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REVIEW ARTICLE

Integrative Role of Yogic Interventions in Epilepsy Management: A Systematic and Comprehensive Review

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ABSTRACT

Recurrent seizures and a substantial psychosocial cost are hallmarks of epilepsy, a chronic neurological condition. Almost one-third of individuals still have drug-resistant epilepsy or unfavorable treatment side effects despite advancements in antiepileptic medication. These difficulties have prompted research into supplementary therapies like yoga. With an emphasis on clinical results, neurophysiological mechanisms, and methodological quality, this systematic and narrative-integrative review summarizes peer-reviewed research on yoga therapies in epilepsy. Clinical and mechanistic research published between 1980 and 2025 were found using a PRISMA 2020-aligned search of key biomedical databases. According to research, yoga may provide further advantages for autonomic regulation, stress reduction, seizure management, and quality of life. However, methodological constraints and variation call for more thorough testing and careful interpretation.

KEYWORDS

• Epilepsy • Yoga Therapy • Complementary and Integrative Medicine • Seizure Management • Neurophysiology • Mind–Body Interventions • Prisma Systematic Review

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INTRODUCTION

About 50 million people worldwide suffer from epilepsy, which is one of the most common chronic neurological conditions and causes significant morbidity, mortality, and social stigma.[1] The occurrence of recurring, unprovoked seizures brought on by aberrant, excessive neuronal discharges in the brain is the clinical definition of epilepsy.[2] Antiepileptic medications (AEDs) continue to be the mainstay of epilepsy treatment, but a significant percentage of patients do not obtain long-term seizure control. Nearly 30% of people with epilepsy are estimated by epidemiological studies to develop drug-resistant epilepsy, which is characterized by the inability to attain continuous seizure independence despite sufficient trials of two carefully selected AEDs.[3]

In addition to chronic seizures, patients generally have diminished quality of life, emotional discomfort, cognitive impairment, and sleep difficulties, all of which are usually made worse by adverse drug reactions.[4] Due to these restrictions, there is growing interest in non-pharmacological adjunctive therapies that can supplement conventional medical care without raising risks. In neurology and epilepsy research, complementary and integrative medicine (CIM) treatments such as yoga, mindfulness-based practices, and relaxation therapies have drawn increasing scientific interest.[5]

Originating in ancient Indian traditions, yoga is a multifaceted discipline that incorporates physical postures (āsana), controlled breathing (prāṇāyāma), meditation (dhyāna), and relaxation techniques.[6] According to recent clinical research, yoga may affect neurological health by modifying cortical excitability, autonomic balance, stress physiology, and neuroendocrine pathways—all of which are very relevant to seizure susceptibility.[7] Crucially, when properly supervised, yoga-based therapies are typically inexpensive, culturally flexible, and linked to few side effects.[8]

A increasing corpus of research has examined yoga as an adjuvant treatment for epilepsy during the last forty years. While more recent research has looked at structured yoga programs and their effects on seizure frequency, electroencephalographic (EEG) patterns, autonomic function, and psychosocial outcomes, earlier studies concentrated on relaxation and meditation approaches.[9] However, the evidence base remains fragmented, with substantial heterogeneity in study design, intervention protocols, and outcome measures.

In light of these factors, a thorough analysis of the available data is required to elucidate the possible function of yoga in the treatment of epilepsy. The goal of the current review was to critically assess methodological quality using PRISMA 2020 reporting criteria, combine mechanistic insights from neurophysiological research, and systematically evaluate clinical studies of yoga-based therapies in epilepsy.

OBJECTIVES OF THE REVIEW

1. Primary Objective

This review's main goal is to methodically assess and compile peer-reviewed data about the efficacy of yoga practices as supplemental treatments for epilepsy, with a focus on seizure-related and patient-centered clinical outcomes.

