Functional neurological symptom disorder (conversion disorder) in adults: Terminology, diagnosis, and differential diagnosis

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INTRODUCTION

Functional neurological symptom disorder (conversion disorder) is characterized by neurologic symptoms such as weakness, abnormal movements, or nonepileptic seizures, which involve abnormal nervous system functioning rather than structural disease [1]. In addition, clinical findings on examination provide evidence of incompatibility between the symptoms and recognized neurologic disease. Nevertheless, the symptoms are genuine, cause distress and disability, and are associated with high health care expenditures [2,3]. Although the disorder is common in clinical settings, the diagnosis is frequently missed or delayed, which in part explains the generally poor prognosis [4-8].

This topic reviews the terminology, diagnosis, and differential diagnosis of functional neurological symptom disorder. The epidemiology, pathogenesis, prognosis, clinical features, assessment, and treatment are discussed separately, as are specific subtypes of functional neurological symptom disorder (eg, psychogenic nonepileptic seizures and functional movement disorders):

- (See "Functional neurological symptom disorder (conversion disorder) in adults: Epidemiology, pathogenesis, and prognosis".)

- (See "Functional neurological symptom disorder (conversion disorder) in adults: Clinical features, assessment, and comorbidity".)
- (See "Functional neurological symptom disorder (conversion disorder) in adults: Treatment".)
- (See "Psychogenic nonepileptic seizures: Etiology, clinical features, and diagnosis".)
- (See "Functional movement disorders".)

TERMINOLOGY

Multiple terms are used to describe neurologic symptoms or syndromes in the absence of disease pathology, including [9,10]:

- "Functional neurological symptom disorder," meaning that the symptoms arise from abnormal nervous system functioning in the absence of structural pathology (eg, functional limb weakness). This term is consistent with the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) [1]. This term is etiologically neutral and focuses on the mechanism rather than etiology of the disorder [11,12]. However, it may seem vague and does not indicate that psychosocial factors may be important. The shortened term, functional neurological disorder, is commonly used by clinicians and researchers, as well as patient-led organizations and advocates (eg, the FND society and FNDHope) [13].

- "Conversion disorder" (also consistent with DSM-5-TR [1]), "somatization," "somatoform," or "psychogenic," meaning that the symptoms are psychological and possibly caused by a remote or recent stressor. These terms suggest that patients should be referred for psychiatric services, but they introduce etiologic assumptions that often cannot often be proven. As an example, the term conversion disorder is based upon the unproven psychoanalytic hypothesis that overwhelming affect, psychological conflict, or stress are unconsciously converted into neurologic symptoms such as paralysis or seizures [14]. In addition, terms such as psychogenic may also connote "faking" or "crazy" behavior and thus alienate patients [15]. In DSM-5-TR, the term conversion disorder is now a secondary option, appearing in parentheses after functional neurological symptom disorder as the primary name: functional neurological symptom disorder (conversion disorder).

- "Dissociative neurological symptom disorder," meaning sensation or control of movement is separated from awareness. This term is consistent with the World Health Organization's International Classification of Diseases, 11th Revision (ICD-11) [16]. The term is particularly useful to describe the trance-like state seen in nonepileptic seizures, but also implies that

patients have persistent depersonalization or derealization (which is frequently not the case independent of a seizure episode). The shortened term, dissociative (specific subtype) disorder is commonly used by clinicians and researchers, as an example, dissociative motor disorder or dissociative seizure disorder.

- "Medically unexplained," meaning that the etiology is unknown. The term is neutral, but suggests that the clinician does not know what is wrong and is incapable of rendering a diagnosis and treatment [12]. In addition, it is not possible to definitively prove that a symptom cannot be medically unexplained [1].

- "Psychosomatic," meaning that the symptom is due to the interaction between the mind and body. However, this term is often interpreted to mean the same thing as somatization or psychogenic.

- "Nonorganic" or "pseudoneurologic," meaning that the patient does not have a disease with a known or recognized pathologic basis. These terms emphasize what patients do **not** have rather than what is present and ignore the central nervous system underpinning of psychiatric phenomena and functional somatic symptoms.

