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Uncovering repressed emotions through lorazepam-assisted interview in dissociative convulsions: A case report with therapeutic implications

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INTRODUCTION

Dissociative disorders involve a disturbance or interruption in the typical integration of consciousness, memory, identity, emotions, perception, bodily awareness, motor functions, and behaviour (American Psychiatric Association, 2022; Koźmin-Burzyńska et al., 2015). Dissociative convulsions are seizure-like episodes that do not align with any known neurological disease, mental or behavioural disorder, or other medical condition (World Health Organization, 2022). The prevalence of dissociative disorders is around 10% (Sar 2011; Vijayan et al., 2025), whereas that of dissociative non-epileptic seizures is approximately 0.03–0.05% (Fritzsche et al., 2013; Kanemoto et al., 2017).

Dissociation generally occurs after experiencing a highly stressful event. Recognising the underlying psychological distress is essential for effective treatment (Avdibegović, 2012; Vijayan et al., 2025). While psychotherapy remains the primary approach, sodium amobarbital or benzodiazepine-assisted interviews have been employed for decades, particularly in cases where patients do not respond to pharmacological or psychological interventions (Fine, 2012; Mushtaq et al., 2014).

Drug-assisted interviews can aid in recalling memories and integrating dissociative experiences (Mallyam & Shanmugamurthi, 2021). Although amobarbital has been widely used over the years, the use of benzodiazepines has been on the rise, largely due to their lower risk of respiratory depression and the availability of a specific antidote (Jiang et al., 2020; Lee et al., 2011; Mushtaq et al., 2014; Stevens, 1990).

There are very few case reports on the use of lorazepam-assisted interview that have demonstrated therapeutic implications for non-epileptic seizures. We present a case of dissociative convulsions in which a lorazepam-assisted interview proved effective in retrieving repressed emotions and guiding subsequent treatment.

CASE DESCRIPTION

A 35-year-old devotional singer who was pre-morbidly well-adjusted was brought to the hospital by his parents with complaints of abnormal body movements for the past 6 months. The movements were associated with reduced responsiveness, drooping of eyelids and facial deviation, but there was no frothing from the mouth, incontinence or tongue bite. The movements were not rhythmic or symmetrical, and would last around 30–45 minutes, about 2–3 times a week. The episodes occurred primarily at home and only rarely at his workplace. The patient did not have any prior medical illnesses or psychiatric history, and family history was also insignificant. No abnormalities were detected on his routine blood workup, Electroencephalogram (EEG) and Magnetic Resonance Imaging (MRI) of the brain. A neurology opinion was sought, and anti-epileptic medication was initiated; however, the abnormal body movements persisted without improvement.

On examination, the patient was cooperative, his mood was euthymic, and he did not report any stressors. He reported no recollection of the episodes, and stated that he was not distressed due to the abnormal body movements. Cognitive functions were also within normal limits. History was also taken from his parents, which revealed that the patient got married 7 months back, though they did not report any interpersonal issues. Even after 2 months of weekly examination and sessions, the patient continued to have episodes of abnormal body movements, but did not express any concerns or worry.

For further diagnostic clarification and to unearth the possibility of any bottled-up stressors, informed consent was taken from the patient and family members and Lorazepam-assisted Interview was conducted. Weekly sessions of 40–45 minutes were taken, with a total of eight sittings. The procedure was explained and the patient was made to

lie down on the bed in a reclining position in the therapy room. He was given a minimum of 2 mg and a maximum of 4 mg till he felt relaxed. Protocol (Ilechukwu & Henry, 2006; Mallyam & Shanmugamurthi, 2021; Seo et al., 2013) for the lorazepam-assisted interview is shown in **Table 1**. Although the cited protocols describe intravenous administration, oral lorazepam was selected in this case to accommodate the patient's preference for a non-invasive route. This represented a case-specific adaptation rather than a validated oral protocol. Dosing was therefore titrated to clinical relaxation/mild drowsiness with vital-sign and pulse-oximetry monitoring, while flumazenil and emergency airway equipment were kept available.