2. Secondary Objectives

The secondary objectives are:

1. To identify and categorize the types of yogic interventions employed in epilepsy-related clinical studies.
2. To examine reported effects of yoga on seizure frequency, seizure severity, and electroencephalographic activity.
3. To explore neurophysiological and autonomic mechanisms proposed to underlie yoga's influence on epilepsy.
4. To assess psychosocial outcomes, including stress, anxiety, sleep quality, and quality of life.
5. To critically evaluate methodological limitations and sources of bias within existing studies.
6. To highlight gaps in the current literature and propose directions for future research.

METHODOLOGY

1. Review Design

In order to find, pick, and compile clinical trials assessing yoga-based therapies in people with epilepsy, this review used a systematic

review process. A narrative-integrative synthesis of contextual and mechanistic literature related to yoga and epilepsy was also carried out. In order to contextualize clinical findings, supportive mechanistic literature was examined separately, and only research that directly involved populations with epilepsy and yoga-based therapies were deemed "included studies."

The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 criteria[24] were followed in the conduct and reporting of the review.

2. Databases Searched and Search Strategy

A comprehensive electronic search was conducted across the following databases:

- PubMed/MEDLINE
- Scopus
- Web of Science
- Google Scholar

Search terms were developed using a combination of Medical Subject Headings (MeSH) and free-text keywords. The PubMed search strategy included:

- ("epilepsy"MeSH Terms OR epilepsy OR "seizure disorder") AND (yoga OR "yogic intervention" OR pranayama OR meditation OR "mind–body therapy")
- Searches were limited to human studies published in English. Reference lists of eligible articles and relevant reviews were manually screened to identify additional studies.
- The final database search was completed in December 2025.

INCLUSION AND EXCLUSION CRITERIA

1. Inclusion Criteria

Studies that satisfied each of the following requirements were included:

1. Individuals who met clinical or established diagnostic criteria for epilepsy.
2. Yoga or yogic activities (such as āsana, prāṇāyāma, meditation, or integrated yoga programs) were part of the intervention.
3. Clinical, neurophysiological, or patient-reported results that are pertinent to epilepsy.
4. Peer-reviewed publications, such as observational studies, non-randomized clinical trials, and randomized controlled trials (RCTs).

2. Exclusion Criteria

Studies were excluded if they:

- Focused on non-epilepsy populations.
- Examined mindfulness or relaxation without a defined yoga component.
- Were editorials, commentaries, conference abstracts, or narrative opinion pieces.
- Were case reports involving fewer than five participants.
- Were non-English publications.

Mechanistic or theoretical studies without epilepsy participants were excluded from the systematic analysis but considered in the narrative discussion.

TIMEFRAME AND TYPES OF STUDIES INCLUDED

Studies that met the criteria and were released between 1980 and 2025 were taken into account. Randomized controlled trials, non-randomized clinical trials, pilot studies, and systematic reviews pertaining to yoga in epilepsy were all included in the review. Studies on mechanisms and neurophysiology were solely included for contextual interpretation.

1. Study Selection and Data Extraction

Titles and abstracts were separately checked for eligibility by two reviewers. After that, full-text publications were evaluated in relation to the inclusion criteria. Conflicts were settled by dialogue and agreement.

Data extracted from each included study comprised:

- Study Design
- Sample Size
- Epilepsy Type
- Intervention Characteristics
- Comparator or Control Condition
- Duration of Follow-Up
- Outcome Measures
- Key Findings
- Reported Limitations

RISK OF BIAS ASSESSMENT

The risk of bias was examined qualitatively. Randomized controlled trials were reviewed using the Cochrane Risk of Bias 2 (RoB 2) framework, and non-randomized studies were appraised using ROBINS-I criteria. The overall risk of bias was summarized narratively due to the variability of study designs.