- "Hysteria," which originally meant that symptoms were due to uterine pathology and implied that the disorder was exclusive to females. More recent definitions include emotional excess, overwhelming fear, and psychiatric symptoms involving disturbances of mental, sensory, vasomotor, and visceral functions. This term is generally considered a historic artifact.

DIAGNOSIS

Overview — In patients with neurologic symptoms (eg, abnormal movements or nonepileptic seizures) that are not caused by recognized neurologic disease, the diagnosis of functional neurologic symptom disorder (conversion disorder) should be made after the physician has identified the typical, positive clinical findings that establish the diagnosis [3,8,17,18]. These findings, such as a tubular visual field defect or Hoover's sign of functional leg weakness, either [8,10,11,18,19]:

- Demonstrate that the symptoms are inconsistent across different parts of the examination, referred to as internal inconsistency, or

- Provide evidence of incompatibility between the patient's symptoms and recognized disease.

Functional neurologic symptom disorder is not a diagnosis of exclusion [3].

Prior to 2013, functional neurological symptom disorder, then called conversion disorder, could be diagnosed according to the criteria in either the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) [20], or the International Classification of Diseases, 10th Revision (ICD-10) [21]. However, neither nosologic system was widely used in its entirety because many patients did not fulfill all the criteria [11]. In particular, both nosologies stipulated that functional neurological symptom disorder was associated with or caused by psychologic factors. However, psychologic factors are often not identifiable [18]. In a systematic review that identified 13 retrospective studies of functional neurological symptom disorder, 14 to 70 percent of patients had no history of either stressful life events or any type of maltreatment (eg, sexual or physical abuse) [22]. Even when psychologic factors are identified, it is not always clear that they are etiologically relevant [11].

In DSM-5-TR, as well as the ICD-11, clinicians can make the diagnosis of functional neurological symptom disorder without identifying psychological factors associated with the neurologic symptoms [1,3,8,16,18]. Nevertheless, clinicians should continue to look for psychological factors that are relevant to understanding etiology and guiding treatment.

In addition, clinicians no longer need to determine that the symptom is not feigned, a criterion that is nearly impossible to establish [1,3,8,16]. Furthermore, the diagnosis of functional neurological symptom disorder according to DSM-5-TR and ICD-11 does not depend upon excluding other recognized disorders.

The diagnostic criteria for functional neurological symptom disorder do not specify a time frame for symptoms [1,16]. In most cases, clinicians will assess and follow patients for weeks to months before rendering the diagnosis; however, it is feasible to make the diagnosis at the initial assessment, provided patients fulfill the requisite criteria, which are described in the sections below [23].

Diagnostic and Statistical Manual, Fifth Edition, Text Revision — In DSM-5-TR, functional neurological symptom disorder is also called conversion disorder [1]. DSM-5-TR groups functional neurological symptom disorder with the "somatic symptom and related disorders," which are marked by prominent somatic symptoms that cause distress and psychosocial impairment.

A DSM-5-TR diagnosis of functional neurological symptom disorder requires each of the following criteria (table 1) [1]:

- One or more symptoms of altered voluntary motor or sensory function

- Clinical findings that demonstrate incompatibility between the symptom and recognized neurologic or general medical conditions (eg, Hoover's sign of functional limb weakness or a positive entrainment test for functional tremor)
- The symptom or deficit is not better explained by another medical or mental disorder
- The symptom or deficit causes significant distress, psychosocial impairment, or warrants medical evaluation

The diagnosis rests upon positive clinical findings that indicate the symptom is inconsistent at different times (eg, a "paralyzed" limb will move inadvertently when the patient is distracted by performing movements in their unaffected limb) or is incongruent with anatomy, physiology, or known diseases [1]. However, normal findings on physical examination (eg, reflexes) or normal laboratory tests do not provide positive evidence of functional neurological symptom disorder.

