Understanding Functional Neurological Disorder: A Practical Guide for PI & CN Solicitors

This ebook is based on insights shared during an INNEG webinar delivered by Dr Bruno Silva, Consultant Neuropsychiatrist, examining functional neurological disorder in the context of personal injury and clinical negligence claims. Drawing directly from that session, it explores why claimants can experience genuine, disabling neurological symptoms despite normal or non-explanatory investigations, how these presentations are diagnosed and understood in clinical practice, and why they create recurring evidential challenges in litigation. Written for solicitors, the ebook provides clarity on diagnosis, causation, credibility and prognosis where symptoms do not fit the scan, helping practitioners navigate an area of evidence that is frequently misunderstood.

A solicitor's guide to functional neurological disorder (FND) in PI and clinical negligence claims. Produced by INNEG based on key clinical insights shared during our Symptoms Without Clear Pathology Webinar

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The Evidential Gap

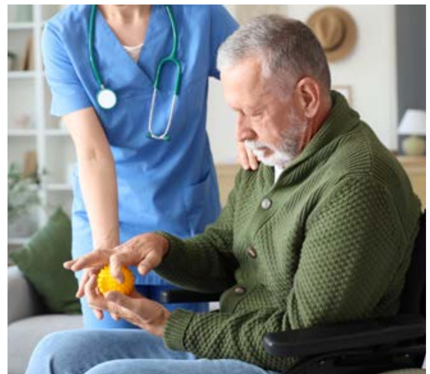
In personal injury and clinical negligence claims, solicitors often encounter a familiar difficulty: a claimant presents with ongoing, disabling neurological symptoms, yet investigations such as scans, EEGs or other tests are reported as normal or non-explanatory.

This apparent mismatch between symptoms and investigations can create uncertainty around diagnosis, causation and, at times, credibility. It may also lead to repeated referrals, delayed progress, or assumptions that the absence of structural findings means there is no underlying neurological problem.

As explained in **this webinar** by Consultant Neuropsychiatrist Dr Bruno Silva, this evidential gap is not unusual and does not mean that nothing is wrong.

In many cases, it reflects functional neurological disorder (FND) - a recognised medical diagnosis in which symptoms are real, involuntary and often disabling, despite the absence of visible structural damage on conventional investigations.

Understanding the difference between structural injury and functional disturbance is critical for solicitors. It underpins clearer expert instruction, more coherent medical narratives, and avoids flawed assumptions that can weaken otherwise well-founded claims.



01

Functional Symptoms

Dr Silva emphasises a core principle throughout the webinar: functional symptoms are real and involuntary. They are not consciously produced, exaggerated, or under the patient's control.

From the patient's perspective, these symptoms are indistinguishable from those caused by structural neurological injury. Individuals experiencing functional symptoms do not perceive them as psychological or imagined; they experience them as genuine neurological problems, with the same intensity, distress and sense of loss of function as any other neurological condition.

Importantly, functional symptoms can be profoundly disabling. They may affect mobility, balance, speech or cognition, or present as seizure-like episodes that significantly disrupt daily life. Even where investigations appear normal or non-explanatory, the functional impact on work, independence and quality of life can be substantial and enduring.

02

Inconsistency Does Not Mean Unreliability

One of the most misunderstood aspects of functional neurological presentations is inconsistency. In a medico-legal context, variation in symptoms is often viewed with suspicion, yet in functional disorders it is not only expected, but diagnostically significant.

Functional symptoms are internally inconsistent. They may fluctuate in intensity, appear and disappear, or change depending on factors such as attention, distraction, stress or perceived threat. As Dr Silva explains, symptoms may worsen when a patient focuses on them and lessens when attention is diverted. This pattern reflects how functional symptoms operate, not a lack of genuineness.

Importantly, this short-term variability sits alongside longitudinal consistency. Over time, functional symptoms tend to follow recognisable patterns that remain consistent across different settings, observations and assessments. This distinction is critical. While symptoms may vary from moment to moment, the overall presentation remains stable and predictable when viewed over a longer period.