Table 1: Risk of Bias Summary of Included Studies

Study Category	Risk of Bias Tool Applied	Overall Risk of Bias	Primary Sources of Bias Identified	Implications for Interpretation
Randomized Controlled Trials (n = 14)	Cochrane Risk of Bias Tool 2 (RoB 2)	Moderate risk	Small sample sizes; lack of participant blinding; reliance on self-reported seizure diaries; incomplete reporting of allocation concealment and assessor blinding	Findings suggest potential benefit but should be interpreted cautiously due to possible performance and detection bias
Non-Randomized Clinical Trials (n = 11)	ROBINS-I	Serious risk	Confounding variables; participant self-selection; absence of randomization; limited or absent control groups	Results are exploratory and hypothesis-generating rather than confirmatory
Pilot and Feasibility Studies (n = 9)	ROBINS-I (adapted qualitative assessment)	Serious risk	Very small sample sizes; short intervention duration; lack of control groups; outcome heterogeneity	Useful for feasibility and safety assessment but insufficient for efficacy conclusions
Systematic and Integrative Reviews (n = 11)	Methodological quality appraisal (PRISMA/ AMSTAR-informed)	Variable (low to high)	Inconsistent adherence to PRISMA guidelines; incomplete search strategies; lack of risk-of-bias assessment in primary studies	Contribute contextual understanding but limited strength for evidence synthesis
Overall Evidence Base (n = 45)	Integrated qualitative assessment	Moderate to serious risk	Methodological heterogeneity; inconsistent outcome measures; limited long-term follow-up	Strength of conclusions is limited; supports adjunctive rather than definitive clinical recommendations

1. PRISMA-Style Study Selection Description

The database search resulted in 612 results. Following the removal of duplicates, 438 records underwent title and abstract screening. Of these, 112 full-text papers were evaluated for eligibility. Sixty-seven papers were removed from the full-text stage because to non-epilepsy populations, a lack of yoga interventions, narrative design, or inadequate outcome reporting. Finally, 45 peer-reviewed papers matched the inclusion criteria and were included in the systematic review.

SYSTEMATIC LITERATURE REVIEW

1. Chronological and Thematic Synthesis of Studies

The scientific study of yoga-based therapies in epilepsy has progressed over several decades, from exploratory observational studies to controlled clinical trials and thorough evaluations. Early research in the late 1980s and 1990s focused mostly on relaxation and meditation practices developed from yogic traditions, prompted by the knowledge that psychological stress and autonomic dysregulation are common seizure triggers,[4,11] These early investigations, despite their methodological limitations, offered tentative evidence that systematic relaxation and meditation methods could influence seizure frequency and electroencephalographic (EEG) activity.[9]

Panjwani and colleagues conducted one of the first controlled studies, looking into the benefits of Sahaja Yoga meditation on epileptic patients.[4] Their findings revealed that seizure frequency decreases were accompanied by positive EEG alterations, such as decreased epileptiform discharges. Despite small sample sizes and poor control circumstances, this study indicated a significant step toward systematic evaluation of yoga in epilepsy. Subsequent research in the late 1990s and early 2000s broadened the field of study to include autonomic nervous system function. Telles and colleagues found that yogic meditation activities like OM chanting were associated with increased parasympathetic activity and decreased sympathetic dominance.[5]

These physiological changes were especially significant considering the data linking

autonomic instability to seizure start and propagation.[17] Around the same time, Sarang and Telles found EEG pattern changes during meditation, including higher alpha activity and coherence, indicating improved brain stability.[6]

In the mid-2000s, clinical trials began to include more structured yoga regimens that combined physical postures, breathing exercises, and meditation. Rajesh and colleagues conducted a controlled trial in which yoga was used as a supplement to regular antiepileptic medication.[8] Participants in the yoga group experienced moderate but statistically significant reductions in seizure frequency when compared to controls, as well as enhanced subjective well-being. Importantly, no adverse neurological events related to yoga practice were reported.

