Decade of progress in motor functional neurological disorder: continuing the momentum

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ABSTRACT
Functional neurological disorder (FND) is a prevalent, disabling and costly condition at the neurology–psychiatry intersection. After being marginalised in the late 20th century, there has been renewed interest in this field. In this article, we review advances that have occurred over the past decade (2011–2020) across diagnosis, mechanisms, aetiologies, treatments and stigma in patients with motor FND (mFND, that is, functional movement disorder and functional limb weakness). In each content area, we also discuss the implications of recent advances and suggest future directions that will help continue the momentum of the past decade. In diagnosis, a major advance has been the emphasis on rule-in physical signs that are specific for hyperkinetic and hypokinetic functional motor symptoms. Mechanistically, greater importance has been given to determining ‘how’ functional neurological symptoms develop, highlighting roles for misguided attention, expectation and self-agency, as well as abnormal influences of emotion/threat processing brain areas on motor control circuits. Aetiologically, while roles for adverse life experiences remain of interest in mFND, there is recognition of other aetiologic contributors, and efforts are needed to investigate links between aetiologic factors and mechanisms. This decade has seen the first randomised controlled trials for physiotherapy, multidisciplinary rehabilitation and psychotherapy performed in the field, with consensus recommendations for physiotherapy, occupational therapy and outcome measures also published. Across patients, clinicians, healthcare systems and society, stigma remains a major concern. While challenges persist, a patient-centred integrated clinical neuroscience approach is primed to carry forward the momentum of the past decade into the future.

INTRODUCTION
Functional neurological disorder (FND), also known as conversion disorder, is a common, disabling and costly condition at the intersection of neurology and psychiatry.1,2 While of interest to founding leaders across the clinical neurosciences in the late 19th century, FND was largely abandoned by academics and researchers alike during the late 20th century.31 The rationale for these difficulties were based in part on a Cartesian dualism of the brain and mind, limited neuropathophysiological understanding and few evidence-based treatments.32 In the 21st century, a resurgence of interest in FND has occurred, catalysed by improved diagnostic specificity, an expanding ‘toolbox’ of treatments and new pathophysiological models that embrace patient-centred biopsychosocial formulations.3 A newly formed professional society (www.fndociety.org), authoritative FND textbooks3,3 and recent special journal issues on this topic have further energised clinical and research efforts in FND.

In this narrative review, we highlight important advancements and their implications for motor FND (mFND) over the past 10 years (2011–2020)—spanning functional movement disorder and functional limb face weakness. We use a transdiagnostic approach across the range of functional motor symptoms given high phenotypic overlap across populations (eg, functional tremor with concurrent functional weakness in the same limb).33 Isolated functional (psychogenic non-epileptic/dissociative) seizures, functional speech/voice disorder, functional cognitive disorder, functional sensory deficits and the spectrum of functional somatic disorders are beyond the scope of this article and have been reviewed elsewhere.34,35 Sections here detail recent developments in diagnosis, mechanisms, aetiological factors, treatments and stigma in patients with mFND. In each content area, future directions are also suggested, aimed at continuing the momentum of the past decade.

DIAGNOSIS
New developments
Establishing the diagnosis of mFND has been made more practicable,36 as physical examination findings with diagnostic specificity have been identified (eg, Hoover’s sign with an estimated specificity of 95.7%–99.9%).37 Educational efforts have also made neurologists more confident in their ability to accurately diagnose patients with mFND, discouraging extensive laboratory testing unless a comorbid neurological disorder is suspected.7

The Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition (DSM-5) criteria for FND include the diagnostic features of inconsistency and incongruity on examination, emphasising positive neurological features; identifying an underlying psychological trauma has been relegated to a discussion note and removed as a criterion.3,38,39 Incongruity refers to changes in manifestation over time, such as variation in tremor frequency and amplitude or remissions and exacerbations. Incongruity refers to discordance with other known neurological disorders or human anatomy and physiology. Additional general diagnostic features

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are distractibility and suggestibility. Most other diagnostic signs are phenotype specific and can be augmented by certain clinical neurophysiologic tests.\(^6\) Clinical neurophysiologic tests (eg, electromyography-assisted identification of tremor pause during ballistic movements) can either objectify bedside observations or identify features that clinicians cannot readily appreciate.\(^8\)

Positive signs on examination that characterise functional limb weakness (and functional sensory and gait disorders) have been analysed for their statistical properties (including sensitivities and specificities)\(^6\) and then subjected to prospective analysis, including inter-rater reliability.\(^9\) Reliable signs of functional limb weakness include give-way/collapsing weakness, drift without pronation, cocontraction, Hoover’s sign, hip abductor sign, Spinal Injuries Center Test and weakness of the sternocleidomastoid with hemiparesis.

Hyperkinetic mFND presentations include tremor, myoclonus and tics (jerky movements), dystonia, parkinsonism and gait disorders. Clinical and laboratory features are described in table 1.\(^1\)\(^10\)\(^5\)\(^7\) Tremor and myoclonus are readily identifiable with established clinical features and excellent neurophysiologic tests that can be used for confirmation in ambiguous cases.\(^1\)\(^10\)\(^11\)\(^3\)\(^7\) Differentiating functional versus neurogenic motor tics can be difficult if the presence of an urge or sensory tic is not present or uncertain.\(^12\) The presence of a Bereitschaftspotential (readiness potential) prior to the movement is common in functional jerky movements.\(^1\)\(^11\) Functional parkinsonism is usually identifiable on physical examination, but a normal dopamine transporter scan can aid the diagnosis in challenging cases.\(^13\) Functional dystonia remains challenging to diagnose given some overlapping clinical features with neurogenic dystonias, and, remarkably, overlapping clinical neurophysiologic features as well.\(^14\) Fixed dystonia,\(^15\) post-traumatic dystonia\(^16\) and intermittent lip deviation to one side\(^17\) are commonly identified functional patterns. Functional facial spasm, a common stroke mimic, is characterised by platysma hyperactivation, jaw deviation and ipsilateral eyebrow depression.\(^18\)

In support of the stability of an mFND diagnosis based on examination signs, a 14-year prospective study in 76 patients with functional limb weakness showed only a 1% misdiagnosis rate.\(^19\) Notably, some patients have both functional neurologic signs and other neurological conditions, such as associations with multiple sclerosis, Parkinson’s disease and other neurodegenerative disorders.\(^16\)\(^17\)