In medico-legal assessment, failing to recognise this distinction can lead to inconsistency being misinterpreted as unreliability or dishonesty. In reality, for functional neurological disorder, inconsistency is often part of the clinical picture and should be understood as such when evaluating evidence.

03

Normal Scans

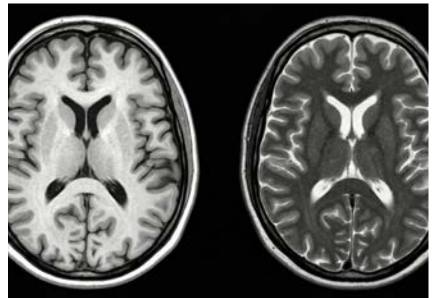
A central message of the webinar is that functional neurological disorder is not a diagnosis of exclusion. It is not reached simply because tests are normal, nor because other explanations have been exhausted.

The presence of normal investigations does not lead to the diagnosis. Instead, FND is diagnosed clinically, based on positive features identified through careful history-taking and examination. In many cases, those features are evident before any investigations are reviewed, and they point directly towards a functional explanation.

To clarify this distinction, Dr Silva uses the analogy of hardware and software. Structural imaging examines the brain's hardware - its physical integrity.

Functional symptoms arise when the brain's functioning, or "software", is disrupted, even though the hardware appears intact on scans.

This principle is already widely accepted across medicine. Conditions such as migraine, asthma or cardiac arrhythmia can cause severe, disabling symptoms despite normal imaging or tests. Functional neurological disorder operates on the same basis: dysfunction without visible structural damage, but with very real clinical consequences.



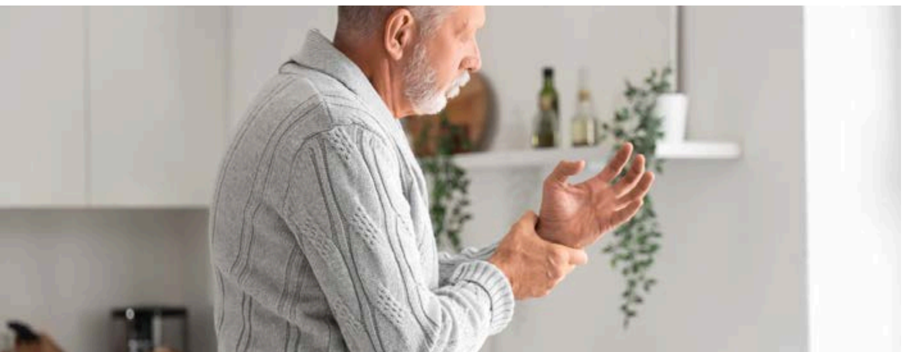
04

What FND Looks Like in Practice

According to the webinar, functional neurological disorder can present in a range of ways that closely resemble other neurological conditions. Common functional presentations include:

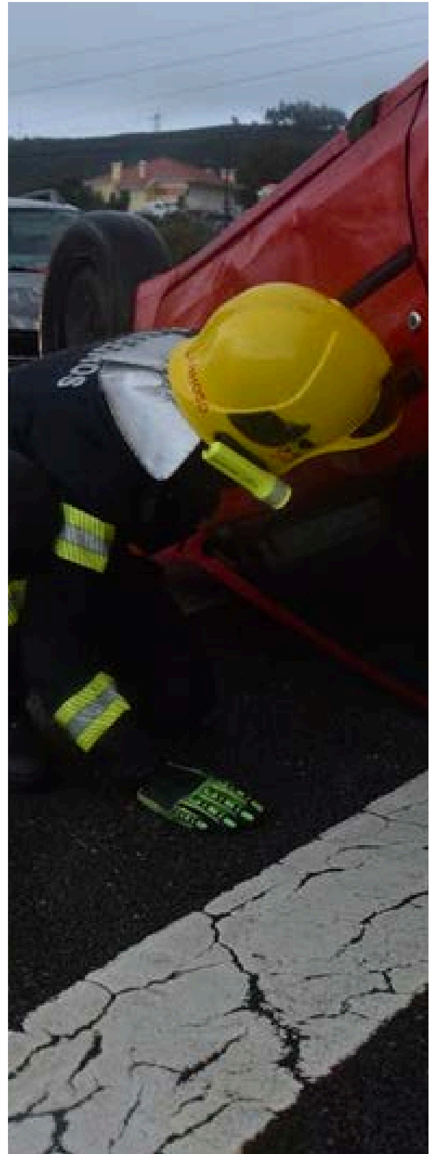
- *Limb weakness or, in some cases, complete paralysis*
- *Gait and balance difficulties*
- *Tremors or abnormal movements*
- *Non-epileptic seizures that resemble epileptic events*
- *Cognitive complaints, often described as functional cognitive disorder*

