Especially bad/strange logic

Stone, J., Binzer, M. and Sharpe, M. (2004) “Illness beliefs and locus of control,” Journal of Psychosomatic Research, 57(6), pp. 541–547. Available at: https://doi.org/10.1016/j.jpsychores.2004.03.013.

'In comparison with patients with epilepsy, patients with recent onset pseudoseizures believed that psychological factors were less important than somatic ones were (P < .005) and had a greater tendency to deny nonhealth life stresses (P < .0001). No significant differences were detected in disease conviction or illness worry.
(...)
Patients with pseudoseizures are less likely than those with epilepsy to see psychological factors as relevant to their symptoms, more likely to deny that they have suffered from life stress and also to have a more external locus of control.'

Gelauff, J.M., Dreissen, Y.E.M., et al. (2014) “Treatment of Functional Motor Disorders,” Current Treatment Options in Neurology, 16(4). Available at: https://doi.org/10.1007/s11940-014-0286-5.

'For the treatment of functional motor disorder, we recommend a three-stage approach. Firstly, patients must be assessed and given an unambiguous diagnosis, with an explanation that helps them understand that they have a genuine disorder, with the potential for reversibility.(...)Finally, although they have confidence in the diagnosis, many patients do not respond to treatment.'

Nielsen, G. et al. (2015) "Physiotherapy for functional motor disorders: a consensus recommendation," J Neurol Neurosurg Psychiatry, 86(10), pp. 1113–1119. Available at: https://doi.org/10.1136/jnnp-2014-309255.

'Background: Patients with functional motor disorder (FMD) including weakness and paralysis are commonly referred to physiotherapists. There is growing evidence that physiotherapy is an effective treatment, but the existing literature has limited explanations of what physiotherapy should consist of and there are insufficient data to produce evidence-based guidelines. We aim to address this issue by presenting recommendations for physiotherapy treatment.

Methods: A meeting was held between physiotherapists, neurologists and neuropsychiatrists, all with extensive experience in treating FMD. A set of consensus recommendations were produced based on existing evidence and experience.

Results: We recommend that physiotherapy treatment is based on a biopsychosocial aetiological framework. Treatment should address illness beliefs, self-directed attention and abnormal habitual movement patterns through a process of education, movement retraining and self-management strategies within a positive and non-judgemental context. We provide specific examples of these strategies for different symptoms.

Conclusions: Physiotherapy has a key role in the multidisciplinary management of patients with FMD. There appear to be specific physiotherapy techniques which are useful in FMD and which are amenable to and require prospective evaluation. The processes involved in referral, treatment and discharge from physiotherapy should be considered carefully as a part of a treatment package.'

Popkirov, S., Carson, A. and Stone, J. (2018) “Scared or scarred: Could ‘dissociogenic’ lesions predispose to nonepileptic seizures after head trauma?,” Seizure-european Journal of Epilepsy, 58, pp. 127–132. Available at: https://doi.org/10.1016/j.seizure.2018.04.009.

'A history of head injury is common in patients with psychogenic nonepileptic seizures (PNES). This association has so far been interpreted as either spurious or psychologically mediated. Biased recall and misattribution could foster illness beliefs about brain damage that promote symptom production. Furthermore, the emotional impact of head injury could induce long-term changes in stress responsivity. Lastly, maladaptive cognitive-behavioural processes involving symptom modelling and aversive conditioning, known to play a role in functional neurological disorders, could contribute to the development of PNES after head trauma. Lesional effects of head injury, on the other hand, remain unexplored in the context of PNES. However, even mild traumatic brain injury without structural MRI abnormalities on routine imaging can lead to disruptions of network connectivity that correlate with short-term cognitive impairments and psychiatric symptoms. Since alterations in global functional connectivity have been demonstrated in PNES patients using imaging and electroencephalography, we hypothesize that, in some patients, TBI and the associated disruption of long-range association fibres could contribute to the individual propensity for dissociative experiences in general and PNES in particular. This possibility is explored in the context of new cognitive-behavioural models of PNES pathogenesis, and the concept of a "dissociogenic" brain lesion is introduced.'

Bolton, C.M. and Goldsmith, P.F. (2018) “Complaints from patients with functional neurological disorders: a cross-sectional UK survey of why patients complain and the effect on the clinicians who look after them,” BMJ Open, 8(11), p. e021573. Available at: https://pubmed.ncbi.nlm.nih.gov/30413498/

‘Patients with functional disorders (sometimes also referred to as medically unexplained symptoms) have symptoms that are caused by maladaptive functioning of one or more particular body system(s), without any underlying tissue or organ damage.
(…)

Optimal management has advanced considerably in recent years, with the importance of making a positive diagnosis being key, rather than telling a patient what they do not have and perpetuating disability.

(…)

Patients with functional conditions tend to show more dissatisfaction with healthcare services,23–25 and anecdotally, functional disorders feature prominently in some of the most problematic and involved complaints. However, there is a dearth of literature in this area.

(…)

Many respondents described an ‘inevitability’ and a ‘lack of surprise’ at receiving complaints from patients with functional neurological disorders, with one clinician suggesting this was due to a ‘defensive agenda’ by patients and another suggesting it was part of a ‘pathological behaviour pattern’ causing them to ‘jump to conclusions’.

(…)

Of 48 respondents, 58% thought the complaint was unjustified. Many clinicians explained they had already taken extra time and effort to explain the diagnosis and explore management options, and despite this, the patient still complained. Many felt the complaint was a personal attack, describing the complaint as ‘vindictive’, ‘personally critical’, and ‘calculated to damage (my) reputation’.’

Andrini, H.J. et al. (2021) “Functional Seizures: The Patient’s Perspective of a Diagnostic and Treatment Odyssey,” Epilepsy & Behavior Reports, 17, p. 100509. Available at: https://www.sciencedirect.com/science/article/pii/S2589986421000836

‘The treatment of functional seizures usually takes months because of the time it takes for the patient to finally come to terms and accept their condition [29]. Studies have shown that episodes can cease in many patients without treatment within 3–6 months.
(…)
Patients who cannot correlate stressors to their condition may have a reduced ability to identify with their diagnosis of functional seizures [12], [14]. Thus, it appears that lack of understanding between this patient and the medical practitioners presented the most significant barrier to pursuing effective treatment and progress for resolving her functional seizures.’