Table 1: Case-specific Oral Adaptation of the Lorazepam-assisted Interview Protocol

Preparation
• Informed consent
• Patient placed in a reclining position
• Vitals monitoring tools, pulse oximetry, Electrocardiogram (ECG)
• Availability of antagonist (Flumazenil)
• Supply oral Lorazepam tablets (2-8mg dose)
• Readiness for emergency intubation kit
Procedure
• Vital signs and pulse oximetry
• Induction of hypnosis with 2-4mg Lorazepam till mild drowsiness
• Maintenance of hypnosis: up to 4mg more of Lorazepam can be given if patient is not relaxed
• Closing of interview: After 30-60 min
• Lorazepam to be withheld if oxygen saturation falls below 85%
• If oversedation or respiratory depression, Flumazenil 0.1mg/ml to be immediately administered intravenously
Termination
• Bed rest for 15-30 minutes after interview is over
• Close observation of vital signs and oxygen saturation

Note: The cited protocols describe intravenous lorazepam. This table summarizes the monitored oral adaptation used in this case according to patient preference and should not be interpreted as a standardized or validated oral dosing protocol.

The first session was conducted with the objective of developing rapport with the patient. The second session aimed to help the patient recollect his memories and identify any underlying conflicts. By the third and fourth sessions, he demonstrated the ability to articulate his distress and exhibited emotional release through repeated episodes of crying during the interview.

During these sessions, he reported ongoing difficulties in initiating and maintaining sexual activity since his marriage. He described reduced libido, erectile dysfunction, and marked anxiety surrounding sexual encounters. He further explained that these difficulties were worsened by an internal conflict arising from the religious vows taken at the solemnisation of his marriage. He felt that struggling with intimacy might mean he was failing to uphold those promises, which led to guilt and a fear that he was acting against his moral and religious principles.

These concerns appeared to be closely intertwined with broader relational and familial dynamics. During the fifth and sixth sessions, the patient reported that his marriage was arranged without his adequate consultation or involvement. He also reported that his parents pressured him to share a room with his wife to initiate sexual relations, which he found deeply uncomfortable but felt unable to resist because of his rigid and authoritarian upbringing. He described a childhood marked by economic hardship, noting that he was required to work from early adolescence, which curtailed his education and often involved night shifts that added further physical and emotional strain. He stated that he could not express his views or refuse demands at home due to his father's strict and controlling nature, reinforced by a highly religious household environment.

During these sessions, he detailed considerable distress related to his parents' coercive efforts to promote intimacy between him and his wife, which further strained his relationship with them, particularly with his father. He expressed emotional distress over his father's frequent negative remarks and comparisons with his brother, which made him feel inferior. He reported experiencing a sense of entrapment in a marriage he believed had been imposed upon him. Additionally, the patient expressed distrust and aversion toward his wife, whom he perceived as inferior to himself. Differences in background, values, and preferences exacerbated emotional distance and impeded intimacy.

Following catharsis during the lorazepam-assisted interview, previously unrecognised symptoms suggestive of a depressive episode emerged. The subsequent two sessions focused on resolving internal conflicts and interpersonal difficulties, and therapeutic suggestions were also used. Summary of the sessions during lorazepam assisted interview is described in **Table 2.**

The patient was started on Tablet Escitalopram 5 mg, increased to 10 mg within a week. Gottman Method Couples Therapy was initiated for the patient and his wife, with an emphasis on psychoeducation, building trust, communication, and addressing internalised beliefs. His parents were also psychoeducated, and further sessions

Table 2: Summary of Sessions during Lorazepam-assisted Interview

Sessions	Focus/Intervention	Patient Experiences and Key Findings
First and Second	Rapport building; helping recollection of memories and exploring potential conflicts	Established therapeutic relationship; patient began accessing past memories and identifying possible internal conflicts
Third and Fourth	Facilitating emotional expression and articulation of distress	Repeated crying spells; difficulty initiating and maintaining sexual activity; high anxiety around sexual encounters; guilt and fear related to religious vows
Fifth and Sixth	Exploring marital and family-related conflicts	Difficult childhood; marriage arranged without adequate consultation; parental pressure to initiate sexual relations; aversion toward wife
Seventh and Eighth	Catharsis and deeper conflict resolution; identification of emerging symptoms; therapeutic suggestions	Revelation of previously unrecognized depressive symptoms; focus on resolving internal conflicts and interpersonal difficulties

were conducted to address their heightened expressed emotions. Over the subsequent 6–8 weeks, the patient demonstrated clinical improvement, with a marked reduction in the frequency of abnormal body movements. Antiepileptic medication was gradually tapered and discontinued. He remained on regular follow-up for antidepressant treatment and psychotherapy. At the 3-, 4-, and 6-month follow-ups, a sustained reduction in the frequency of episodes was noted, along with gradual improvement in his marital relationship.