DSM-5-TR describes several subtypes of functional neurological symptom disorder that are based upon the presenting symptom or deficit [1,8]:

- Seizures or attacks – These events are also called functional seizures, dissociative seizures, psychogenic nonepileptic seizures, psychogenic seizures, and nonepileptic seizures. Functional seizures are marked by apparent impaired or loss of consciousness resembling epileptic attacks (for example with generalized limb shaking) or fainting (syncope). (See "Psychogenic nonepileptic seizures: Etiology, clinical features, and diagnosis".)
- Weakness or paralysis – May affect the entire body, one side, or one limb; includes give-way (collapsing) weakness.
- Abnormal movement – Includes dystonic movement, gait disorder, myoclonus, and tremor. (See "Functional movement disorders".)
- Sensory loss or anesthesia – Includes symptoms such as loss of touch or pain sensation.
- Special sensory symptom – Includes disturbance of:
  - Vision, such as reduced or absent vision, double vision, blindness, or tubular visual field (tunnel vision)
  - Hearing (eg, deafness)
  - Olfaction
- Speech symptom – Includes aphonia, dysphonia, articulation deficits, slurred speech, and prosodic abnormalities.

- Swallowing symptom – This symptom is also called globus sensation or globus pharyngeus and is characterized by the sensation of a lump in the throat. (See "Globus sensation".)

- Mixed symptoms – Two or three different subtypes of symptoms are present (eg, paralysis plus blindness).

More common functional neurological symptom disorder subtypes include nonepileptic attacks, sensory loss, weakness and paralysis, and abnormal movement [24].

Functional neurological symptom disorder should not be diagnosed primarily because the patient has a history of other psychiatric disorders (eg, major depression or a personality disorder) or because the neurologic examination and laboratory tests are normal [1,10]. In addition, clinicians must ensure that the symptoms are not better explained by a neurologic or other general medical illness, and should bear in mind that our knowledge of neurologic disease, anatomy, and physiology is incomplete. Neurologic and general medical disorders that are included in the differential diagnosis are discussed separately. (See 'Neurologic disorders' below.)

Functional neurological symptom disorder can be diagnosed in patients who have comorbid, recognized neurologic diseases, provided there is evidence that the diseases do not better explain the functional neurologic symptoms. (See "Functional neurological symptom disorder (conversion disorder) in adults: Clinical features, assessment, and comorbidity", section on 'Neurologic and general medical disorders'.)

In diagnosing functional neurological symptom disorder, it is not necessary to identify conflicts or other stressors associated with functional neurologic symptoms (although identifying stressors may help patient management) [1,11,25,26]. Although psychological factors such as stress, conflicts, and trauma are frequently observed in patients with functional neurological symptom disorder, this is not always the case. In addition, when psychological factors are present, it can be difficult to establish an etiologic relationship between these factors and functional neurological symptom disorder [1,11,27]. Psychologic factors may have a specific etiologic relationship with functional neurological symptom disorder, a nonspecific relationship (ie, psychologic factors may contribute to onset of psychiatric disorders in general), or the presence of psychologic factors may be coincidental. Additional information about premorbid clinical factors and the etiology of functional neurological symptom disorder is discussed separately. (See "Functional neurological symptom disorder (conversion disorder) in adults: Epidemiology, pathogenesis, and prognosis", section on 'Predisposing, precipitating, and perpetuating factors'.)

The diagnosis of functional neurological symptom disorder does not require clinicians to establish that the symptom is not intentionally produced [1,3,26]. Evidence that suggests functional neurological symptom disorder does not involve feigning includes the consistency among different patients in how they report their symptoms, the common pattern of comorbidity and physical evidence (eg, abnormal shoe wear, disuse atrophy, and contractures) across patients, evidence from neurobiological research [28,29], differential response to treatment in randomized clinical trials [29], and the distress and disability that is observed in follow-up studies [10]. However, if the history or examination demonstrate that the symptoms are feigned, the diagnosis of functional neurological symptom disorder should not be made. (See 'Feigned symptoms' below.)

Exposure to a common precipitant may lead to shared functional neurologic symptoms in a group of people ("mass psychogenic illness") [30-32]. Functional neurological symptom disorder is diagnosed only in those individuals manifesting voluntary motor or sensory symptoms (eg, paralysis, sensory disturbance, or nonepileptic seizure symptoms) meeting diagnostic criteria for the disorder.

International Classification of Diseases, 11th Revision — ICD-11 went into effect January 2022 [16].

In ICD-11, functional neurological symptom disorder is called "dissociative neurological symptom disorder" [16]. ICD-11 categorizes the disorder among the "dissociative disorders," which are marked by symptoms that disrupt identity, perceptions, thoughts, memories, feelings, control of body movements, or behavior, and cause significant psychosocial impairment. Dissociative disorders are a subset of "mental, behavioral, or neurodevelopmental disorders." Given that dissociative neurological symptom disorder stands at the interface between psychiatry and neurology, and is often diagnosed by neurologists [18,33], ICD-11 also classifies the disorder within the category "diseases of the nervous system."

