LETTER TO THE EDITOR

The Problem of Functional

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Functional neurological disorder is an entity that is commonly referred to by names such as psychogenic or conversion disorder. It is defined as a neurological disorder caused by psychological factors, falling into the category of somatic symptom disorders in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V). Some well-known examples of somatic symptom disorders involving other organ systems include irritable bowel syndrome, interstitial cystitis, and chronic pelvic pain.

Patients with functional disorders are seen in various clinical settings and are commonly admitted as an inpatient for further work-up and symptom management. Those with neurological symptoms in particular may receive work-up beyond the scope of being thorough, as their symptoms can be concerning for neurological disorders such as stroke, epilepsy or multiple sclerosis. Physicians may ultimately become convinced that these patients’ symptoms are due to a psychological cause, but convincing these patients may not be easy, as the suffering is real but the treatment is not instantaneous.

As a movement disorders clinical fellow, I often see patients with functional movement disorders. Functional movement disorders can present in various ways such as tremor, myoclonus, or dystonia, but share common clinical features on examination such as variability, distractibility and entrainability of the movements. Although the term psychogenic is considered to be less ambiguous than functional, its negative nuance may add to the patients’ struggle to accept the diagnosis. Some common reactions are: “Are you saying it is all in my head?” “I find it hard to believe that what I am experiencing is just from stress.” “...but I don't feel stressed.”

Through my fellowship, I have tried different ways of delivering the diagnosis of a functional movement disorder. My strategy has evolved with experience, a mix of successful and unsuccessful situations. For example, the patient might seem to be initially receptive of the diagnosis and considering the recommended treatment options with a positive attitude. When this appeared to be the case, I would feel not only relieved, but also a sense of triumph-I had successfully dealt with a challenging situation, and now surely the patient would be on the road to recovery! I quickly realized that this was not always the case. In the following days, I would receive emails doubting or misinterpreting the diagnosis that seemed to be clear at the time. Some patients seemed unhappy, if not angry or disappointed. I would often review the approach that I had used to deliver the diagnosis on the day of the visit, and try to revise my strategy accordingly, hoping to be more successful the next time.

Several reasons may underlie this difficulty of accepting the diagnosis of a functional disorder. Currently, the knowledge on the physiology of the disorder is limited, and we cannot satisfactorily explain to these patients exactly how this occurs, which may add to the patient’s skepticism towards the diagnosis. The variability of symptoms, a common feature of the disorder itself, may confuse and deceive the patients, leaving them to wonder what rare organic neurological disorder they might have as the cause. Last but not least, patients may be influenced by the stigma of having any disorder that has relation to psychological factors, and even misinterpret the diagnosis as malingering, an intentional production of symptoms.

But do we physicians also have difficulty embracing the diagnosis of a functional disorder? Some patients are seen by several physicians and undergo extensive testing until seen by someone who might finally share the diagnosis. It is not unusual that this can be years later since the beginning of symptoms. Delivering the diagnosis is certainly challenging for reasons mentioned above, and physicians fear missing an organic neurological disorder. However, simply labeling these patients as having 'medi-
cally-unexplained symptoms' not only leads to increased healthcare cost, but can result in increased morbidity and mortality from unnecessary diagnostic workup or treatment.

“How can you tell me it’s functional when I am not functional?” The words of a patient echo through my head as I share this diagnosis with yet another patient. I only hope to be able to help my patients so that they understand that the diagnosis was achieved through identifying positive signs and symptoms, and that it is not merely a diagnosis of exclusion. I try to reassure them that this disorder is very much real, involuntary and acknowledge that it can be very disabling. Some patients have accepted the diagnosis and made a substantial recovery through cognitive behavioral therapy. Hopefully, with more knowledge on the physiology, increased awareness of the disorder in both patients and the medical community and better strategies of sharing the diagnosis—functional—can one day become truly functional.

Conflicts of Interest
The author has no financial conflicts of interest.

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