Management of Functional Seizures

Diagnosis, co-occurring psychiatric disease and epilepsy, general care principles, psychological interventions, and pharmacologic avoidance for functional seizures.

2026 AAN Practice Guideline (Executive Summary)
Management of Functional Seizures
AAN Guidelines Subcommittee · Neurology
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LEVEL · B · Should (Moderate Confidence) · Background / Context

1 Diagnosis & Initial Workup

B	**Differential:** include functional seizures in the differential and initial workup of seizure-like/syncope-like episodes for prompt, accurate diagnosis.
B	**History:** seek historical and semiological information from patients and witnesses, including smartphone videos, when available.
B	**Video-EEG:** VEEG of all typical seizure-like episodes is the diagnostic gold standard where feasible; may obtain in acute prolonged episodes.

2 Co-occurring Psychiatric Disorders

B	**Evaluate:** screen for affective, trauma-related, personality, and substance use disorders to facilitate treatment of both conditions.
B	**Refer:** offer mental health referral for active co-occurring psychiatric disorders if not already receiving care.

3 Co-occurring Epilepsy

B	**Evaluate:** assess for co-occurring epilepsy (present in up to 20% of adults, 30%–40% of children with functional seizures).
B	**Distinguish:** use history, semiology, and VEEG where feasible to accurately identify and distinguish seizure types.
B	**Counsel:** discuss risks/benefits of antiseizure medications for epilepsy and their lack of efficacy for functional seizures.
B	**Treat:** prescribe appropriate antiseizure treatment for the epileptic seizure component when co-occurring epilepsy is present.

4 Communication & Engagement

B	**Communicate:** adhere to universal standards of respectful, non-stigmatizing care; provide a specific diagnostic label with a clear, empathetic rationale.
B	**Engage:** use shared decision making for the treatment plan; counsel on managing acute episodes and provide self-management resources.

5 Assessing Impact & Coordinating Care

B	**Assess impact:** ask about driving (per regional regulations) and occupational/social functioning to identify psychosocial needs.
B	**Coordinate:** neurologists and mental health clinicians should collaborate; provide continuity of care to support treatment and satisfaction.

6 Psychological Interventions

B	**Counsel:** when indicated and accessible, discuss potential benefits/risks to support shared decision making.
B	**Refer out** if counseling on psychological treatment is outside scope of practice, to a knowledgeable clinician.
B	**Refer for treatment:** refer interested, appropriate patients to psychological interventions to improve seizure frequency, quality of life, and function.
B	**Involve support system:** with permission, involve family/caregivers in adult treatment; involve family in treatment of children to improve outcomes.

7 Pharmacologic Interventions — Avoid

B	**Benzodiazepines:** counsel on risks and lack of benefit; do not prescribe for acute abortive treatment (no co-occurring epilepsy/indication).
B	**Antiseizure meds:** counsel on lack of benefit and potential risks; do not prescribe to reduce adverse-effect risk.
B	**Taper** off antiseizure medications when there is no other indication, to reduce risk of adverse effects.

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