Dr Laila Paruk, Psychiatrist, Johannesburg
drparuk@psychiatryvillagemed.co.za

FUNCTIONAL NEUROLOGICAL SYMPTOM DISORDERS

Functional disorders are conditions, such as irritable bowel syndrome, fibromyalgia, and functional neurological symptom disorder (FNSD) — whose origin arises primarily from a disorder of nervous system functioning rather than clearly identifiable pathophysiological disease. They are the second most common reason for new neurology consultations. The exact prevalence of FNSD is unknown, however an estimated incidence rate of between 4 and 12 per 100 000 population per year has been reported.

One definition of FNSD is as a disorder of the voluntary motor or sensory system, with symptoms that can be positively identified as internally consistent or incongruent with recognised pathophysiological disease. It's recognised in ICD-11 as an acute dissociative disorder with neurological symptoms.

FNSD is common in emergency, primary care, neurological and psychiatric settings. It may include psychogenic non epileptic seizures (PNES), functional movement disorders like dystonias, weakness and paralysis, speech symptoms, and visual symptoms. It causes considerable physical disability and distress, loss of work hours, and is characterised by looping pathways through healthcare services, which places a huge economic burden both on patients and health services.

Psychiatric co-morbidities are common, and include anxiety, panic, depression, substance use disorders and other functional syndromes. PNES may occur in the presence of epilepsy. Few clinicians have had formal clinical education on the assessment and management of these disorders, and patients are often not offered potentially effective treatment pathways.

Some notable points to consider:

- Functional neurological symptom disorder (FNSD) is associated with considerable distress and disability. The symptoms are not faked
- Diagnose FNSD positively on the basis of typical clinical features. It is not a diagnosis of exclusion
- FNSD can be diagnosed and treated in presence of comorbid, pathophysiologically defined disease
- Psychological stressors are important risk factors but are neither necessary nor sufficient for the diagnosis
- Patients describe the psychological diagnosis as a major challenge because it is not considered a "real" disorder
- When positive social support is available, it can be a tremendous resource to those with PNES

In the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), the term **"Functional Neurological Symptom Disorder"** was added in parentheses after the DSM-IV term **"Conversion Disorder."** In the DSM-5 Text Revision (DSM-5-TR), published in March 2022, the terms are **reversed** so that Conversion Disorder is in parentheses. The American Psychiatric Association reports the rationale for the change:

"The decision to reverse the parenthetical order for the disorder was based on the following reasons:

- Functional neurological (symptom) disorder is the term of choice for the international research and patient community.
- Conversion disorder is falling from use by researchers and clinicians in the field.
- Conversion disorder is not an etiologically neutral term" (Psychiatry.org/DSM)

CASE STUDY : A 34 year old teacher is admitted with a three month history of shaking attacks. They occur up to ten times daily, lasting between 2–15 minutes. Initially, she does not report any auras but after further questioning admits to depersonalisation, which is distressing, and a 'warm feeling' just prior to the attacks. She reports being able to hear people around her but being unable to respond. Although she was told that she had epilepsy and had been prescribed anticonvulsants from a different hospital, she has been getting the feeling that health professionals thought she was "making it up". She reports exhaustion, poor sleep, and poor concentration, and there is a past history of chronic pelvic pain and laparoscopic surgery, along with a history of childhood sexual abuse, and prior contact with a psychiatrist. She strongly denies current feelings of depression or anxiety, or any recent life stressors. Although she describes her job as challenging it's also very rewarding and she's unhappy to be off work. Physical and neurological examination is normal. During a witnessed attack, her eyes are observed to be shut, she has an increasingly fast respiratory rate, and limb movements are asynchronous. Video EEG monitoring during the attacks is normal.

EXPLANATION OF THE DIAGNOSIS AND MANAGEMENT OF THIS PATIENT

The history and investigations are typical for psychogenic non-epileptic seizures(PNES). In this patient it can be counterproductive to wade in with a psychological explanation. She has angrily denied any emotional symptoms and has already been given a diagnosis of epilepsy, a valid diagnosis that may be difficult to take away. Non-epileptic attacks can be explained as a common and treatable temporary "short circuit" of the nervous system but without the abnormal electrical activity of epilepsy. Repeated reminders that you don't think she is making the symptoms up, are necessary. Written information including a leaflet will help confirm to the patient and her family that this is a real diagnosis. It's usually inadvisable to make connections between childhood trauma and current symptoms unless there is an established relationship with the patient over a period of time. Even if you think there is a connection between her abuse, her pelvic pain, and the non-epileptic attacks — and there may be — the patient is unlikely to want to hear your thoughts on the matter or be helped by them, at least for some time.

The most important first step is to undo the diagnosis of epilepsy and make a clear and unequivocal diagnosis of non-epileptic attacks. Her anticonvulsants should be stopped. Use of the word *seizure* should be avoided, *episode* or *attack* is more useful. The presence of prodromal symptoms is helpful. Explain that depersonalisation is common and not life threatening. Explain how patients can learn to stop attacks like these in time with practice. Referral by a neurologist to a psychiatrist must be carefully done, with both specialists reinforcing that the patient is not crazy, but that Dr X has special expertise in these kinds of symptoms. The psychiatrist ought to be able to engage her, begin to explore psychological aspects, manage psychiatric co-morbidities, and monitor progress. Referral to other members of the MDT is critical, namely a psychologist, occupational therapist and neurophysiotherapist. An interdisciplinary approach promotes successful exchange across the multiple care providers needed to diagnose and treat patients diagnosed with PNES. (Case study adapted from Stone et al, 2005).

References available upon request