<table>
<thead>
<tr>
<th>Functional motor symptom</th>
<th>Clinical features</th>
<th>Laboratory tests</th>
</tr>
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<tbody>
<tr>
<td>Tremor</td>
<td>Entrainment (tremor takes on the rhythm of paced movements performed with another body part)</td>
<td>Clinical neurophysiological measurements can quantify entrainment, pause with quick movement, variability, tonic contraction at onset, increase amplitude with weighting and coherence between limbs</td>
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<tr>
<td></td>
<td>Pause with quick movement of another limb</td>
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<td></td>
<td>Variability in frequency, amplitude</td>
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<td></td>
<td>Tonic contraction at onset</td>
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<td></td>
<td>Increase in amplitude with weighting</td>
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<td></td>
<td>Coherence of tremor between two limbs</td>
<td></td>
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<tr>
<td></td>
<td>Whack-a-mole sign</td>
<td></td>
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<tr>
<td>Myoclonus</td>
<td>Variability and long duration of the movement</td>
<td>Long electromyography bursts</td>
</tr>
<tr>
<td></td>
<td>Complex movement</td>
<td>Presence of a Bereitschaftspotential (readiness potential) before the jerk</td>
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<tr>
<td></td>
<td>Appearance of startle</td>
<td>With stimulus-induced jerks: long and variable latency</td>
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<tr>
<td></td>
<td>Long and variable latency of stimulus induced jerks</td>
<td></td>
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<td></td>
<td>Jerks when tendon hammer stops short of contact</td>
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<tr>
<td>Tic</td>
<td>Lack of urge</td>
<td>Normal Bereitschaftspotential</td>
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<td></td>
<td>Lack of voluntary control (suppressibility)</td>
<td>Normal dopamine transporter scan</td>
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<tr>
<td>Dystonia</td>
<td>Certain patterns such as fixed dystonia or pulling lip to one side</td>
<td>Normal blink reflex recovery</td>
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<td></td>
<td>Normal plasticity with paired associative conditioning</td>
<td></td>
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<tr>
<td>Parkinsonism</td>
<td>Marked slowness or incoordination in examination but not with normal movements</td>
<td>Normal dopamine transporter scan</td>
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<td></td>
<td>Gegenhalten (variable resistance during passive movement)</td>
<td></td>
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<td></td>
<td>Lack of sequence effect (slowness without amplitude decrement during repetitive movements)</td>
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<td></td>
<td>Huffing and puffing sign (fatigue with minimal effort)</td>
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<tr>
<td>Gait disorders</td>
<td>Specific patterns including knee buckling, dragging a monoplegic leg, astasia-abasia, excessive slowness and atypical limping</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Better balance than claimed, including improvement with distraction</td>
<td></td>
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<tr>
<td></td>
<td>Either no falls, controlled falls or falling toward support</td>
<td></td>
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<tr>
<td></td>
<td>Chair test (can use legs to move a chair better than walking)</td>
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**Implications**

Improved diagnostic specificity has made it easier for neurologists to present the diagnosis to patients, which is the first step in treatment.\(^18\) It is generally necessary for the patient to agree with the diagnosis or, at least, allow for the possibility of such before moving onto additional treatments. Additionally, it has been suggested that it is helpful to demonstrate positive signs to the patient to show how the diagnosis was made.\(^19\) Increased diagnostic specificity also permits identification of cohorts with content validity for research studies.

**Future directions**

There is a need to further test the specificity, sensitivities and inter-rater reliability of the growing range of positive functional signs compared with other neurological populations, particularly given that statistical properties for some signs have been only tested in a single cohort.\(^4\) Additionally, functional dystonia remains among the most challenging mFND diagnoses. The overlap of clinical features and neurophysiologic tests with other dystonia subtypes remains obscure and needs to be explained. However, there are some promising tests (eg, blink reflex recovery and paired-associative stimulation induced plasticity) that need further validation.\(^20\)\(^5\)\(^12\)
Although relevant to only a small minority of cases, there is also a need to better distinguish mFND (where symptoms are experienced as involuntary) from factitious disorder and malingering; in both factitious disorder and malingering, there is conscious feigning of symptoms. The latter two presentations are rare but unfortunately influence physician attitudes toward patients, and they should be addressed differently.

Another challenge is to identify adjunctive diagnostic biomarkers. Quantitative neuroimaging alone in its current form may not provide the answer. Neuroimaging findings are valuable in understanding the neuropathophysiology of mFND, but are sufficiently subtle (and heterogeneous) that they will likely not have high sensitivity and specificity on an individual basis. While neurophysiological testing shows encouraging value in some circumstances, it will be important to show high specificity when used in relevant uncertain clinical circumstances. Composite diagnostic biomarkers across multiple neurobiological data points (electrophysiology, neuroimaging, autonomic, etc) also warrant future investigation.

Lastly, the field needs to better contextualise the overlap between mFND and other FND subtypes (eg, functional seizures), as well as to explore optimal approaches to contextualise other bodily symptoms frequently present in patients with mFND that closely relate to quality of life (eg, pain, fatigue, cognitive symptoms). Furthermore, the intersection of FND, functional somatic disorders (eg, fibromyalgia) and other neuropsychiatric conditions (anxiety and trauma-related disorders, somatic symptom disorders, mild traumatic brain injury, etc) requires clarification.

MECHANISMS

New developments

An important recent focus of mechanistic theorising has been to shift the typical viewpoint from which mFND has been studied. Traditional ‘Freudian’ and related viewpoints have been, arguably, ones that prioritise aetiological factors over mechanisms. In other words, the precise mechanics of how a particular functional motor symptom arises has not been of high concern, and instead emphasis had been almost exclusively on the influence of hypothesised stressors and psychological factors.

Emphasis on mFND mechanisms has drawn on a broad neuroscientific knowledge base, including from the fields of motor control (eg, the underpinnings of sense of agency), cognitive-affective neuroscience (eg, attention and emotion processing) and computational neuroscience. One of the important questions such work has sought to answer is: if functional neurological symptoms are truly involuntary, what are the implicated brain mechanisms of these unconscious processes?