DISCUSSION

Dissociation most commonly occurs between the second and fourth decades of life, which is consistent with the age of our patient (Boland & Verduin, 2024; Sarisoy et al., 2015; Vijayan et al., 2025). Dissociative episodes have a strong association with highly stressful situations, including childhood sexual abuse or trauma (Avdibegović, 2012; Sar, 2011). Although no childhood sexual trauma was identified in our case, the patient described an adverse developmental environment characterised by a father who was profoundly authoritarian, emotionally rigid, and exerted pervasive control. Such early experiences may have shaped inflexible coping patterns and heightened sensitivity to interpersonal stress. Additionally, the presence of marked marital discord likely served as a significant psychosocial stressor. These factors together may have contributed to the patient's current symptomatology. Studies have also shown an association between dissociative disorders and depression (Gelder et al., 2003; Igwe, 2013; Sarisoy et al., 2015; Scopetta et al., 2025). Likewise in our case, symptoms of depression were unmasked after emotional expression was facilitated during the lorazepam-assisted interview, and the patient improved with Selective Serotonin Reuptake Inhibitor (SSRI) and therapy.

Despite limited case reports on lorazepam-assisted interviews in dissociative seizures, this method has been widely used for other types of dissociation (dissociative fugue, identity disorder and amnesia) to facilitate emotional expression and symptom relief (Jiang et al., 2020; Lee et al., 2011; Mushtaq et al., 2014; Seo et al., 2013; Vijayan et al., 2025). Lorazepam has gained preference in recent years due to its lower need for intensive monitoring compared to barbiturates, reduced risk of respiratory depression, and the availability of an antagonist for reversal (Jiang et al., 2020; Seo et al., 2013; Vijayan et al., 2025). Studies have recommended the use of 2–4 mg of Lorazepam in the preparation stage of the interview, followed by an additional 4 mg if sedation does not occur after 15 minutes (Ilechukwu & Henry, 2006; Seo et al., 2013). In our case, 4 mg of Lorazepam was required to attain the relaxed state. Research indicates that each session generally lasts between 30 to 60 minutes. While a single interview may be sufficient in some cases (Mushtaq et al., 2014; Vijayan et al., 2025), others may require multiple sessions spaced 7 to 10 days apart, depending on the patient's suggestibility (Mallyam & Shanmugamurthi, 2021; Seo et al., 2013). In the present case, eight sessions of 40 to 45 minutes were needed to achieve the therapeutic goal.

Recent reports provide additional context for abreaction beyond benzodiazepine-assisted interviewing. Rijal et al. (2025) described intravenous ketamine-assisted abreaction in a patient with depressive and dissociative symptoms, illustrating a pharmacologically distinct approach to facilitating emotional disclosure under close monitoring. Non-pharmacological trauma-processing

approaches have also documented abreaction during eye movement desensitization and reprocessing (EMDR): Pašalić and Hasanović (2018) reported a strong abreaction during bilateral stimulation in a case of childbirth trauma, while Šabanović (2021) described intense abreaction during EMDR processing in a complex trauma presentation. Together, these reports show that abreaction may occur across different facilitated therapeutic approaches and is not specific to a single medication or technique. They also underscore the importance of preparation, monitoring, containment, and subsequent psychotherapy. In the present case, oral lorazepam was used as a patient-preferred, case-specific adaptation. While this single case cannot establish the efficacy or generalizability of oral lorazepam-assisted interviewing, it adds to the limited clinical literature describing pharmacologically facilitated access to emotionally salient material in dissociative presentations and may provide a basis for further clinical investigation.

CONCLUSION

Drug-assisted interviews are valuable in managing dissociative disorders that are unresponsive to standard pharmacological or psychological interventions. Over time, benzodiazepines have become the agents of choice for these interviews due to their favourable side effect profile, effective outcomes, and lower potential for drug interactions. In this case, the lorazepam-assisted interview was pivotal in uncovering underlying stressors and guiding the treatment approach toward couple therapy, which proved essential in alleviating the patient's symptoms.

Ethical considerations: Does this study include human subjects? YES

Authors confirmed the compliance with all relevant ethical regulations.

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