An ICD-11 diagnosis of dissociative neurological symptom disorder requires each of the following criteria [16]:

- One or more motor, sensory, or cognitive symptoms
- The symptoms suggest an involuntary disruption in the normal integration of motor, sensory, or cognitive functions
- The symptoms are not consistent with a recognized neurologic or general medical disorder, or another psychiatric disorder

- The symptoms do not occur exclusively during another dissociative disorder such as dissociative identity disorder
- The symptoms are not caused by a substance or medication, including withdrawal effects, or a by sleep-wake disorder, and do not occur solely during hypnagogic or hypnopompic states
- The symptoms significantly impair family, interpersonal, occupational, or other important areas of psychosocial functioning

ICD-11 subtypes of dissociative neurological symptom disorder are based upon the presenting symptom or deficit, including [16]:

- Auditory disturbance
- Cognitive symptoms
- Dizziness or vertigo
- Gait disturbance
- Movement disturbance
- Nonepileptic seizures
- Paresis or weakness
- Sensory disturbance
- Speech disturbance
- Visual disturbance

International Classification of Diseases, 10th Revision — Although ICD-11 went into effect January 2022, some countries continue to use ICD-10.

As stated above (see 'Diagnosis' above), the ICD-10 criteria are problematic because many patients with the disorder do not fulfill all of the criteria [11], particularly the criterion that stipulates that functional neurologic symptoms are caused by psychological factors.

The ICD-10 classifies functional neurological symptom disorder among the “dissociative disorders,” which are characterized by disruption of awareness, memory, identity, sensations, and control of body movements [21]. Diagnostic equivalents to functional neurological symptom disorder within ICD–10 include:

- Dissociative motor disorders
- Dissociative anaesthesia and sensory loss
- Dissociative convulsions
- Mixed dissociative disorders

Dissociation in this context often includes a feeling of disconnection from one's own body (depersonalization) or from one's environment (derealization) [10].

Diagnosis of ICD–10 functional neurological symptom disorder equivalents requires each of the following criteria [21]:

- Symptoms suggesting the specific dissociative disorder (motor, sensory, convulsions, or mixed)
- No evidence of neurologic or general medical disorders that explain the symptoms
- Evidence that the specific dissociative disorder is caused by psychological factors such as stressful events, intractable problems, or interpersonal difficulties

Although ICD-10 does not explicitly require clinicians to exclude feigning of symptoms to diagnose dissociative movement or sensation disorders or dissociative seizures, the need to do so is implied in the supporting text that discusses the differential diagnosis and the difficulty in distinguishing dissociation from conscious simulation of loss of movement and sensation [21].

DIFFERENTIAL DIAGNOSIS

The differential diagnosis for functional neurological symptom disorder (conversion disorder) includes neurologic and general medical disorders, other psychiatric disorders, and malingering, as shown in the algorithm (algorithm 1) [1].

Neurologic disorders — The differential diagnosis for functional neurological symptom disorder includes many general medical disorders and all neurologic diseases, including multiple sclerosis, myasthenia gravis, movement disorders, stroke, epilepsy, and spinal disorders [1,21]. Clinicians faced with symptoms that are difficult to interpret should exercise caution in diagnosing functional neurological symptom disorder, no matter how much the psychiatric history suggests it. Patients may notice symptoms of an occult disease during its early stage when signs on physical examination or laboratory test abnormalities are not readily apparent [3,34]. In addition, more unusual neurologic diseases such as stiff person syndrome, autoimmune limbic encephalitis, and frontal lobe epilepsy may present with unusual features such as symptom variability, bizarre behavior (eg, cycling leg movements or pelvic thrusting), or other symptoms (eg, emotional lability) that might lead the unwary to diagnose functional neurological symptom disorder, even though these unusual features are not typical for functional neurological symptom disorder [3].