Research has started to coalesce around the idea that there is a mechanism (or set of inter-related mechanisms) which mediates the relationship between conscious experience of movement control and the neural networks that enable movement and related sensory experiences to occur. In one expression of this idea grounded in the computational theory of active inference, perception and movement control rely on a dynamic relationship between actual sensory data and predictions about these data. The relative weighting of these ‘bottom up’ and ‘top down’ sources of information (known as precision) can be influenced by attentional focus (including modulation via limbic/salience networks). The suggestion in mFND is that abnormally strong predictions, relevant to symptoms such as weakness, tremor and gait difficulties, develop and are made more precise by body-focused attention. This drives symptom production in line with abnormal predictions and overwhelms contradictory sensory evidence. Notably, efforts are underway to test these theories, such as the recent use of the ‘broken escalator’ paradigm probing non-conscious and conscious forms of motor learning in patients with functional gait disorder to identify persistence of a locomotor after effect (representing a failure of deadaptation) (see figure 1). This mechanism can also lead to motor symptoms without a sense of agency, with functional neuroimaging studies in mFND implicating the right temporoparietal junction/inferior parietal lobule in deficits in action authorship perceptions.

Recent work, using neuroimaging and other experimental approaches, has also begun to contextualise the role of emotion/threat processing in the pathophysiology of mFND. This research has sought to elucidate the way in which networks relevant to voluntary movement might be abnormally influenced (‘hijacked’) by networks serving affective and threat processing. Noteworthy findings include: (1) a direct effect of recall of relevant traumatic life events on supplementary motor area activation; (2) abnormal connectivity between motor control areas and amygda/insula brain areas during rest and affective provocation and (3) altered temporoparietal junction and insula cortex connectivity in the resting state.

Implications

An important implication of this work has been to support mFND as a brain-based condition. In this sense, it is simply a process of the mFND field catching up with the rest of neuro psychiatry, benefiting from recent neuroscientific advances, building on historical concepts, which further bridges neurology and psychiatry. However, this change has a danger of creating a solely neurocentric view of mFND, ending up swapping one extreme viewpoint (psychology only) for another (neurology only)—a sentiment that we caution against.

Future directions

The path forward is one that continues building an integrated, mechanistic framework for mFND that is neither exclusively psychological nor neurological. A key future goal is to attempt to unpack, at an individual level, the different influences on symptoms, aetiologies, treatment response and prognosis. For example, efforts to integrate active inference principles not only for sensorimotor percepts but also pertaining to interoception and ‘emotion making’ based on the theory of constructed emotion may provide additional mechanistic advances in mFND. How mFND neural mechanisms relate to treatment mechanisms and clinical outcomes is crucially important and under-researched. Additionally, it remains unclear if outward presenting phenotypes (eg, functional tremor) are driven by the same set of mechanisms across all patients or if there are a range of biological mechanisms that may lead to the same clinical phenotype. If neural mechanisms differ across patients with similar phenotypes, it will be important to understand if biologically informed subtypes are linked to specific treatments. Future research should be encouraged to investigate if there are common neural mechanisms across FND and the spectrum of functional disorders across medicine. To

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AETIOLOGICAL FACTORS

New developments

Over the past decade, aetiological research in mFND contextualising predisposing vulnerabilities have identified the presence of a number of potential putative contributing factors, while at the same time, acknowledging the importance of individual differences. A systematic review and meta-analysis showed that the odds of being diagnosed with FND was 3.9 times higher given childhood physical abuse compared with controls and 3.3 times higher given childhood sexual abuse.27 In a separate systematic analysis, acknowledging the importance of individual differences, while at the same time, aetiological research in mFND contextualising predisposing vulnerabilities has identified the presence of a number of potential putative contributing factors. Within this model, abnormal prior expectation is formed within prediction units of intermediate motor areas (here the supplementary motor area (SMA) (black triangles)). This prior is afforded abnormal precision by attentional processes (blue arrow) that cause intermediate level motor predictions (thick black arrows) to elicit movement and prediction errors (thick red arrows) from prediction error units (red triangles) to report the unpredicted content of the movement to higher cortical areas (here, pre-SMA (pSMA)). The secondary consequence of these prediction errors is that prefrontal regions try to explain them in terms of symptomatic interpretation or misattribution of agency to external causes. Based on findings of Lin et al., (B) (top portion) displays the broken escalator phenomenon.22 Following a series of initial ‘before’ tasks where participants step onto and off of a stationary platform (not shown), participants then go on to step onto a moving sled performed 10 times (‘moving’). In the ‘after’ trials, participants once again step onto a stationary sled five times. The ‘broken escalator’ phenomenon, also called the locomotor after effect, occurs when the learnt motor response during the ‘moving’ phase is carried forward in the ‘after’ trials. In (B) (lower panel), linear trunk displacement measurements show that only patients with a functional gait displayed persistence of the locomotor after effect across repeated ‘after’ trials. Lin et al. suggested this reflected evidence of failed deadaptation (failure to update expectations).

A heightened bodily attentional focus, at increased arousal may also help explain associations between physical injury and the subsequent development of mFND.30 Two examples from the functional MRI literature include: (1) the observation that resting-state connectivity strength between salience/limbic network brain areas (amygdala, insula) and the precentral gyrus correlated with the magnitude of previously experienced childhood physical abuse in patients with mFND10 and (2) the finding that the G-703T polymorphism (rs4570625) in the tryptophan hydroxylase-2 (TPH2) gene moderated the relationship between childhood trauma and functional movement symptom severity; differential amygdala-prefrontal connectivity profiles were also identified in patients with mFND based on TPH2 genotype (see figure 2).31

Acknowledging that not all patients with mFND endorse adverse life experiences, risk factors for mFND extend beyond these considerations. A heightened bodily attentional focus, at times to the decrement of perceptual accuracy, has been characterised in patients with mFND.32 Altered bodily attention and increased arousal may also help explain associations between physical injury and the subsequent development of mFND, given that physical injury promotes heightened attention to the self and activation of bodily arousal systems.33 The traditional conceptualisation of several demographic and psychosocial factors has also been challenged, including the increased appreciation of mFND symptoms in older populations (eg, Parkinson’s disease)34 and findings that patients with mFND and neurological controls have similar histories of comorbidity (eg, Parkinson’s disease)17 and findings that patients with mFND and neurological controls have similar histories of neurological, psychiatric, and medical diagnoses, will also inform the specificity of neural mechanisms in mFND.518

comprehensively answer these questions, behavioural, electrophysiological, neuroimaging, autonomic, neuroendocrine and neuroinflammation data will likely be needed. Use of patient control groups, across co-occurring neurological, psychiatric and medical diagnoses, will also inform the specificity of neural mechanisms in mFND.518

biological (genetic/epigenetic) risk, life events and precipitating (triggering) factors.28 29 While in early stages, pathophysiology studies have started to contextualise the neurobiological importance of childhood maltreatment in promoting the development of mFND.24 Two examples from the functional MRI literature include: (1) the observation that resting-state connectivity strength between salience/limbic network brain areas (amygdala, insula) and the precentral gyrus correlated with the magnitude of previously experienced childhood physical abuse in patients with mFND10 and (2) the finding that the G-703T polymorphism (rs4570625) in the tryptophan hydroxylase-2 (TPH2) gene moderated the relationship between childhood trauma and functional movement symptom severity; differential amygdala-prefrontal connectivity profiles were also identified in patients with mFND based on TPH2 genotype (see figure 2).31

