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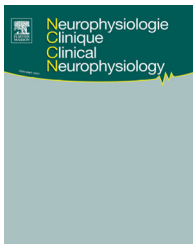

ORIGINAL ARTICLE/ARTICLE ORIGINAL

Functional neurological disorders: The neurological assessment as treatment☆

Troubles neurologiques fonctionnelles : l'évaluation neurologique comme traitement

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Summary The neurologist's role in patients with functional disorders has traditionally been limited to making the diagnosis, excluding a 'disease' and pronouncing the symptoms to be 'non-organic' or 'psychogenic'. In this article, I argue that there are multiple opportunities during routine assessment of a patient with a functional disorder for the neurologist to take the lead with treatment. These opportunities occur throughout history taking, during the examination and, with greatest potential for treatment, at the end of the consultation. Elements of the neurologist's discussion that may be most useful include: (a) emphasis that symptoms are genuine, common and potentially reversible; (b) explanation of the positive nature of the diagnosis (i.e. not a diagnosis of exclusion); (c) simple advice about distraction techniques, self-help techniques and sources of information; (d) referral on to appropriate physiotherapy and/or psychological services; (e) offering outpatient review. I also discuss how new diagnostic criteria for DSM-5 and changes proposed for ICD-11 may facilitate changes that allow neurologists to bring their management of patients with functional disorders in line with other multidisciplinary neurological disorders in the outpatient clinic.

MOTS CLÉS
Troubles conversifs ;
Psychogène ;
Symptômes neurologiques fonctionnels ;
Traitement ;
Hystérie

Résumé On considère classiquement que, chez les patients présentant des symptômes neurologiques fonctionnels, le rôle du neurologue se limite à poser un diagnostic, exclure une « pathologie » et annoncer que les symptômes sont « non organiques » ou « psychogènes. Dans cet article, j'explique que, durant la mise au point de routine habituellement réalisée chez un patient présentant des symptômes neurologiques fonctionnels, le neurologue a de nombreuses occasions de jouer un rôle thérapeutique de premier plan. Ces occasions se présentent lors de l'anamnèse, de l'examen neurologique et, surtout, en fin de consultation. Les éléments de discussion les plus utiles qu'il peut fournir sont les suivants : (i) insister sur le fait que les symptômes sont bien réels, non exceptionnels et potentiellement réversibles ; (ii) expliquer

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qu'il pose un diagnostic positif et non un diagnostic d'exclusion ; (iii) donner un avis simple à propos des techniques de distraction, d'autosuggestion ainsi que sur les sources d'information ; (iv) donner accès à un service de physiothérapie ou de psychologie adapté ; (v) proposer au patient une consultation de suivi. Je montrerai également dans quelle mesure les nouveaux critères diagnostiques du DSM-5 et les modifications proposées par l'ICD-11 faciliteront la tâche du neurologue dans sa prise en charge des patients présentant des symptômes fonctionnels, dans le cadre d'une approche multidisciplinaire en consultation de routine.

Introduction

Doctors in nearly all medical specialities see patients with physical symptoms, which are genuine but cannot be explained on the basis of a recognised 'organic' disease. Around 30—50% of outpatient visits in primary and secondary care are for this reason [23,34].

Some specialties, such as gastroenterology, have developed a pragmatic approach to the diagnosis and treatment of their functional disorders such as irritable bowel syndrome and functional dyspepsia [9]. Functional gastrointestinal disorders now occupy a standard part of their curriculum for training, practice and research. As a consequence gastroenterologists have primary responsibility for the management of patients with these disorders even though they may call on members of the multidisciplinary team to help.

Other specialities, such as cardiology and neurology, have not developed in the same way. Interest in this area from neurologists actually declined over the 20th century for many reasons. These include the success of the clinico-anatomic method, the dualistic split from psychiatry and prevailing notions that the diagnosis of ''conversion disorder'' (requiring evidence of psychic conflict) and treatment (psychodynamic unravelling of the presumed conflict) were essentially the territory of psychiatry rather than neurology [37].

For most of the 20th century, the pendulum swung strongly towards a psychiatric model of functional disorder/conversion disorder. However in the last 10—20 years the pendulum has started to swing back with increasing numbers of biological studies. It will hopefully come to rest on a model where both ''neurology and psychiatry'', ''brain and mind'' are equally important in considering the diagnosis and treatment of these disorders [3,10,11].

In this article, I give a personal view regarding features of the neurological assessment, which I believe can be used by the general neurologist for the day-to-day benefit of their patients with functional disorders. Some of this advice is evidence-based, from prognostic or treatment studies, but much is not and is instead suggested from 15 years of subspecialty interest and referrals of patients often perceived by colleagues to be 'difficult' or at the 'hard end' of the spectrum of functional neurological disorders.

My experience is that there are very few patients who are truly 'difficult' to have a consultation with. Many consultations are time-consuming. Many patients give ''wandering'' histories that need frequent 'reigning in' and considerable patience. There are many patients whom I have not been able to help. But with only a couple of exceptions, the ''recipe'' presented here creates consultations that rarely results in an angry or complaining patient, even though this is a common scenario in many neurology services [4]. Sometimes single consultations have been highly therapeutic without the need for any other intervention. In many others, consultations appear to have helped patients make improvements and work more effectively with other health professionals. Even when a patient's symptoms and disability remain the same I am struck how often patients with functional disorders report 'peace of mind' and improved quality of life after developing a good understanding of their diagnosis. I am aware that a ''recipe'' on a printed page may not be enough. Some colleagues of mine appear to ''say the right things'' but still have unhappy patients, perhaps because those colleagues rushed the consultation or do not fundamentally believe that the patient has anything much the matter with them. When some of my neurologist colleagues ''roll their eyes'' or make comments such as 'no — I think she is genuine/real (i.e. not functional)' they are reminders of the professional ambiguity that characterises views about whether patients with functional disorders are deserving of help or not [19].

The suggestions here allow a model of care, like those in gastroenterology, where functional disorders, like migraine or multiple sclerosis (MS), become part of the accepted repertoire of conditions that a neurologist diagnoses and then takes responsibility for managing. Here I am arguing that, as with those conditions, the neurological assessment should not be regarded as a prelude to treatment, but the *first stage of treatment itself*.

For a systematic description of terminology [6], components of the assessment [42] and pitfalls in diagnosis [39] the reader is directed elsewhere. This article has been adapted from a previous review article by the author [42].

Therapeutic elements of history taking

The purpose of taking a history is not just to obtain information — ideally, it also enables the patient to feel unburdened and gain confidence in the doctor before the diagnosis has even been discussed.

Patients with functional disorders have often had bad experiences with previous doctors. Some common reasons for this include:

- not getting a chance to describe all their symptoms;
- feeling that their symptoms were being 'dismissed' or that they were 'disbelieved';