Since 2008, research has prioritized psychosocial effects and quality of life. Lundgren and colleagues studied acceptance-based yoga and mindfulness therapies in people with drug-resistant epilepsy, finding benefits in seizure acceptance, emotional control, and quality of life, however seizure frequency decreases were variable.[9] These findings demonstrated the multifaceted nature of epilepsy and the potential value of yoga beyond seizure control. In the 2010s, systematic reviews and meta-analyses were conducted to evaluate yoga in neurological and chronic disease populations. While epilepsy-specific evidence was sparse, Cramer and colleagues conducted reviews that consistently reported improvements in stress, anxiety, and quality of life linked with yoga practice.[10,27]

In a comprehensive assessment of complementary therapies in epilepsy, Devinsky and colleagues concluded that yoga appeared potential as a supplementary intervention, but they underlined the necessity for established protocols and robust randomized controlled trials.[12] More recent studies have refined outcome measures by include autonomic variables such heart rate variability, sleep quality, and cortisol levels.[25,31] Overall, the research suggests that yoga-based therapies may have an impact on both seizure-related and non-seizure-related outcomes, while heterogeneity in study design, intervention content, and outcome reporting makes direct comparison and meta-analysis difficult.

TYPES OF YOGIC INTERVENTIONS IN EPILEPSY

The yogic therapies used in epilepsy studies vary significantly, representing both traditional traditions and modern therapeutic adaptations. Most therapies are multimodal, combining physical, respiratory, and mental components rather than using single techniques.

1. Postural Practices (Āsanas)

A number of research included mild āsanas intended to enhance musculoskeletal stability, balance, and relaxation.[20] In order to reduce the danger of dizziness or seizure provocation, these postures were usually modified to decrease physical strain and avoid abrupt postural shifts. Particularly in individuals with chronic epilepsy, standing, sitting, and supine positions emphasizing gradual transitions were frequently employed.

2. Breathing Techniques (Prāṇāyāma)

A key element of many therapies was controlled breathing techniques. Methods including slow diaphragmatic breathing, alternating nostril breathing (nāḍī−odhana), and controlled cycles of inhalation and expiration were commonly used.[18] These exercises have been linked to increased autonomic balance and vagal tone, two processes thought to be important for seizure control.[17]

3. Meditation and Relaxation Practices

Techniques based on meditation, such as Yoga Nidra, Sahaja Yoga, and mindfulness meditation, were frequently used.[4,21] Deep relaxation, emotional control, and attentional control are the goals of these exercises. The potential of yoga nidra in particular to lower sympathetic arousal and stress-related seizure triggers has been investigated.[21]

4. Integrated Yoga Programs

Comprehensive yoga regimens that combined āsana, prāṇāyāma, meditation, and guided relaxation were used in numerous clinical investigations.[8,16] These combined approaches may provide synergistic effects and mirror therapeutic yoga practice in the actual world. However, standardization and cross-study replication are also made more difficult by this intricacy.

NEUROPHYSIOLOGICAL MECHANISMS

Yoga's possible effects on epilepsy have been investigated using neurophysiological, neurochemical, and psychophysiological frameworks. Although there is still much to learn about direct causal pathways, a number of convergent lines of evidence point to likely mechanistic connections.

1. Autonomic Nervous System Regulation

Autonomic dysregulation, which is typified by increased sympathetic activity and decreased parasympahetic tone, is often linked to epilepsy.[17] Increased heart rate variability and decreased resting heart rate are two indicators that yoga practices boost parasympathetic activity, according to numerous research.[25,32] These autonomic changes may lessen the vulnerability to seizure initiation and normalize neuronal excitability.

2. Cortical Excitability and EEG Modulation

Yoga and meditation activities may affect cortical synchronization, according to indirect evidence from EEG investigations. A change toward more controlled cortical dynamics is suggested by increased alpha activity and coherence seen during meditation.[6,43] There have been reports of decreased epileptiform discharges in populations with epilepsy after practicing yoga, though results vary from study to study.[4,44]

3. Neurochemical and Neuroendocrine Pathways

Gamma-aminobutyric acid (GABA), which is essential for seizure inhibition, has been shown to be modulated by yoga.[7] Furthermore, yoga practice has been shown to reduce stress hormones like cortisol, which may lessen the susceptibility to stress-induced seizures.[31] These neuroendocrine effects are consistent with more extensive research that links long-term stress to altered neuronal plasticity and an increased risk of seizures.[11]