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Figure 1  Model and evidence supporting the role for sensorimotor expectations and misdirected attention in the pathophysiology of motor functional neurological disorder. Based on Edwards et al, (A) shows the hierarchical anatomy that is theorised to underlie false inference in patients with functional motor symptoms.22 Within this model, abnormal prior expectation is formed within prediction units of intermediate motor areas (here the supplementary motor area (SMA) (black triangles)). This prior is afforded abnormal precision by attentional processes (blue arrow) that cause intermediate level motor predictions (thick black arrows) to elicit movement and prediction errors (thick red arrows) from prediction error units (red triangles) to report the unpredicted content of the movement to higher cortical areas (here, pre-SMA (pSMA)). The secondary consequence of these prediction errors is that prefrontal regions try to explain them in terms of symptomatic interpretation or misattribution of agency to external causes. Based on findings of Lin et al., (B) (top portion) displays the broken escalator phenomenon.22 Following a series of initial ‘before’ tasks where participants step onto and off of a stationary platform (not shown), participants then go on to step onto a moving sled performed 10 times (‘moving’). In the ‘after’ trials, participants once again step onto a stationary sled five times. The ‘broken escalator’ phenomenon, also called the locomotor after effect, occurs when the learnt motor response during the ‘moving’ phase is carried forward in the ‘after’ trials. In (B) (lower panel), linear trunk displacement measurements show that only patients with a functional gait displayed persistence of the locomotor after effect across repeated ‘after’ trials. Lin et al. suggested this reflected evidence of failed deadaptation (failure to update expectations).
in all patients with mFND. Trait psychological constructs remain important, such as the finding that alexithymia, independent of depression scores, was elevated in patients with mFND compared with neurological and healthy controls; patients with mFND and prominent alexithymia also exhibited higher rates of obsessive-compulsive personality disorder. Novel risk factors for the development of mFND have also been identified, such as aberrant sensory and information processing.

Implications
Identification of a broad array of relevant, yet non-deterministic, risk factors for developing mFND suggests that links between aetiological factors and disease mechanism remain incompletely understood. More specifically, while adverse life experiences remain important vulnerabilities for developing mFND and are linked to other predisposing and perpetuating factors, the presence or absence of these events neither helps rule in nor rule out a diagnosis of mFND.

Future directions
Additional research is needed to understand the intersection of disease mechanisms, aetiological factors and treatment response within the context of the biopsychosocial framework (including spiritual and cultural influences). A precision medicine approach may be needed to not only link psychosocial risk factors to brain circuits but also to contextualise a range of relevant mediating factors including genetic/epigenetic information. The importance of developmental trajectories (including critical periods), gene–environment interactions and sex differences are also underexplored factors that may help better explain connections between risk factors and the later-life development of mFND. Given significant childhood maltreatment in a subset of patients with mFND, future research may also inquire if there is a ‘trauma subtype’ of mFND, while also clarifying important risk factors in patients who lack such a history. The relevance of aetiological factors to treatment selection and response (eg, targeting concurrently present PTSD symptoms as an approach to treat mFND) also requires more research inquiry.

**Treatments and Prognosis**

New developments
The late 20th century’s lack of interest and investment in mFND by healthcare systems is reflected in exceedingly few care programmes for this population, which in turn is reflected in patients feeling marginalised and unable to access treatments. With the DSM-5 modifications, the neurologist’s (and other clinician’s) role in mFND has now expanded to making a positive ‘rule-in’ diagnosis, communicating the diagnosis effectively and facilitating access to additional treatments. ‘How to’ articles have disseminated good clinical practices on the delivery of the diagnosis and longitudinal care. Specialist FND clinics, often led jointly by neurologists and psychiatrists, have also been developed in some countries for complex cases (eg, those with diagnostic uncertainty, multiple comorbidities). With the time required to adequately manage this population, challenges have been raised regarding clinical bandwidth.

The website neurosymptoms.org has become a valuable educational resource for patients and clinicians. Other information websites have been created, including from patient support charities (eg, fndhope.org, fndaction.org.uk). The efficacy of online information and self-help used in isolation was assessed in a randomised controlled trial (RCT). At 3 months, there was no difference in improvement on self-rated health or in secondary outcomes between groups. This suggests that online education, while generally rated favourably, is inadequate as a stand-alone treatment.
There has been a rise in physical rehabilitation and multidisciplinary research. Since 2010, no less than 17 rehabilitation cohort studies of patients with mFND have been published (2 RCTs, 7 prospective and 8 retrospective). The first RCT, published in 2014, compared a 3-week inpatient multidisciplinary rehabilitation programme to a waiting list control, for patients with functional gait disorders. Improvements were seen in the treatment arm in measures of physical health that were maintained at 12-month follow-up. The second RCT was a feasibility study of specialist physiotherapy, comprising psychologically informed education and movement retraining. Sixty patients were randomised to the intervention versus standard community neurophysiotherapy, with 72% of the intervention participants reporting motor improvements compared with 18% of controls at 6-month follow-up. See table 2 for additional details and supporting evidence.

A factor complicating synthesis of the evidence for physiotherapy and multidisciplinary rehabilitation is heterogeneity in the interventions. Differences include treatment setting (outpatient, inpatient, day hospital), medical specialty involved (psychiatry, neurology, physical rehabilitation, etc), treatment duration/intensity and type of therapy and combination of modalities (physiotherapy, cognitive behavioural therapy (CBT), psychoeducation, movement retraining, non-specific exercise, etc). Despite differences, common elements across treatments include starting with a diagnostic explanation based on a patient-centred biopsychosocial model. Motor symptoms are often conceptualised as a disconnect between the brain and body, and...
self-directed attention is usually emphasised as a factor exacerbating symptoms. Physical therapies aim to retrain movement with diverted attention, and physical interventions are informed by a psychological understanding of symptoms (eg, addressing fear-avoidance behaviours using graded exposure).

