties
Cognitive Difficulties	Memory Problems	Partial memory recall, complete memory loss, forgetfulness, impaired recall, long-term memory decline
	Concentration and Thinking Difficulties	Poor concentration, attention difficulties, slowed thinking, impaired decision-making, delayed comprehension, information processing difficulties

Main themes	Subthemes	Codes
	Post-Seizure Confusion	Mental disorientation, confusion, cognitive exhaustion, lack of mental clarity, difficulty understanding surroundings
Emotional and Psychological Distress	Fear and Anxiety Before Seizures	Fear, anticipatory anxiety, panic, nervousness, worry about seizure occurrence, emotional instability
	Emotional Distress After Seizures	Sadness, crying, embarrassment, emotional withdrawal, shame, emotional exhaustion, low mood
	Psychological Stress and Trauma as Triggers	Financial stress, bereavement, marital stress, traumatic experiences, psychological distress, stress-induced seizure exacerbation
Social and Occupational Impacts	Educational and Occupational Difficulties	Academic impairment, reduced concentration in studies, work difficulties, job performance issues, employment disruption, absenteeism
	Social Reactions and Stigma	Social stigma, public embarrassment, negative social reactions, pity from others, ridicule, fear of judgment, intrusive questioning
	Family and Social Burden	Dependency on family members, restricted social participation, family stress, caregiver burden, reduced independence, interpersonal difficulties
Healthcare Experiences	Neglect of Emotional and Psychological Concerns	Lack of psychological support, emotional concerns ignored, inadequate mental health assessment, dissatisfaction with care, unmet emotional needs
	Medication-Focused Treatment	Medication-cantered care, limited communication, lack of counseling, insufficient psycho-education, overreliance on medication, dissatisfaction with treatment approach

INTERNATIONAL JOURNAL OF SOCIAL SCIENCES BULLETIN
ISSN: (E) 3007-1917 (P) 3007-1909
Volume 4, Issue 3, 2026

Figure 1Conceptual Mind Map of Main Themes, Subthemes, and Codes Identified Through Thematic Analysis

Theme 1: Peri-Ictal Physical Experiences

Bodily Tremors and Jerking Movements

The theme "peri-ictal physical experiences" emerged flagrantly from the narrative of many individuals, they described different types of physical sensations happening before, during and after the seizure episodes. Most common physical experiences include jerking movement, body tremors, dizziness, numbness, weakness, stiffness of muscles and loss of bodily control. Most of the participants explained that the seizure started with warning signs such as rapid heartrate, feeling of weakness, and heaviness in head, P1 stated that *"my hands and feet start trembling and my body become stiff"* P2 said my *"whole body experience jerking movements"* P3 stated that *"my all body become stiff"*. These all experiences were coded as physical rigidity, bodily tremors and jerking movements.

Loss of Awareness and Bodily Control

The second important subtheme elaborate inability to control bodily movements and altered awareness during the seizure episodes. Most of the individuals reported during episode complete or partial loss of consciousness. P4 stated that *"I completely loss control of my surroundings"* P2 stated *"I completely loss control over my body"* whoever some participants reported partial awareness during the episode and shared experience P5, P7*"sometimes remain aware to some extent"*. These experiences showed varying level of responsiveness and consciousness among the participants.

Post-Seizure Physical Exhaustion

Participants constantly described weakness, exhaustion and fatigue resulting seizure episodes. P1 stated, after the seizure episode, *"I feel weak and very tired"*, while the other participants P2 reported *"I become sleepy after the seizure"*, similarly P10 explained, *"I feel sever fatigue afterward"*. These experiences showed the significant physical exhaustion related to seizure recovery.

Theme 2: Cognitive Difficulties

Memory Problems

The other major theme is cognitive difficulties is identified in participants experiences. Participants described problems related to memory and recall during or after the episode, P1 reported "I remember something but not completely" participant P2 explained "I do not remember anything during seizure" furthered participant 010 reported "my memory has become weak or deteriorated", these responses were initially coded as complete memory loss, long term memory decline and partially memory recall.

Concentration and Thinking Difficulties

Participants described difficulties related to understanding, thinking process and concentration. P1 reported *"my attention decreases before the seizure episode"* while P3 stated *"I have face difficulty making decisions"* participant P4 additionally reported *"It take much time t understand things"* these experiences of different participants highlighted slowed thinking, difficulty processing information and impaired concentration.

