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A Communication-Centered Approach to Managing Functional Neurological Disorders in the Emergency Room

Abordagem Centrada na Comunicação para a Gestão da Perturbação Neurológica Funcional no Serviço de Urgência

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INTRODUCTION

Functional neurological disorder (FND) describes a group of disorders of the voluntary motor or sensory system, whose origin arises primarily from a modification of nervous system functioning, rather than from a documented pathophysiological disease.[1] It is a common cause of emergency room (ER) presentations.

This condition often mimics stroke, epileptic seizures, movement disorders or acute vestibular syndromes, making it critical to find balance between timely assessment in the emergency setting and its correct identification. Neuroimaging and other tests are valuable to exclude acute or chronic structural disease when clinically indicated, but they are neither sufficient nor required to diagnose FND. In ER practice, both recognition and communication can fail; improving these aspects helps reduce stigma, iatrogenic escalation, and avoidable reattendance. We provide a quick guide on what to say (and what not to say) in a conversation that is respectful, clinically grounded, and able to support an appropriate care pathway.[1,2]

Common emergency room scenarios

These are common FND presentations in the ER. They are described with practical 'rule-in' features to keep in mind[1,3]:

1. Functional seizures: Rule-in features can include prolonged episodes (often longer than three minutes), asynchronous or side-to-side movements, ictal eye closure, fluctuating responsiveness, and rapid recovery without a typical postictal phase (suggestive, not pathognomonic). If vital signs and clinical examination findings support a functional seizure, avoid treatment escalation with benzodiazepines or intubation; focus on safety, calm verbal grounding, and appropriate follow-up.[4,5]
2. Stroke mimic (functional weakness, sensory loss or speech disturbance): After completing time-critical stroke assessment, explain the working diagnosis using positive bedside features (variability, distractibility, inconsistency across tasks), and document the reasoning. Patients benefit from hearing that the stroke pathway was taken seriously and that the ER team is now providing a probable diagnosis and a plan.[1-3]
3. Functional movement or speech symptoms (functional tremor, gait difficulty, dysphonia/stutter or swallowing symptoms): Rule-in features for functional tremor or dystonia often include variability, distractibility and entrainment. For gait or speech/voice symptoms targeted physiotherapy and speech and language therapy can be helpful when delivered within an FND framework, and both written resources and referral pathways can be provided.[3,6-8]
4. Persistent dizziness [possible postural-perceptual dizziness (PPPD)]: When persistent PPPD is suspected, symptoms can be present on most days (often most of the day) and exacerbated by upright posture, active or passive motion, and exposure to moving or complex visual stimuli, and frequently after an acute vestibular event. Diagnosis and management often require follow-up; when in doubt, a neurology (and/or ENT) referral is advised.[6]

Principles for communication in the emergency room

We suggest a concise set of principles that can be delivered in a short period of time and reinforced with written information:

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- ER recognition and communication are the first steps of the plan, but structured follow-up is essential.[1,2]
- Validate symptoms and suffering, explicitly stating that the symptoms are real, disabling, and not under voluntary control.
- Name the diagnosis (or working diagnosis) and specify which positive clinical findings support it (a "rule-in" approach).[1,3]
- Avoid a mind-body dichotomy; frame FND as altered nervous-system functioning (a 'software' problem), rather than structural damage.
- Be transparent about uncertainty and comorbidity: urgent investigations may be needed to exclude time-sensitive emergencies, but routine investigations may be normal and are not sufficient on their own to diagnose FND, and FND can coexist with other neurological or medical disorders. In complex or uncertain cases, seek senior input and consider multidisciplinary discussion and/or neurology review and referral.[1,3]

What should an explanation cover?

A brief ER explanation can still be complete. It is likely more effective if it covers four elements:

1. The diagnosis: state clearly "functional neurological disorder" and emphasize that the symptoms are genuine and involuntary.
2. The clinical basis: describe the positive signs you observed, with a spirit of "ruling-in" rather than "ruling-out".
3. The disease mechanism: clarify that symptoms arise from altered nervous-system functioning (how the brain sends and processes signals) and that this is not typically identifiable on routine structural investigations. Psychological stressors are known risk factors and can modulate symptoms but are not present or identifiable in all patients.
4. The prospect of treatment and next steps: provide a concrete plan that continues in outpatient care, including red-flag symptoms, follow-up pathway and patient-friendly written material.[1,3]

Discharge, documentation, and follow-up

A clear discharge plan is part of communication[1,2,9] It protects patients from iatrogenic escalation and helps the next clinician continue the same narrative. When FND is the leading working diagnosis, consider documenting[1,3,9]:

- The working diagnosis ("probable FND") and the key positive signs observed.
- Which red flags were assessed and why urgent alternative diagnoses were not suspected.
- What was explained to the patient (including that symptoms are real and involuntary), and any written resources provided.
- A concrete follow-up pathway and referral targets, aligned with local service availability. Based on clinical history, presenting symptoms and comorbidities, prioritizing referral to neurology or psychiatry outpatient follow-up. Consider rehabilitation-focused therapies (physiotherapy, occupational therapy, speech and language therapy when communication or swallowing is impaired) and psychotherapy, acknowledging that access may be limited or delayed.[1,2,7,8]
- Clear return precautions (new persistent focal deficit, new red-flag symptoms, injury, prolonged altered consciousness, or clinical deterioration).
- Provide a patient leaflet/URL (e.g. Portuguese resources from the Sociedade Portuguesa de Neurologia and the Portuguese pages of neurosymptoms.org) as a complement to the discharge plan and include it in the discharge report. Patients often read the ER explanation later; written online material can reinforce the message and support adherence between appointments.[5,10]

Where clear pathways exist, the burden of FND can decrease, both for patients (possibly better long-term prognosis) and for healthcare systems.

Practices to avoid

1. Diagnosing FND based on the patient having a previous or concurrent psychiatric disorder such as anxiety, depression or personality disorder. On the other hand, not considering FND due to the patient having no history of psychological stressors.
2. Attributing symptoms only to stress. Prefer a formulation centered on nervous-system functioning.
3. Not considering the diagnosis because the symptoms are apparent in a man or in old age, only considering that FND is frequently reported in women and younger age groups.

4. Any implication of voluntariness or malingering. Symptoms are not under voluntary control.
5. Labelling symptoms as FND solely based on normal imaging or blood tests. Negative tests do not confirm a diagnosis of FND and FND should not be used as an umbrella term for paroxysmal or unusual events with negative imaging. Use a positive-sign ("rule-in") approach and provide a structured plan and appropriate referrals when FND is the leading working diagnosis. In complex or uncertain presentations, discuss with senior physicians and consider multidisciplinary management, including neurology review.
6. Using pejorative labels such as "pseudoseizures". Prefer neutral terms such as functional seizures (previously termed functional nonepileptic seizures).[4,5]
7. Not considering additional acute or chronic structural disease comorbidity. Multiple sclerosis, epilepsy, and stroke may coexist with and can be associated with increased risk of FND.[1,3]

CONCLUSION

In FND, accurate naming and precise ER communication are therapeutic acts. A brief, positive-sign-based explanation that validates symptoms, avoids stigma, and offers a concrete follow-up pathway can change the patient's trajectory. It helps patients leave the ER with understanding rather than uncertainty, and it opens the way for the right next steps.

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AUTHOR CONTRIBUTIONS

ARE: Study design, writing of the manuscript.

IPG, MM: Literature review, critical review of the manuscript.

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