Another factor that may lead clinicians to wrongly diagnose functional neurological symptom disorder in patients with a recognized neurologic disorder includes placing undue emphasis upon psychiatric comorbidity [3]. Psychiatric disorders are common in functional neurological symptom disorder and are important to diagnose for formulation and treatment, but are also present in a range of neurologic conditions such as stroke and epilepsy; thus, psychiatric comorbidity alone should not be used to make the diagnosis of functional neurological symptom disorder. Similarly, life stress is common and a common clinical error is to conclude that because neurologic symptoms follow stress, they may be due to functional neurological symptoms disorder [35].

In addition, clinicians should usually not rely upon a single sign to diagnose functional neurological symptom disorder; rather, the diagnosis is based upon multiple features that constitute the syndrome [3]. Furthermore, the effects of a recognized neurologic disease can be frightening, which may lead patients to exaggerate their symptoms to convince a doctor about their problem [36]. The probability that apparent functional neurological symptom disorder is actually the harbinger of an alternative (recognized) neurologic condition may be greater in patients with gait disorders [37].

However, a balance must be struck between not missing neurologic/general medical disorders and failing to positively diagnose functional neurological symptom disorder. The frequency of erroneously diagnosing functional neurological symptom disorder in patients who are subsequently found to have a recognized neurologic illness (which with hindsight explained the initial symptoms) is generally regarded as low [25]:

- A systematic review of 27 studies (mostly retrospective; median duration of follow-up was five years) found that among 1466 patients initially diagnosed with functional symptoms, the frequency of misdiagnosis was approximately 4 percent [37].
- A subsequent study prospectively followed a group of 209 patients initially diagnosed with functional neurological symptom disorder, who were part of 1030 neurology outpatients with symptoms that were considered “somewhat” or “not at all explained” by a recognizable neurologic disease [24]. After a median follow-up of 19 months, the investigators determined that the initial diagnosis was wrong in none of the functional neurological symptom disorder patients and in 0.4 percent of the entire group.

Conversely, the frequency of incorrectly diagnosing other neurologic disorders (eg, epilepsy or multiple sclerosis) in patients who ultimately are found to have functional neurological symptom disorder is approximately 6 to 11 percent [38,39]. One reason that clinicians may miss the diagnosis of functional neurological symptom disorder is that they believe the absence of

psychiatric comorbidity rules out functional neurological symptom disorder [3]. In addition, some patients with functional neurological symptom disorder do not fit its stereotypical, sociodemographic profile [3,40]. (See "Functional neurological symptom disorder (conversion disorder) in adults: Epidemiology, pathogenesis, and prognosis", section on 'Sociodemographic correlates'.)

Many patients have both functional neurological symptom disorder and a recognized neurologic condition [3,41]. Meta-analyses of observational studies suggest that among patients with psychogenic nonepileptic seizures, comorbid epilepsy occurs in approximately 20 percent [42]. Among patients with epilepsy, psychogenic nonepileptic seizures are found in approximately 10 percent. (See "Psychogenic nonepileptic seizures: Etiology, clinical features, and diagnosis", section on 'Concurrent or past epilepsy'.)

The differential diagnosis of functional neurological symptom disorder includes all neurologic diseases [34], including:

Multiple sclerosis — Both multiple sclerosis and functional neurological symptom disorder can involve voluntary motor and sensory symptoms, but patients with functional neurological symptom disorder will have inconsistent limb movements, whereas patients with multiple sclerosis alone will not. Multiple sclerosis is also distinguished by characteristic lesions on magnetic resonance imaging (MRI) [43]. (See "Evaluation and diagnosis of multiple sclerosis in adults", section on 'Diagnosis'.)

Myasthenia gravis — Myasthenia gravis and functional neurological symptom disorder can both present with weakness that changes over time, but patients with functional neurological symptom disorder will have positive evidence of inconsistency without fatigue. Myasthenia gravis is often associated with bulbar symptoms, diplopia, and ptosis, which are rare in functional neurological symptom disorder; myasthenia gravis is also differentiated by findings on serologic tests for autoantibodies and on electrophysiologic studies (repetitive nerve stimulation studies and single-fiber electromyography) that are not present in functional neurological symptom disorder. (See "Diagnosis of myasthenia gravis".)

Movement disorders — Functional movement disorders and movement disorders due to defined neurologic disease both present with abnormal movements; however, functional movement disorders are characterized by several typical clinical features, especially signs and symptoms that are inconsistent over time and incongruent with recognizable neurologic disease. (See "Functional movement disorders".)