Post-Seizure Confusion

Another subtheme is post-seizure confusion emerged. Participants reported cognitive exhaustion and mental disorientation after the seizures. P4 reported "sever confusion after seizure" P7 stated "I feel confused afterward". These experiences demonstrated that the seizures episodes significantly affected the persons cognitive functioning and mental clarity.

Theme 3: Emotional and Psychological Distress

Fear and Anxiety before Seizures

The third major theme is emotional and psychological distress that is a strongest theme in the participants narratives. Most participants experience anxiety, fear, panic attacks, and emotional instability before seizure. P1 reported *"I feel restlessness and fear"* while the P3 stated *"severe anxiety or panic"* likewise P5 explained *"I feel panic and fear"*. These all narratives reflected anticipatory anxiety and emotional fear related to seizure episode.

Emotional Distress after Seizures

Participants also highlighted the emotional sufferings after the seizure including crying spells, embarrassment, emotional exhaustion and sadness. P3 shared the experience *"I feel crying spells afterward"* similarly P9 reported *"I feel sadness after the seizure"* participant P8 also describe the experience *"I remain silent and sad afterward"*. These experiences coded as emotional withdrawal, sadness, and post-seizure emotional instability.

Psychological Stress and Trauma as Triggers

Another important subtheme emerged that involved traumatic experiences and psychological stress are major contributor to seizure episodes. Several participants believed that psychological stress increased the severity and frequency of seizures P2 reported *"financial burden increased mental stress that leads to seizures"* while P4 shared *"the problem worsened after my father's death"* participant P4 additionally reported to marital issues and stated *"my stress increased after my marriage"*. These findings suggest a strong relationship between seizure experience and psychological distress.

Theme 4: Social and Occupational Impacts

Educational and Occupational Difficulties

The findings exposed that seizure episodes had considerable psychosocial consequences on daily functioning of participants. Participants reported that seizures negatively affected their educational and occupational routine and performance. P1 sated that *"my studies*

have been affected" while participant P2 reported "*my work has been affected and faced difficulty at workplace*" participant P6 stated "*my job has affected due to seizures*" and similarly P10 explained "*my livelihood has been affected*" these findings revealed the reduce academic performance and occupational impairment.

Social Reactions and Stigma

Another subtheme reveled negative social reactions and stigma also associated with seizures. P1 explained "people often get scared and feel pity" while P2 reported "people also make fun" participant P9 similarly explained "people ask questions". These findings reflected stigma, social embarrassment, and fear of public judgment.

Family and Social Burden

Another subtheme is family and social burden. Many participants described emotional burden on family relationships and social functioning. Participants reported P7 "*because of me others (family members) become worried*" also P8 similarly reported "*my parents experience stress because of me*". Some individuals also reported they experience dependency on family members and face difficulty to participate in social activities. The recurrent seizure creates stress with in family relationship and also limited their independence.

Theme 5: Healthcare Experiences

Neglect of Emotional and Psychological Concerns

Another major theme emerged as healthcare experiences. Participants expressed their dissatisfaction regarding the management of their psychological and emotional concerns. P1 reported "*doctors often ignore my emotional problems*", while P3 stated, "*doctors do not pay attention to my mental stress*". Participants believed that healthcare providers focused only on the physical symptoms and completely overlook the psychological sufferings

Medication-Focused Treatment

Another recurring subtheme involved medication-centered treatment approaches. Participants reported that doctors relied mainly on medications without providing emotional support or detailed discussion regarding their conditions. P2 reported "*doctors do not listen they only give medicines*" while P6 similarly stated that "*doctors only focus on medications*" these narratives reflected dissatisfaction with holistic care and communication within healthcare settings.