These symptoms can be striking in their severity and are often indistinguishable, at first glance, from symptoms caused by structural neurological disease.



Dr Silva explains that functional symptoms frequently arise after a physical injury or medical event. This may include a road traffic accident, mild traumatic brain injury, stroke, critical illness, or a period of prolonged pain, stress or medical uncertainty. In clinical negligence cases, delayed diagnosis or extended periods without explanation can be particularly relevant triggers.

In many cases, the resulting symptoms appear disproportionate to the severity of the initial injury. This disproportion is a common source of diagnostic and legal complexity, as the observable disability does not align neatly with the objective findings. Understanding functional mechanisms helps explain why significant and persistent symptoms can develop even when the original injury was relatively mild.



05

How FND is Diagnosed

A key takeaway for solicitors is that functional neurological disorder is diagnosed through positive clinical evidence, not by ruling everything else out. It is not a default diagnosis reached after normal test results, but a condition identified through specific features observed during clinical assessment.

As Dr Silva explains, clinicians diagnose FND by carefully examining how symptoms present and behave. During assessment, they may observe features such as:

- *Improvement of weakness or tremor when the patient is distracted*
- *Automatic movements functioning more effectively than voluntary ones*
- *Symptoms that do not follow recognised anatomical or neurological patterns*
- *Cognitive complaints that contrast with preserved real-world memory, recall or functioning*

These findings demonstrate an incompatibility between the symptoms and structural neurological disease, which is central to the diagnosis. Importantly, these features can

often be identified before investigations are reviewed.

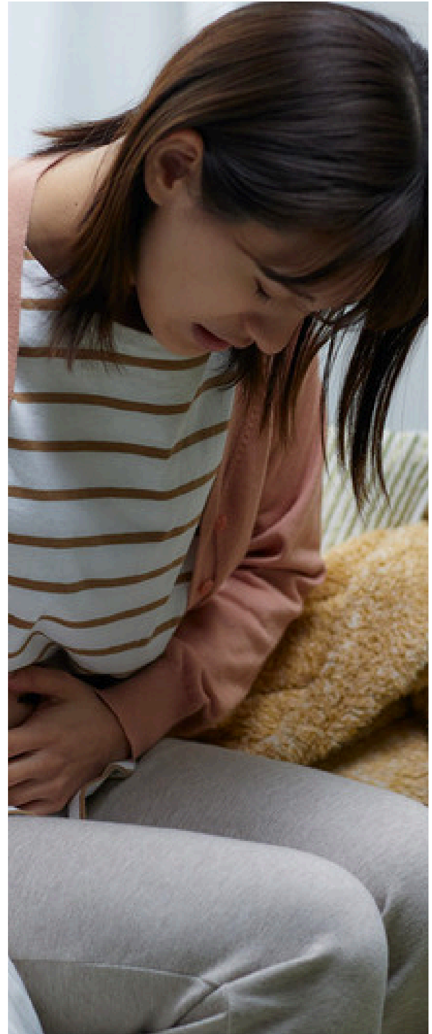
Investigations may still be carried out, but their purpose is different. They are used to exclude competing diagnoses or to clarify co-existing conditions, not to confirm FND simply because results are normal. Understanding this distinction helps solicitors appreciate why expert evidence in functional cases relies heavily on clinical reasoning, rather than imaging alone.