As well summarised in a recent systematic review, the major advance for psychotherapy in mFND is that initial RCTs have been conducted and published—after a dearth of controlled data in decades prior. Examples of the interventions are described below and summarised in table 2 and online supplemental table 1.

Psychotherapy trials for mFND include a pilot single-blind RCT of 29 patients with mFND (mostly functional tremor) randomised to receive 12 weeks of conventional CBT alone (90-minute session, once a week) versus CBT + adjunctive physical activity (APA) (60-minute session, two times per week of low-intensity/moderate-intensity walking). The control group consisted of eight patients receiving standard medical care (SMC). The CBT intervention focused on the interplay of somatic misinterpretations, negative thoughts, illness beliefs and low mood or anxiety, along with use of distraction, relaxation and other problem-solving techniques. The two CBT containing interventions (with and without APA) showed improvements in functional motor symptoms, depression and anxiety scores at 12 weeks, while the SMC arm showed no significant improvements. A prospective single-arm study in 15 patients with functional tremor also demonstrated the efficacy for CBT in reducing tremor severity. Furthermore, an RCT of self-guided CBT in 127 patients with mixed FND randomised to CBT + usual care (n=64) versus usual care alone (n=63) showed a statistically significant improvement in patient-rated global improvement at 3 months for those receiving CBT; reductions in somatic symptom burden and health anxiety were also observed. These gains were no longer significant at 6-month follow-up. See online supplemental table 1 for details regarding two small psychodynamic psychotherapy RCTs, as well as other psychotherapy cohort studies in mFND populations.

Regarding paediatric mFND—while there are ethical and practical challenges to performing RCTs in this population—efficacious multidisciplinary programmes generally combine psychotherapy, physiotherapy, occupational therapy and family work targeting focus of attention and pertinent stressors and school attendance/integration (see online supplemental table 1).

There remains little evidence for pharmacological therapy in the direct treatment of mFND symptoms, yet medications have a role in managing concurrently present anxiety, depression, migraines and insomnia. Regarding other treatments, a recent randomised placebo-controlled trial of botulinum neurotoxin (BoNT) for jerky and tremulous functional movement disorder (n=48) found no benefit compared with placebo. Here, approximately two-thirds of patients in both groups improved, demonstrating a large placebo effect. A similar positive placebo response was observed in a pilot randomised trial of BoNT followed by 12 weeks of CBT in patients with functional dystonia (n=14). While placebo effects are important considerations, there is an argument to be made for the use of BoNT in patients with chronic symptoms that have not benefited from other treatments. Transcranial magnetic stimulation (TMS) also continues to be investigated as a promising therapeutic, although disentangling circuit-level neuromodulatory effects from placebo remains challenging. When placebo is considered the ‘active ingredient’, there remains debate regarding how transparent to be with patients (we favour an open and transparent stance).

Implied is that non-specialist clinicians may feel ill prepared to assess and manage patients with mFND, expert opinion-based recommendations and practical advice are welcomed additions. These include:

- Assessment and diagnosis of mFND symptoms.
- Neuropsychiatric assessment.
- Delivering the diagnosis (including providing clear, empathic communication with a cautiously optimistic stance for improvement).
- mFND presenting to stroke services.
- Physiotherapy.
- Occupational therapy.

Consensus recommendations to standardise outcome measures for clinical trial research in FND have also been published, emphasising patient-reported data.

Regarding prognosis, a systemic review of long-term follow-up studies from 10 to 491 individuals reported that 39% of patients across the spectrum of FND were the same or worse and the majority (approximately 80%) remained symptomatic. The same research group recently published a 14-year follow-up study in 76 adults with weakness, identifying that 20% had symptom resolution, 31% improved, 23% were the same and 26% were worse. In terms of discrete prognostic factors in adults, findings have been inconsistent and understudied in more recently developed care models. Outcomes from specialist paediatric multidisciplinary programmes are more optimistic with approximately three quarters of children returning to full health and full-time school attendance. Outcomes are less favourable for children with chronic mFND symptoms at presentation; those with cognitive vulnerabilities, whose comorbid mental health disorders or other (comorbid) functional somatic symptoms do not resolve and those who subsequently develop chronic mental health problems.

Implications

While delivery of the diagnosis is the first step in treatment, online self-help information alone is insufficient for symptom reduction and should not be considered definitive treatment. Likewise, self-help psychotherapy approaches appear to lack durability in maintaining improvement. Careful assessment is needed to triage patients towards the most suitable treatment based on available options, including psychotherapy, skills based psychotherapy and/or multidisciplinary interventions. Given evolving care models and lack of robust predictors of prognosis, those with chronic symptoms, formerly considered refractory, should not be excluded from evidence-based treatments.

Future directions

To further advance mFND treatments, future research should continue to pursue fully powered RCTs across rehabilitative and psychological interventions. Studies examining optimal treatment setting(s) are also needed.

an important future direction could be to develop specific interventions that are tailored both towards the mFND phenotype (eg, weakness, tremor, dystonia) and the wider clinical syndrome. For example, in addition to motor symptoms, common comorbidities and other health-related problems could be considered within a single-treatment package (eg, PTSD, anxiety, chronic pain, migraine, joint hypermobility, social difficulties, etc). The timing of the different treatment elements may also be important, and the value of a modular approach to treatment could be explored, where the focus of whole-person treatment can be personalised and evolve according to the patient’s
biopsychosocial clinical formulation. As an example, a patient with a functional gait disorder and major depression with suicidality may benefit from physical therapy at some point, but it is probably more important initially to treat aggressively their depression and existential concerns. Conversely, a patient with sudden onset disabling physical symptoms may need to make some initial progress with physical therapy (eg, to regain sitting balance) before engaging well in psychotherapy.