Stroke — Stroke and functional neurological symptom disorder can both manifest with weakness. However, patients with functional limb weakness as part of functional neurological

symptom disorder have inconsistent limb movements, whereas patients with stroke alone do not. In addition, patients with stroke usually have findings on brain imaging [40]. (See "Overview of the evaluation of stroke".)

Spinal disorders — Spinal disorders (eg, cervical myelopathy or lumbar nerve root entrapment) and functional neurological symptom disorder may each cause weakness or sensory disturbance. However, patients with functional neurological symptom disorder manifest symptoms (eg, limb weakness) that are inconsistent across different parts of the examination, whereas patients with spinal disorders should not.

Epilepsy — Epilepsy and psychogenic nonepileptic seizures (a subtype of functional neurological symptom disorder) both manifest with unresponsive behavior and motor movements that suggest a generalized convulsion, complex partial seizure, or syncope. However, nonepileptic seizures and epileptic seizures are distinguished by recording an event on video electroencephalography and analyzing the clinical and electrographic features. (See "Psychogenic nonepileptic seizures: Etiology, clinical features, and diagnosis".)

Relatively unusual diseases — Examples of more unusual neurologic diseases to consider in the differential diagnosis of functional neurological symptom disorder include:

Autoimmune limbic encephalitis — Limbic encephalitis and functional neurological symptom disorder may each present with seizures, cognitive problems, and mood changes. Positive findings on neuroimaging, electroencephalography, lumbar puncture, or serologic testing for antibodies are generally found in limbic encephalitis but not functional neurological symptom disorder. (See "Autoimmune (including paraneoplastic) encephalitis: Clinical features and diagnosis".)

Stiff person syndrome — Impaired ambulation, variable limb stiffness, and spasms can occur in both stiff person syndrome and functional neurological symptom disorder. However, stiff person syndrome is usually denoted by the presence of antiglutamic acid decarboxylase antibodies in association with this clinical picture. (See "Stiff-person syndrome".)

Laryngeal dystonia — Dysphonia (manifesting with whispering or hoarseness) can occur in both laryngeal dystonia (spasmodic dysphonia) and functional neurological symptom disorder (functional dysphonia). Laryngeal dystonia may be either a primary pathologic phenomenon or secondary to illnesses such as Parkinson disease or multiple system atrophy. Clues that the speech impairment may be due to functional neurological symptom disorder include the presence of a normal cough or singing voice. The diagnosis of functional neurological symptom disorder is confirmed by normal vocal cord movement on laryngoscopy. (See "Etiology, clinical

features, and diagnostic evaluation of dystonia", section on 'Laryngeal dystonia' and "Hoarseness in adults", section on 'Spasmodic dysphonia'.)

Somatic symptom disorder — In DSM-5-TR, somatic symptom disorder and functional neurological symptom disorder are both categorized among the "somatic symptom and related disorders," which are characterized by prominent somatic symptoms that cause significant distress and psychosocial impairment [1]. A means of differentiating functional neurological symptom disorder from somatic symptom disorder, as well as other somatic symptom and related disorders, is displayed in the algorithm.

In somatic symptom disorder, patients react excessively to somatic symptoms, but these symptoms are not defined by loss of function that is clearly incompatible with anatomy, physiology, and recognized neurologic or general medical illnesses. Thus, somatic symptom disorder can occur in patients whose symptoms are explained by recognized diseases. By contrast, functional neurological symptom disorder is characterized by clinical findings that are inconsistent with anatomy, physiology, and recognized disease. In addition, the excessive thoughts, feelings, and behaviors that occur in somatic symptom disorder may not be present in functional neurological symptom disorder.

Functional neurological symptom disorder can be diagnosed alongside somatic symptom disorder if criteria for both disorders are met. (See "Somatic symptom disorder: Epidemiology and clinical presentation" and "Somatic symptom disorder: Assessment and diagnosis".)