06

Causation

Dr Silva explains causation in functional neurological disorder using a vulnerability-trigger-maintaining factor framework. This approach reflects how causation is understood across neuropsychiatry and helps explain why functional cases often resist simple, linear explanations.

- Vulnerability may include prior trauma, earlier life experiences, or enduring personality traits such as high levels of self-monitoring or perfectionism. These factors do not cause FND in themselves, but they may increase susceptibility.
- Triggers are commonly physical injuries, medical events, or periods of prolonged pain, stress or diagnostic uncertainty. -



-In both PI and clinical negligence claims, the index accident or negligent event frequently plays this triggering role.

- Maintaining factors are influences that allow symptoms to persist or become entrenched. These may include ongoing disability, lack of a clear diagnosis or explanation, inappropriate treatment pathways, and in some cases the stresses and processes associated with litigation itself.

Importantly, Dr Silva stresses that vulnerability does not mean inevitability. Many people have pre-existing vulnerabilities yet never develop functional neurological disorder. In medico-legal terms, this distinction is crucial. In many cases, the index injury or negligent event acts as a material trigger which, on the balance of probabilities, explains why symptoms developed when they did.

07

Symptom Validity and Credibility

The webinar cautions strongly against over-interpreting symptom validity testing in cases involving functional neurological disorder. While such tests can provide useful information, they do not, in isolation, determine whether symptoms are genuine or exaggerated.

As Dr Silva explains, failure on a symptom validity test does not, by itself, prove exaggeration or malingering. In individuals with FND, performance can be affected by uneven attention, distress, fatigue, or cognitive interference - all features commonly seen in functional presentations. For this reason, test results must always be interpreted within the wider clinical context.

Diagnosis and credibility assessment depend on the totality of the evidence, not on a single score or result. A careful review of clinical history, examination findings, behavioural patterns and consistency over time is essential.

Dr Silva distinguishes FND from malingering by highlighting several key differences. In functional disorder, symptoms tend to show patterned fluctuation but remain consistent across different settings and over time. Patients are usually willing to engage with assessment, treatment and rehabilitation, and their symptoms have a genuine impact on real-world functioning. These features contrast with malingering, where presentations may shift strategically, engagement is often limited, and reported symptoms do not align with everyday behaviour.

Treatment & Prognosis

Effective treatment for functional neurological disorder focuses on restoring function and reducing maladaptive patterns, rather than rehabilitating presumed structural damage. As Dr Silva explains, although functional symptoms can resemble those caused by brain injury or stroke, the treatment approach is fundamentally different and must be matched to the diagnosis.

Outcomes for FND are variable. Drawing on clinical experience, Dr Silva notes that approximately:

- *30-40% of patients show meaningful improvement with appropriate treatment*
- *30-40% show partial improvement*
- *20-30% show little or no improvement, even with intervention*

Crucially, prognosis is influenced by timing and accuracy of diagnosis. Earlier identification, a clear and credible explanation of the condition, and access to diagnosis-matched rehabilitation are all associated with better outcomes. Conversely, delays in diagnosis, repeated investigations, and treatment pathways designed for structural injury can entrench symptoms and worsen long-term prognosis.

For solicitors, this reinforces the importance of early clarity. Correct expert instruction and timely formulation do not just strengthen the medical evidence - they can materially influence outcome, rehabilitation prospects and the overall trajectory of the claim.

09

Key Takeaways

- *Functional symptoms are real, involuntary, and disabling*
- *Normal investigations do not negate neurological dysfunction*
- *Inconsistency is a diagnostic feature, not evidence of dishonesty*
- *FND requires positive clinical evidence, not exclusion alone*
- *Causation is multifactorial but often materially linked to index events*
- *Early, correct expert instruction improves both outcomes and evidence*

Understanding why symptoms do not fit the scan allows solicitors to build clearer, more credible cases grounded in contemporary neuropsychiatric evidence.

How INNEG Supports Solicitors

INNEG helps solicitors simplify expert evidence in complex clinical negligence claims.

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