Additional research should explore the development of technology-rehabilitation adjuncts (informed by advances in elucidating mFND pathophysiology) and innovations to improve access to specialist treatment (eg, tele/remote health as has been used in other FND subtypes, virtual reality, wearable technology, biofeedback, TMS, etc). More aggressive focus on psychosocial factors might also be useful. Additional work is needed to define the most suitable clinical outcome measures and to also determine if the creation of new FND-specific outcome measures may be beneficial. Further clarifying neural mechanisms and predictors of treatment response will also be important, offering the potential to develop novel psychologically and biologically informed treatment interventions. Finally, it is crucial that more treatment programmes are developed; it will not do any good to find optimal treatment strategies if they will not be available to the majority of patients.

STIGMA

New developments

Stigma pertaining to the diagnosis of mFND is increasingly recognised as an important, multifaceted issue requiring clinical and research attention. In mFND, stigma represents a complex interplay between patients, clinician–patient relationships, healthcare systems and sociocultural factors. The very fact that mFND sits at the intersection of neurology and psychiatry challenges deeply rooted medical and societal norms of health and disease. Furthermore, the variability/distractibility seen in many individuals mistakenly perpetuates a framing that symptoms are voluntary (when perceived nonetheless as involuntary by the patient). These and other nuanced issues related to stigma can be discussed across three levels—public stigma, personal self-stigma and patient label avoidance—and we use these categories to frame our discussion (see box 1).

Box 1  Three different aspects of stigma

Stigma category and definition

- Public stigma occurs when the general population—or certain subsets of the population—endorses negative beliefs pertaining to a certain illness and acts on these beliefs in a discriminatory manner, often by avoidance and withdrawal.
- Personal stigma occurs when the individual person—child or adult or the family—becomes aware of the negative beliefs about a certain illness, internalises these beliefs and applies them to the self.
- Patient label avoidance refers to the patient’s reluctance and efforts to distance himself or herself from a label—in the case of motor functional neurological disorder, a diagnosis—because the label is perceived as being socially unacceptable. This type of stigma is more commonly perceived in relation to mental health disorders, because such disorders are commonly misperceived as being the result of personal weakness or poor character.

With the growth of scientifically based medicine and the complexities in how to understand functional neurological symptoms, mFND was sidelined and publicly stigmatised into the category of ‘medically unexplained’ disorders in the late 20th century. Interest in mFND waned reflected in mFND largely disappearing from medical textbooks, educational curricula and bedside teaching. Relatively, many physicians avoided the diagnosis—or used terminology that was offensive (eg, confusing mFND with malingering)—leaving patients perplexed or angry and setting up a negative process whereby patients sought help from multiple physicians, were subjected to repeated unnecessary diagnostic tests and treatment was delayed or not provided. Public stigma regarding mFND has unfortunately continued. Some physicians caring for patients with mFND may manifest their discomfort in non-verbal communication patterns that convey uncertainty, negative treatment expectations and/or their own perceptions that the diagnosis is a delicate (stigmatised) matter that needs to be managed cautiously (or at least not by a neurologist). In doing so, physicians undermine their own capacity to use positive suggestion to influence belief—relevant in the treatment of mFND—and core to the art of healing in all of medicine. Patients can also have negative interactions with other healthcare professionals (eg, nurses, administrative staff), coworkers, friends and family—driven in part by the conceptual misunderstandings outlined above. The general lack of dedicated services in hospitals and the failure to include FND in national research priorities also communicate a powerful message that mFND is seemingly unimportant.

Patients with mFND may internalise stigma, make it personal and report being harmed by it. Internalisation of stigma promotes feelings of vulnerability, helplessness, hopelessness, frustration and anger. Stigma contributes to the shaping of patients’ own internal beliefs and expectations, which may limit their ability to improve. These factors also contribute to negative doctor–patient interactions.

As a consequence, some patients find it difficult to accept an mFND diagnosis and others reject the diagnosis altogether or litigate the physician. This label avoidance contributes both to clinician anxiety and potentially to endless doctor shopping (and medical procedures) in hopes of receiving a different ‘medical’ diagnosis. Sometimes label avoidance even propels patients to accept explanations that are outlandish or that conceptualise their mFND as a ‘medical mystery’. Changes in how the diagnosis is communicated to patients are occurring, including more clinicians using the term ‘functional’. Educational efforts are underway to help physicians avoid the pitfalls of oversimplified explanations to patients that ‘it is all stress-related’ and moving towards describing ‘stressors’ in the context of life events. The Multidisciplinary FND Society, several authoritative FND textbooks, growth of specialised treatment programmes and high impact publications advocating for change and research funding indicate that mFND is re-entering mainstream medicine.

Implications

Public stigma, personal self-stigma and patient label avoidance in mFND remain major concerns, and efforts to mitigate stigma need to be driven by clinicians, researchers, patients, advocacy groups and policy-makers. A helpful transition that has occurred in recent years is the framing of mFND at the intersection of neurology and psychiatry (synonymous with a core neuropsychiatric disorder), and rigorous pathophysiology research in mFND is also decreasing stigma by advancing a brain-based, mechanic
understanding of the condition. Unfortunately, mental health is stigmatised in many societies and healthcare systems in comparison to medical/neurological conditions. This is a notable issue, given that the multidisciplinary approach to mFND patient care includes important roles for mental health clinicians. Treatment implications that emerge from this body of work highlight the importance of the biopsychosocial model—the body, mind and family and social context—to address each patient’s particular presentation and issues. The mFND field needs to be cautious so as to strike a good balance between neurological and psychological/psychiatric conceptualisations of the disorder. Moreover, mental health professionals need to be empowered at the same level of engagement as neurologists, rehabilitation specialists and research scientists, as we work collaboratively for the benefit of patients.

Future directions
In addition to increasing advocacy to further decrease stigma pertaining to mFND and related conditions across medicine and society, mFND can serve as a model condition through which to challenge the inherently artificial divide between physical and mental health that is pervasive in medicine and society—a dualism exposed most directly by mFND. This condition also offers the potential to bring the disciplines of neurology and psychiatry, two specialties for the same organ system, increasingly together to leverage an integrated clinical neuroscience perspective.

CONCLUSIONS
Significant advances have occurred in the past decade in the diagnosis, conceptual understanding and treatment of mFND. This progress reflects a renaissance taking place across the field of FND, bringing neurology and psychiatry together again, as we are confronted by the need for multidisciplinary and collaborative care models for this complex population. With a biopsychosocial understanding of mFND and with better neuroscientific tools to provide rigorous biological phenotyping and classification, we are poised to design well-constructed and patient-centred clinical trials to benefit patients with this condition.