Discussion

The current study explored the multidimensional experiences of individuals who are experiencing seizure and seizure-like episodes, especially focusing on peri- ictal physical symptoms, cognitive issues, social and occupational problems, emotional distress, and experiences related to healthcare. The findings revealed that participants experienced a variety of physical manifestations including body jerks, tremors, muscular rigidity, loss of consciousness, impaired awareness and post-seizure fatigue and exhaustion. These findings are relatable with previous studies suggesting that both psychogenic non-epileptic seizures (PNES) and epileptic seizures (ES) share overlapping physical features, often confusing accurate diagnosis (LaFrance et al., 2013). Some previous studies demonstrated that PNES frequently involve asynchronous body movements, prolonged duration, instable responsiveness, and emotional triggers linked to epileptic seizures (Kerr et al., 2019). Widyadharma et al. (2021) reported that observable peri-ictal behaviors play a significant role in distinguishing PNES from ES, mainly in settings where video electroencephalography (vEEG) is not readily available.

The findings of the current study further indicated that many participants experienced significant cognitive difficulties before and after seizure episodes. Participants frequently reported confusion, impaired concentration, forgetfulness, difficulty understanding information, and slowed thinking processes. These findings support previous evidence demonstrating that individuals with PNES often exhibit cognitive impairments associated with attentional difficulties, executive dysfunction, and emotional dysregulation (Karaaslan & Hamamcı, 2020). Research conducted by Kausar et al. (2021) similarly found

that both PNES and epilepsy patients experience deficits in memory and concentration; however, cognitive complaints are often more strongly associated with psychological distress among PNES populations. Chronic stress and emotional burden may further contribute to cognitive dysfunction and reduced mental clarity among individuals experiencing recurrent seizure episodes (Brown et al., 2010). Therefore, the cognitive symptoms identified in the present study may represent clinically relevant indicators for differentiating seizure subtypes.

One of the strongest theme identified in participant's narratives is emotional and psychological distress. Participants consistently reported anxiety, panic attacks, sadness, fear, embarrassment, emotional instability and psychological stress all associated with seizure episodes. Many participants specifically linked seizure occurrence with stressful life events, financial burden, family conflicts, trauma experience and emotional suppression. These findings strongly supported by previous literature, the emotional dysregulation and psychological burden represent core underlying mechanism in psychogenic non-epileptic seizures (Reuber & Elger, 2003). Individuals with PNES reported significantly high level of depression, anxiety and emotional insatiability compared to individuals with non-epileptic seizures (Hopp et al., 2022). Traumatic experiences and chronic stress as major precipitating and perpetuating factors liked with psychogenic seizures (Bewley et al., 2005). The findings of current study therefore the biopsychosocial understanding of PNES in which emotional difficulties play a vital etiological role.

Another important finding of the current study involved dissociative experience reported by many participants. Individuals described the feelings of detachment from self and others, surroundings, emotional numbness, and sensations of unreality during or after seizure episodes. Detachment has consistently been recognized as an important psychological characteristic among PNES population (Brown et al., 2010) participant's narratives self-detachment and environmental unreality are consistent with findings reported in previous studies. Neurological disorders and dissociative mechanisms are associated (LaFrance et al., 2013). Dissociation may function as a maladaptive coping strategy in response to overwhelming emotional distress and traumatic experiences (Reuber et al., 2002). These findings indicated that dissociative symptoms may provide clinically useful information in distinguishing psychogenic seizures from neurological seizures.

The finding also highlighted substantial social and occupational difficulties associated with seizure experiences educational troubles occupational impairment, dependency on family members, stigma, social embarrassment, all collectively reduce quality of life. Younger individuals reported academic difficulties and social isolation while married and older highlighted occupational and family related issues band burden. The previous literature also supported the findings of current study, PNES significantly affects the social functioning educational attainment, interpersonal relationships and occupational performance (Kanner, 2021). Individuals with PNES frequently experience social stigma due to misinterpretation and misunderstanding of the symptoms (Kanemoto et al., 2017). The psychoscial burden identified in the current study reflects the long erm impact of seizure episodes on multiple domains of daily life functioning and further emphasize the important role of holistic psychological care.

Another significant dimension in participant's narratives is healthcare experiences. Many participants reported dissatisfaction with healthcare services, particularly about psychological concerns and lack of attention to emotional and mental health. Individuals commonly perceived that the healthcare providers only focus on medication management while they neglect the psychological difficulties and emotional sufferings. These findings also have evidences from previous literature, the ONES patients frequently experience invalidation of symptoms, inadequate psychological referral and delayed diagnosis (LaFrance et al., 2013). PNES requires multidisciplinary collaboration involving psychologist, psychiatrist, neurologist and neuropsychologist (Kanner, 2021). The current study suggests the need for improvement in

patient centered communication and bio psychosocial assessment approaches within psychiatric and neurological services.