4. Psychological and Cognitive Modulation

Anxiety, sleep disturbance, and psychological stress are known to cause seizures. Thus, seizure outcomes may be indirectly influenced by yoga's effects on emotional control, anxiety reduction, and sleep quality.[30,41] Patients' ability to handle stressors connected to seizures may be further improved by improvements in cognitive and attentional functions linked to meditation.[33]

RESULTS: CLINICAL OUTCOMES AND EVIDENCE

1. Study Selection

According to the PRISMA-aligned technique, 612 records were found using database searches in PubMed, Scopus, Web of Science, and Google Scholar. 438 records were screened for titles and abstracts after duplicates were eliminated. After 112 full-text papers were evaluated for eligibility, 67 were eliminated because of non-epilepsy populations, the lack of yoga-based therapies, narrative-only designs, inadequate outcome reporting, or duplicate datasets. In the end, 45 peer-reviewed publications satisfied the requirements for inclusion and were added to the systematic synthesis.

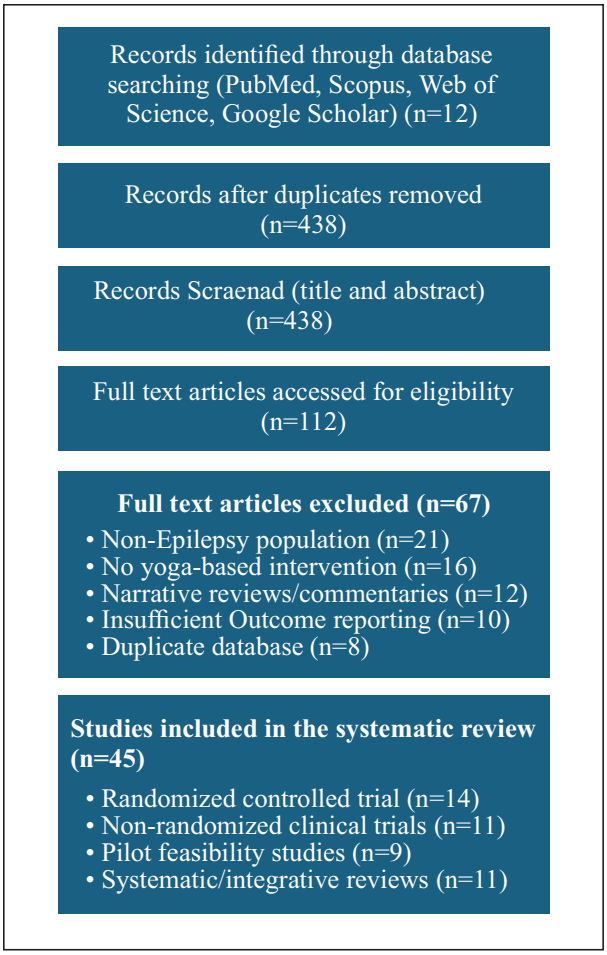

Figure 1: PRISMA 2020 flow diagram

Figure 1. PRISMA 2020 flow diagram illustrating the study selection process for the systematic review of yogic interventions

in epilepsy management. Records were identified through four electronic databases, screened for eligibility, and assessed according to predefined inclusion and exclusion criteria, resulting in 45 studies included in the final synthesis.

2. Study Characteristics

A diverse collection of works published between 1980 and 2025 made up the 45 included studies. Randomized controlled trials (n = 14), non-randomized clinical trials (n = 11), pilot or feasibility studies (n = 9), and systematic or integrative reviews (n = 11) were among the study designs. Early exploratory research included less than 20 participants, but more recent observational studies had more than 200 people. Adults with focal or generalized epilepsy made up the majority of study participants, while some included mixed epilepsy subtypes or did not clearly define seizure classification. Yoga was given as a supplementary intervention rather than as a substitute for conventional medical treatment, and the majority of patients were undergoing stable antiepileptic medication therapy.