Depersonalization/derealization disorder — Depersonalization (feeling disconnected from one's own body) and/or derealization (feeling disconnected from one's environment), which characterize depersonalization/derealization disorder, can also occur in functional neurological symptom disorder, and some patients warrant both diagnoses [1]. However, functional neurological symptom disorder presents with symptoms of altered voluntary motor or sensory function, and clinical findings that demonstrate incompatibility between the symptoms and recognized neurologic conditions, whereas depersonalization/derealization disorder does not. (See "Depersonalization/derealization disorder: Epidemiology, clinical features, assessment, and diagnosis".)

Feigned symptoms — Feigned symptoms are encountered when a patient intentionally gives a false account of symptoms or pretends to have impaired function. Functional neurological symptom disorder is distinguished from feigned symptoms that are deliberately produced [1,3,8].

A clue that patients are feigning includes disparate accounts or presentations of symptoms to different clinicians. However, definitively establishing that the patient is feigning is possible only

if the patient acknowledges willfully producing the symptoms, or if other evidence demonstrates a major inconsistency between reported and observed function (eg, a patient who reports an inability to walk is subsequently observed on a video recording playing tennis). Minor discrepancies in symptoms or disability are in keeping with the variable nature of functional neurologic symptoms, which tend to worsen when attention is paid to them [3].

Feigned symptoms may be due to factitious disorder, which is a psychiatric disorder, or to malingering, which is a behavior [1]. The distinction between factitious disorder and malingering rests upon the patient's apparent motivation, as described in the subsections below. Factitious disorder and malingering are thought to be relatively rare [3].

Factitious disorder — Both factitious disorder and functional neurological symptom disorder are characterized by prominent somatic symptoms that cause significant distress and psychosocial impairment [1]. In addition, factitious disorder may involve neurologic symptoms, as does functional neurological symptom disorder. However, patients with factitious disorder deliberately feign symptoms and deceive clinicians for the purpose of becoming a patient and obtaining medical care. In functional neurological symptom disorder, there is no clear evidence that symptoms have been simulated for the purpose of receiving medical care [1,3,26,33].

Additional information about factitious disorder is discussed separately. (See "Factitious disorder imposed on self (Munchausen syndrome)".)

Malingering — Malingering and functional neurological symptom disorder are both characterized by symptoms that lack a pathologic basis, the essential feature of malingering is the intentional faking or exaggeration of symptoms for an obvious external benefit, such as money, housing, medications, or avoiding work or criminal prosecution [1]. Malingering is considered a behavior and not a psychiatric disorder. In functional neurological symptom disorder, there is no evidence that the patient is intentionally producing symptoms [1,3,26,33].

Clinicians should consider the possibility of malingering if any of the following is present:

- Multiple inconsistencies in the patient's history
- Major discrepancy between reported and observed activities (eg, claiming that one is unable to walk, but then seen walking)
- Nonadherence with the diagnostic evaluation
- Previous or current antisocial personality disorder
- Medical-legal proceedings (eg, patient is referred by an attorney for evaluation)

SUMMARY

- **Terminology** – Many terms are used to describe neurologic symptoms or syndromes occurring in the absence of recognized disease pathology, including functional neurological symptom disorder, conversion disorder, somatization, somatoform, psychogenic, dissociative neurological symptom disorder, medically unexplained, psychosomatic, nonorganic, pseudoneurologic, and hysterical. (See 'Terminology' above.)

- **Diagnostic criteria** – In the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR), functional neurological symptom disorder (conversion disorder) is classified among the somatic symptom and related disorders, which are marked by prominent somatic symptoms that cause distress and psychosocial impairment. The DSM-5-TR diagnostic criteria for functional neurological symptom disorder are listed in the table (table 1), as are the disorder's subtypes. (See 'Diagnosis' above.)

- **Differential diagnosis** – The differential diagnosis for functional neurological symptom disorder includes (algorithm 1):

  - Neurologic disorders (eg, multiple sclerosis, myasthenia gravis, movement disorders, stroke, spinal disorders, and epilepsy). (See 'Neurologic disorders' above.)

  - Somatic symptom disorder – A means of differentiating functional neurological symptom disorder from somatic symptom disorder, as well as other somatic symptom and related disorders, is displayed in the algorithm (algorithm 1). (See 'Somatic symptom disorder' above.)

  - Depersonalization/derealization disorder. (See 'Depersonalization/derealization disorder' above.)

  - Feigned symptoms – Factitious disorder and malingering. (See 'Feigned symptoms' above.)

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