This study therefore supports multidimensional conceptualization of seizure and seizure related disorders. The findings of current study indicated peri-ictal behavioral symptoms, cognitive impairment, psychological burden, emotional distress and healthcare experiences are interconnected dimensions that contribute to the seizure presentation and patient daily life functioning.

Implications of the Study

The findings of the present study have important implications for clinical practice, psychological assessment, research, and healthcare services. By exploring the lived experiences of individuals with seizure and seizure-like episodes, the study provides valuable insights into the multidimensional nature of psychogenic non-epileptic seizures (PNES) and epileptic seizures (ES). The identified themes and subthemes may contribute to improving the assessment and differentiation of these conditions, particularly in settings where advanced diagnostic tools such as video electroencephalography (vEEG) are not readily available.

From a clinical perspective, the findings highlight the importance of considering cognitive, emotional, psychosocial, and healthcare-related factors alongside physical symptoms during assessment. Healthcare professionals may benefit from adopting a more comprehensive bio-psychosocial approach when evaluating individuals presenting with seizure-like episodes. Such an approach may facilitate earlier identification of PNES and reduce the likelihood of misdiagnosis, unnecessary medical investigations, and inappropriate use of antiepileptic medications.

The study also has significant implications for scale development. The themes, subthemes, and codes identified through qualitative analysis provide an empirical foundation for generating culturally relevant items for a multidimensional screening scale aimed at differentiating PNES and ES. The resulting scale may serve as a useful screening instrument for neurologists, psychiatrists, psychologists, and other healthcare professionals working with seizure populations.

Furthermore, the findings emphasize the need for integrated mental health services within neurological care settings. Participants frequently reported emotional distress, psychological stress, social stigma, and dissatisfaction with healthcare experiences. These findings suggest that multidisciplinary collaboration among neurologists, psychiatrists, psychologists, and social workers may improve patient outcomes and quality of life. Psychological interventions addressing anxiety, stress, coping strategies, and psychosocial functioning may be particularly beneficial for individuals experiencing seizure-like episodes.

From a research perspective, the study contributes to the limited qualitative literature on seizure experiences within the Pakistani context. The findings provide a conceptual framework for future quantitative validation studies and may guide further investigations examining the psychological and social correlates of PNES and ES. Future research can build upon these findings to establish the reliability, validity, sensitivity, and specificity of the proposed screening scale.

Finally, the study has implications for public awareness and health policy. Increased awareness regarding the psychological and psychosocial aspects of seizure disorders may help reduce stigma, improve help-seeking behaviors, and promote more patient-centered healthcare services. The findings support the development of educational and training programs aimed at enhancing healthcare professionals' understanding of the complex interplay between neurological and psychological factors in seizure disorders.

Limitations and Recommendations of the Study

The current study has several limitations that should be consider when the interpretation of findings. First of all, the study was conducted on a small sample size (N=10), therefore the findings of current study cannot be generalized to all population with epileptic and non-epileptic seizure. Although detailed and rich data were

obtained, a greater and more diverse sample would enhance transferability.

Secondly, the current study relied on self-reported interviews, which may be affected by recall biasness, subjective interpretation of experiences and emotional distress. Some individuals may also have had accurately recalling seizure related events due to impaired cognitive awareness or memory issues.

Thirdly, the nonappearance of neurological and clinical confirmation (e.g., video-EEG) limits he diagnostic certainty in distinguishing psychogenic epileptic and non-epileptic seizure.

Finally, the cross-sectional design limits understanding of how psychological experiences and symptoms change over time. Longitudinal studies would provide deeper insight into the progression of these experiences.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.).

Benbadis, S. R., & Hauser, W. A. (2000). An estimate of the prevalence of psychogenic non-epileptic seizures. *Seizure, 9*(4), 280-281.

Benbadis, S. R., et al. (2006). Heart rate changes during seizures. *Epilepsy & Behavior, 8*(3), 529-531.