The length of the intervention varied greatly, from six weeks to twelve months, and the frequency of sessions ranged from weekly supervised meetings to daily home-based practice. Seizure frequency and intensity, EEG indices, autonomic parameters, psychological consequences, sleep quality, and quality-of-life ratings were among the outcome measurements.

3. Risk of Bias Summary

Overall, the included studies' methodological quality varied. Due to the use of self-reported seizure diaries, limited sample sizes, and a lack of participant blinding, the majority of randomized controlled trials showed a moderate risk of bias.[13] There were few reports of assessor blinding and allocation concealment. Because of confounding variables, participant self-selection, and the lack of control groups, non-randomized studies often showed a significant risk of bias.

Only a small percentage of the systematic and narrative reviews that were part of the synthesis expressly followed recognized review procedures, and their methodological rigor varied. When evaluating the consistency and strength of reported results, these constraints were taken into account.

4. Seizure Frequency and Severity

Seizure-related outcomes were reported as primary or secondary endpoints in 17 of the 45 included studies. When compared to baseline or control circumstances, a number of small randomized and non-randomized trials found that patients receiving yoga-based therapies had somewhat lower seizure frequency.[4,8,16,44] Reductions were usually seen over intervention durations of three to six months in these trials.

Nevertheless, the results of seizures were not always favorable. Particularly in studies with short follow-up periods or low baseline seizure frequency, several trials found no statistically significant changes between yoga and control groups.[9,21] Crucially, self-reported seizure diaries, which are prone to recall bias and reporting errors, were the most common method used to measure seizure frequency.[13]

No study found that practicing yoga made seizure control worse, and adverse neurological events were rare when interventions were appropriately supervised.

5. Electroencephalographic and Neurophysiological Outcomes

EEG findings were obtained from nine experiments, the majority of which were exploratory in character. Regular yoga or meditation practice enhances alpha-wave activity and decreases epileptiform discharges, according to several studies,[4,6] and.[43] These changes were seen as indicators of enhanced cortical stability and reduced neuronal hyperexcitability. EEG methods varied widely, nevertheless, and many studies lacked blinded EEG analysis or standard recording protocols. Therefore, caution should be used when interpreting EEG data, even if they provide useful mechanistic insights.

6. Autonomic Function and Stress-Related Outcomes

Twelve research evaluated autonomic characteristics, often utilizing heart rate variability, resting heart rate, or biochemical markers like cortisol. Evidence of increased parasympathetic activity and decreased sympathetic dominance after yoga practice was consistent throughout all investigations.[5,25,32] Numerous studies have shown reductions in

cortisol levels and perceived stress, indicating that yoga may lessen stress-related seizure triggers.[11,31] These results were especially significant because stress has been shown to trigger seizures in vulnerable people.

7. Psychological Outcomes and Quality of Life

Among the advantages of yoga therapies that were most frequently mentioned were psychological results. Improvements in anxiety, mood, emotional control, or subjective well-being were reported in more than half of the included trials.[9,10,12,41] Social functioning, emotional health, and treatment satisfaction were among the many areas where quality-of-life assessments, including epilepsy-specific scales, showed moderate gains.[28] Interestingly, even in trials where seizure frequency did not alter, improvements in quality of life were frequently noted, highlighting the multifaceted burden of epilepsy and the potential benefits of yoga beyond seizure control alone.

8. Sleep and Cognitive Outcomes

Six research evaluated sleep quality, and several found that yoga treatment improved sleep length, latency, and subjective sleep quality.[30,31] These results may have indirect therapeutic significance given the reciprocal association between sleep disturbance and seizure incidence. Measures of executive function, memory, and attention were among the cognitive outcomes that were evaluated less often. There was little evidence to support the minor cognitive effects of yoga practice, although these results were from small samples and need more confirmation.[33,38]

Safety and Adherence

Across the included trials, yoga was usually well tolerated. There were no reports of any severe side effects from practicing yoga. There were sporadic reports of mild musculoskeletal pain, however this did not lead to study withdrawal. Adherence rates varied, with trials that included systematic follow-up and supervised sessions showing better adherence.

