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Believing is power: Physicians' first step in treating functional neurological disorders



Functional neurological disorder (FND) has been considered a contentious topic in neurology literature. While one of the most misunderstood and poorly managed conditions in neurology, it is beginning to receive deserved attention. Since initial academic recognition in the 19th century, burgeoning research in recent years has led to adoption and streamlining of “functional” terminology, modified diagnostic criteria, and marked growth of research publications from around the globe.

Historically, FND has been assumed to be primarily psychogenic, suggesting that symptoms are a physical manifestation of psychological distress. Several diagnostic criteria for functional movement disorders (FMDs; a subtype of FND) have been published over the years including the original proposal by Fahn and Williams [1], an updated version by Shill and Gerber [2], and subsequent revision by Gupta and Lang [3] that incorporated ancillary electrophysiological assessments. The evolution of criteria reflects ongoing advancement of our understanding of FMD. However, one aspect that appears to have remained the same is how documented or clinically definite FMD is defined: remittance of symptoms when the patient feels unobserved. This specific metric may lead to an unintended impression that symptoms experienced by patients with FMD may be voluntary and non-disabling.

New studies have allowed better understanding of the brain's complex volitional motor system and its biopsychosocial associations. For example, recent fMRI research has demonstrated distinct differences in resting-state connectivity for those with FND versus healthy controls [4]. Research developments have helped to create nascent guiding principles for diagnosing and treating FND in an evidence-based and non-judgmental approach.

The road to improving FND care is not without barriers. As predicted by Edwards, Stone, and Lang in their 2013 article [5], a change in diagnostic label, from “psychogenic” to “functional” may not necessarily mean a change in historical beliefs and associated stigma. Rebranding is a meaningless activity if healthcare providers do not believe in the diagnosis itself. FND patients often complain of feeling dismissed or that symptoms are minimized because of functional etiology. In a systematic review of 21 qualitative studies of patients' accounts of living with paroxysmal nonepileptic seizures (PNES; a subtype of FND), one of the main themes emerged was the concern that healthcare professionals would doubt the truthfulness of their symptoms [6]. The mismatch in perceptions between providers and patients may create mistrust and medical noncompliance. Another PNES study demonstrated a considerable difference between neurologists' and patients' beliefs about the volitional control that patients may exert over their symptoms, which could lead to lack of trust and agreement some patients report after receiving the diagnosis [7].

In this issue of Parkinsonism and Related Disorders, the current article

underlines the importance of better understanding functional tremor phenomenology and how it may compare to that of more organic tremor. In contrast to previous studies [8], results suggest that the objective duration of functional tremor is more persistent than previously reported in other studies. The study also indicated that tremor does not significantly alleviate outside of acute observation, such as during medical appointments. Moreover, the functional tremor patients reported similar subjective symptom burden compared to organic tremor patients.

The current study findings highlight the need to earnestly address patients' FND symptoms. A predictor of successful treatment is effective communication of the initial diagnosis as well as validation from the medical provider that the patient's symptoms are real and are causing distress and impairment. Given that more emphasis has been placed on identifying positive clinical features in the diagnostic process, the practical utility and validity of the “remittance of symptoms while unobserved” criterion for clinically definite FND may need to be revisited. While it has been advocated that one of the first steps in FND treatment is patient education and their acceptance of the diagnosis, we would add that the very first step toward a successful treatment is believing in your patients' symptoms. Through trust and communication, an effective patient-provider alliance may be achieved.

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Associate Staff, Functional Movement Disorders Program Co-Director
Taylor E. Rush*, Xin Xin Yu
Center for Neurological Restoration, Cleveland Clinic Foundation, United States
E-mail address: rusht@ccf.org (T.E. Rush).

* Corresponding author. 9500 Euclid Ave, C15, Cleveland Clinic Foundation, Cleveland, OH, 44195, United States.