Contributors
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Competing interests
DLP has received honoraria for continuing medical education lectures in functional neurological disorder and is on the editorial board of Epilepsy & Behavior. MW is an inventor of patents held by National Institutes of Health (NIH) for an immunotoxin for the treatment of focal movement disorders and the H-coc for magnetic stimulation; in relation to the latter, he has received license fee payments from the NIH (from Brainway). He is on the medical advisory boards of Cala Health and Brainway. He has research grants from Allergan for studies of methods to inject botulinum toxins, Medtronic, Inc. for a study of deep brain stimulation (DBS) for dystonia and Cala Health for studies of a device to suppress tremor. WCL receives editor’s royalties from the publication of Gates and Rowan’s Nonepileptic Seizures, 3rd edition (Cambridge University Press, 2010) and 4th edition (2018) and author’s royalties for Taking Control of Your Seizures: Workbook and Therapist Guide (Oxford University Press, 2015) and receives research support from the Department of Defense (DoD.W81XWH-17-0169).

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Supplementary References


[published Online First: 2013/01/11]


Supplementary Table 1. Other notable cohort treatment studies in motor functional neurological disorder.

<table>
<thead>
<tr>
<th>Study</th>
<th>n</th>
<th>Description</th>
<th>Key Points</th>
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<tbody>
<tr>
<td>Multidisciplinary rehab</td>
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<tr>
<td>Theuer et al 2020 [S43]</td>
<td>129</td>
<td>Retrospective review of patients admitted to a rehabilitation unit over a 20-year period. 185 patients were identified, 129 received treatment (multidisciplinary rehabilitation).</td>
<td>Duration and setting: length of inpatient stay not reported&lt;br&gt;&lt;br&gt;Outcome measures: Improvement defined as remission of symptoms, marked improvement (75%) or moderate improvement (50%)&lt;br&gt;&lt;br&gt;Treatment involved physiotherapy, occupational activities, psychiatric, and psychological support.&lt;br&gt;&lt;br&gt;After treatment, 70% of patients improved (36.2% with complete remission).&lt;br&gt;&lt;br&gt;Younger patients and those with an acute onset had a better outcome.</td>
</tr>
<tr>
<td>Hebert et al 2020 [S35]</td>
<td>20</td>
<td>Prospective cohort study of multidisciplinary rehabilitation based on the MoRe protocol in patients with functional movement disorders.</td>
<td>Duration and setting: mean 7.5 inpatient days&lt;br&gt;&lt;br&gt;Outcome measures: CGI-severity; MAS; FGA; BBS; TUG; FIST; FIM&lt;br&gt;&lt;br&gt;17 of 20 patients completed inpatient rehabilitation. 93% of patients completing treatment rated themselves as much improved. While not statistically significant at 1-year follow-up, patient-rated improvement was noted in 10 of 13 patients with available date.</td>
</tr>
</tbody>
</table>
| Kozlowska et al. 2020  | 57, 60, 25 | Three prospective cohort studies of pediatric multidisciplinary rehabilitation. | Duration and setting: 1-3 weeks, inpatient<br><br>67%, 53%, and 80% of children in the 3 cohorts had mFND.<br><br>Treatment included physiotherapy, psychotherapy (individual and family), attendance at hospital school,
<table>
<thead>
<tr>
<th>Study</th>
<th>Sample Size</th>
<th>Study Design</th>
<th>Setting</th>
<th>Outcome Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Butz et al 2019 [S48]</td>
<td>100</td>
<td>Prospective cohort study of pediatric</td>
<td>Inpatient, average 10.5 days (range 2-103 days)</td>
<td>GAF, resolution of FND, return to school and reintegration to home school post</td>
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<tr>
<td></td>
<td></td>
<td>multidisciplinary rehabilitation</td>
<td></td>
<td>discharge. FND symptoms resolved in 95%, 85% and 88%, and 61%, 53% and 52%</td>
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<td></td>
<td></td>
<td></td>
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<td>returned to full health and to full-time school.</td>
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<tr>
<td>Jimenez et al 2019 [S37]</td>
<td>63</td>
<td>Retrospective review of patients with</td>
<td>Outpatient, 5 days a week (intensive), for 3-4 weeks</td>
<td>Pain-disability index; mean timed up and go; mean stair climbing; 6-minute walk</td>
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<td>functional motor symptoms participating in</td>
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<td>test</td>
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<td></td>
<td></td>
<td>an interdisciplinary chronic pain</td>
<td></td>
<td>The cohort of patients had pain plus mixed FND symptoms including functional</td>
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<tr>
<td></td>
<td></td>
<td>rehabilitation program over a 4-year period</td>
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<td>movement disorders and functional seizures.</td>
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<td>On discharged, participants showed improvements in a range of outcome measures</td>
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<td>including pain related disability, depression, anxiety, and physical function.</td>
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<td></td>
<td></td>
<td>There was a 22% treatment dropout rate.</td>
</tr>
<tr>
<td>Jacob et al 2018 [S36]</td>
<td>32</td>
<td>Retrospective cohort study of specialist</td>
<td></td>
<td>This study replicates the intervention described by (Czarnecki et al 2012) – see</td>
</tr>
<tr>
<td></td>
<td></td>
<td>multidisciplinary rehabilitation</td>
<td></td>
<td>below. The focus of treatment is motor retraining and psychotherapy.</td>
</tr>
<tr>
<td>Study</td>
<td>Duration and Setting</td>
<td>Outcome Measures</td>
<td>Description</td>
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<tr>
<td>Bolger et al 2018 [S47]</td>
<td>One-week, inpatient</td>
<td>CGI-patient rated, PMDRS</td>
<td>87% of patients reported improvement at the end of treatment. At 6-month follow-up, this reduced to 69%. Improvements occurred despite the long average symptom duration of 7.4 years.</td>
<td></td>
</tr>
<tr>
<td>Demartini et al 2014 [S33]</td>
<td>8.4 ± 4.2 days, inpatient</td>
<td>WeeFIM</td>
<td>25/30 children had mFND as part of their clinical presentation. Treatment included physiotherapy, occupational therapy, recreational, and music therapy, and psychological support. WeeFIM score change of 30 ± 11.9 (P &lt;.001), maintained at 3 months.</td>
<td></td>
</tr>
<tr>
<td>McCormack et al 2014 [S40]</td>
<td>101-day median length of stay, inpatient</td>
<td></td>
<td>Similar to Demartini et al (2014) above, the outcomes of patients admitted for rehabilitation on a neuropsychiatric unit are presented. Outcomes are reported at discharge, with no follow up data. As with Demartini</td>
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</table>

Retrospective cohort study of pediatric multidisciplinary rehabilitation.