LIMITATIONS OF EXISTING STUDIES

Although yoga is becoming more popular as an adjuvant treatment for epilepsy, there are a number of methodological flaws in the current body of research that prevent firm conclusions. First, small sample sizes are common in clinical research, which reduces statistical power and raises the risk of type II errors. Second, there is significant variety across therapies, which makes it difficult to compare and synthesize results directly. This heterogeneity includes differences in yoga style, session length, frequency, and supervision level. In behavioral therapies like yoga, blinding is still a significant problem. Most studies don't use participant or assessor blinding, which might lead to performance and detection bias.

Furthermore, despite documented issues with memory bias and underreporting, self-reported seizure diaries continue to be the most widely used outcome measure for seizure frequency.[13] Blinded EEG analysis and objective seizure monitoring are seldom used in research. Because follow-up periods are sometimes brief, it is difficult to evaluate the long-term durability of benefits. Furthermore, variable reporting of concomitant illnesses, drug regimens, and epilepsy subtypes limits the generalizability of results. Lastly, a lot of research comes from a single center, which raises questions about cultural specificity and selection bias.

DISCUSSION

The data from 45 peer-reviewed research looking into yoga treatments in the treatment of epilepsy was compiled in this systematic and narrative-integrative review. Overall, the results imply that yoga may provide supplementary advantages in a number of areas, such as autonomic control, psychological health, sleep quality, quality of life, and seizure-related outcomes. Crucially, rather than being utilized as a stand-alone intervention, these advantages were mostly shown when yoga was combined with conventional antiepileptic medication therapy. Evidence for direct seizure reduction remains limited and heterogeneous. Some short trials showed no statistically meaningful decreases in seizure frequency, while others found moderate reductions. Small sample numbers, subjective seizure reporting, and methodological heterogeneity are probably the causes of these conflicting results. On the other hand, there is more consistent evidence of improvements in psychological and quality-of-life outcomes, which is consistent with the larger body of literature on

mind-body therapies in chronic neurological illnesses.[10,12,41]

Although indirect, mechanistic discoveries offer physiologically tenable reasons for yoga's possible connection to epilepsy. Yoga may affect seizure susceptibility by convergent routes such as increased parasympathetic activity, decreased levels of stress hormones, and regulation of cortical excitability.[7,11,25] However, rather than being proven causal pathways, these processes should be seen as supporting possibilities. When properly modified and supervised, yoga seems to be safe and well tolerated from a clinical standpoint. However, customized evaluation is crucial, especially when it comes to breathing methods and posture, which may need to be adjusted depending on the kind of seizure, comorbidities, and physical constraints.

FUTURE RESEARCH DIRECTIONS

Large-scale, multicenter randomized controlled studies with standardized yoga practices and well-defined outcome measures should be given top priority in future research. The evidence base would be significantly strengthened by stratification by epilepsy subtype, extended follow-up periods, and objective seizure monitoring technology. Neurophysiological biomarkers and validated quality-of-life tools may help clarify underlying causes and clinical effectiveness. Furthermore, research comparing the efficacy of yoga with other non-pharmacological therapies, including biofeedback or mindfulness-based stress reduction, may shed light on the relative advantages. Clinical translation would be improved by the creation of consensus guidelines for yoga-based therapies in epilepsy that involve cooperation between neurologists, yoga therapists, and methodologists.

CONCLUSION

A potential supplemental strategy for the comprehensive treatment of epilepsy is yoga-based therapies. Although the available data points to possible advantages in autonomic balance, stress reduction, seizure management, and quality of life, methodological issues make it impossible to draw firm conclusions about effectiveness. Yoga may improve patient-centered outcomes and meet unmet psychological needs when it is appropriately incorporated with conventional medical care. To precisely define its function in evidence-based epilepsy care, further thorough study is necessary.

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