Bewley, S., Murphy, P. N., & Mallows, J. (2005). Alexithymia in psychogenic nonepileptic seizures. *Seizure, 14*(8), 575-582. https://doi.org/10.1016/j.seizure.2005.09.005

Boateng, G. O., et al. (2018). Best practices for developing and validating scales for health research. *Frontiers in Public Health, 6*, 149.

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health, 11*(4), 589-597. https://doi.org/10.1080/2159676X.2019.1628806

Braun, V., & Clarke, V. (2021). *Thematic analysis: A practical guide*. SAGE.

Brown, R. J., et al. (2010). Psychological characteristics of PNES. *Seizure, 19*(8), 446-456.

Brown, R. J., Syed, T. U., Benbadis, S., LaFrance, W. C., & Reuber, M. (2010). Psychological and psychiatric aspects of psychogenic nonepileptic seizures (PNES): A systematic review. *Clinical Psychology Review, 30*(6), 678-688. https://doi.org/10.1016/j.cpr.2010.05.006

Clark, L. A., & Watson, D. (1995). Constructing validity in scale development. *Psychological Assessment, 7*(3), 309-319.

DeVellis, R. F. (2017). *Scale development: Theory and applications* (4th ed.). Sage.

Duncan, R., et al. (2011). Nonepileptic Seizure Recognition Checklist. *Epilepsy & Behavior, 21*(1), 58-63.

Hopp, J., Anderson, K. E., & Kanner, A. M. (2022). Peri-ictal anxiety and depression changes in psychogenic nonepileptic seizures and epilepsy. *Frontiers in Psychiatry, 13*, 912697. https://doi.org/10.3389/fpsyt.2022.912697

Kanemoto, K., et al. (2017). ILAE PNES Task Force report. *Epilepsia, 58*(7), 1105-1119.

Kanemoto, K., LaFrance, W. C., Duncan, R., Gigineishvili, D., Park, S. P., Tadokoro, Y., & Perez, D. L. (2017). PNES around the world: Where we are now and how we can close the diagnosis and treatment gaps. *Epilepsia Open, 2*(3), 307–316. https://doi.org/10.1002/epi4.12060

Kanner, A. M. (2021). Diagnosing psychogenic nonepileptic seizures. *Journal of Clinical Psychiatry, 82*(3), 20ac13692.

Karaaslan, Ö., & Hamamcı, M. (2020). Cognitive impairment differences. *Neurological Research, 42*(3), 179-188.

Kausar, N., et al. (2021). Cognitive impairment comparison study. *Journal of Pakistan Medical Association, 71*(2), 436-441.

Kerr, W. T., et al. (2019). Reliability of peri-ictal behavior reports. *Seizure, 69*, 282-285.

LaFrance, W. C., Baker, G. A., Duncan, R., Goldstein, L. H., & Reuber, M. (2013). Minimum requirements for the diagnosis of psychogenic nonepileptic seizures: A staged approach. *Epilepsia, 54*(11), 2005–2018. https://doi.org/10.1111/epi.12356

LaFrance, W. C., et al. (2013). PNES treatment advances. *Neurology*, *81*(3), 226-236.

Nunnally, J. C., & Bernstein, I. H. (1994). *Psychometric theory* (3rd ed.). McGraw-Hill.

Reuber, M., & Elger, C. E. (2003). PNES review. *Epilepsy & Behavior*, *4*(3), 205-216.

Reuber, M., Pukrop, R., Bauer, J., Derfuss, R., & Elger, C. E. (2002). Multidimensional assessment of personality in patients with psychogenic non-epileptic seizures. *Journal of Neurology, Neurosurgery & Psychiatry*, *73*(6), 675–680. https://doi.org/10.1136/jnnp.73.6.675

Virginia Braun, V., & Victoria Clarke. (2021). *Thematic Analysis: A Practical Guide*. SAGE Publications

Widyadharma, I. P. E., et al. (2021). Clinical differentiation of PNES. *Egyptian Journal of Neurology, Psychiatry and Neurosurgery*, *57*, 132.

Xiang, X., et al. (2019). Semiology-based differentiation. *Acta Epileptologica*, *1*, 4. Virginia Braun, V., & Victoria Clarke. (2019). *Reflecting on reflexive thematic analysis*. Qualitative Research in Sport, Exercise and Health, 11(4), 589-597.