Prospective cohort study of multidisciplinary rehabilitation.

Together with Saifee et al (2012) below, the outcomes of a 4-week multidisciplinary rehabilitation program for patients with chronic mFND symptoms are reported. Significant but modest improvements were seen in a range of assessments post treatment and at 12-month follow-up (55% retention at 12 months). This included two-thirds of individuals rating their general health as better or much better at discharge; similar though slightly less positive gains were reported at 12-months.
**Outcome measures**: qualitative mobility and ADL performance, MRS et al (2014), improvements are seen despite long symptom durations and complex psychiatric comorbidity.

<table>
<thead>
<tr>
<th>Study</th>
<th>Duration and Setting</th>
<th>Outcome Measures</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Czarnecki et al 2012 [S32]</td>
<td>Retrospective cohort study of a multidisciplinary rehabilitation vs. treatment-as-usual controls.</td>
<td>Physician-rated improvement; patient-rated improvement (5-pt Likert) scale at 25 months post-treatment</td>
<td>This study reports the outcomes of an established specialist rehabilitation program with a focus on motor retraining with psychotherapy input. Treatment includes twice daily physical/occupational therapy and speech therapy if relevant. 69% of patients rated themselves as improved after treatment. At long-term follow up, 60% of patients reported to have remained improved.</td>
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</table>

**Physiotherapy - cohort studies**

<table>
<thead>
<tr>
<th>Study</th>
<th>Duration and Setting</th>
<th>Outcome Measures</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Maggio et al 2020 [S38]</td>
<td>Retrospective cohort study of outpatient physiotherapy in consecutive patients.</td>
<td></td>
<td>This study found that physiotherapy delivered in an outpatient setting, in a less intensive manner than previous rehabilitation studies, has the potential to benefit patients with mFND.</td>
</tr>
<tr>
<td>Study</td>
<td>Participants</td>
<td>Design</td>
<td>Duration and Setting</td>
</tr>
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<td>-----------------------</td>
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<tr>
<td>Demartini et al 2020</td>
<td>21</td>
<td>Prospective cohort study of physiotherapy, supplemented by psychiatry, delivered by telehealth.</td>
<td>24 sessions, including 21 weekly tele-sessions</td>
</tr>
<tr>
<td>Matthews et al 2016</td>
<td>35</td>
<td>Prospective cohort study of physiotherapy treatment.</td>
<td>18 days (mean length of stay), inpatient</td>
</tr>
<tr>
<td>Nielsen 2015</td>
<td>47</td>
<td>Prospective cohort study of physiotherapy treatment programme.</td>
<td>5-day, intensive outpatient</td>
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</tbody>
</table>

**Cognitive behavioural therapy – cohort studies**

<table>
<thead>
<tr>
<th>Study</th>
<th>Participants</th>
<th>Design</th>
<th>Outcome Measures</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>O’Connell et al 2020</td>
<td>98</td>
<td>Retrospective review of CBT for mFND.</td>
<td></td>
<td>Observational study revealed improvements in physical and psychological functioning were similar for patients with mFND</td>
</tr>
<tr>
<td>Duration and setting: 12-15 sessions, outpatient</td>
<td>Outcome measures: 3-point scale of improvement based on clinical note review, CORE-OM</td>
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<tr>
<td>and patients with other neuropsychiatric condition who were treated in a specialist CBT clinic.</td>
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<tr>
<td>12-15 sessions, outpatient</td>
<td>3-point scale of improvement based on clinical note review, CORE-OM</td>
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<tr>
<td>Functional tremor severity improved significantly after 12 weeks of CBT. The improvement was associated with changes in the anterior cingulate / paracingulate activity on fMRI.</td>
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<tr>
<td>Espay et al 2019</td>
<td>PMDRS</td>
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</table>

**Psychodynamic psychotherapy – RCTs**

| Kompoliti et al 2014 [S45] | Randomized cross-over design study of psychodynamic psychotherapy vs. continued observation and support by a neurologist. |
| Duration and setting: 12 weekly 1 hour sessions, outpatient | While patients in both groups improved in terms of CGI-severity scores with time, there were no statistically significant group-level differences at 3-months. |
| Outcome measures: CGI-severity, PMDRS |

| Hubschmid et al 2015 [S44] | Randomized study of interdisciplinary psychotherapeutic intervention (psychodynamic interpersonal treatment) vs. standard care. |
| Duration and setting: 4-6 sessions over a 2-month period, outpatient | Outcome assessments occurred at 2, 6 and 12-months post intervention initiation. |
| SDQ-20 and CGI scores showed statistically significant group x time effects favouring the group receiving the interdisciplinary psychotherapeutic intervention vs. standard care. |
Outcome measures: SDQ-20, CGI, MRS, healthcare utilization, SF-36

The intervention group also showed reduced inpatient hospital use compared to standard care. There were, however, no treatment group differences in terms of reported quality of life.

The study included 174 participants, of which only 98 had a diagnosis of mFND. Additionally, outcome measures listed in this table focus on the selected physical functioning and quality of life instruments used in each study. Abbreviations: ADL, activities of daily living; BBS, Berg Balance Scale; CBT, Cognitive Behavioural Therapy; CGI, Clinical Global Improvement scale; COPM, Canadian Occupational Performance Measure; CORE-OM, Clinical Outcomes in Routine Evaluation-Outcome Measure; FGA Functional Gait Assessment; FIM, Functional Independence Measures; FIST, Function in Sitting Test; GAF, Global Assessment of Function; MAS, motor assessment scale; mFND, motor functional neurologic disorder; MRIMI, modified Rivermead Mobility Index, MRS, modified Rankin scale; PHQ-15, Patient Health Questionnaire 15; PHQ-9, Patient Health Questionnaire 9; PMDRS, Psychogenic Movement Disorder Rating Scale; RCT, randomized controlled trial; SF-36, Short Form Health Survey – 36; SDQ-20, Somatoform Dissociation Questionnaire – 20; TUG, Timed Up and Go; WeeFIM, Functional Independence Measure for Children; WSAS, Work and Social Adjustment Scale.