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# Psychotherapy Experiences within Multidisciplinary Care for Functional Neurological Symptom Disorder: A Qualitative Study

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**ABSTRACT**

**Objective:** Functional Neurological Symptom Disorder (FNSD) is a complex neuropsychiatric condition associated with significant disability and shaped by the interaction of biological, psychological, and social processes. Although clinical recognition of FNSD has increased, patients' subjective experiences of psychotherapy within multidisciplinary treatment remain insufficiently examined. This study aimed to qualitatively explore psychotherapy experiences of individuals diagnosed with FNSD who received short-term cognitive behavioral therapy (CBT) as part of a multidisciplinary treatment program.

**Method:** Semi-structured online interviews were conducted with 12 patients diagnosed with functional movement disorders who had completed a multidisciplinary inpatient treatment program. Interviews were audio-recorded, transcribed verbatim, and analyzed using thematic analysis to identify recurrent patterns across the narratives.

**Results:** Patients described therapeutic change across four domains: reduced symptom burden, improved emotional regulation, shifts in illness-related perspectives, and increased behavioral engagement in daily functioning. Change was primarily attributed to three domains: (i) the therapeutic relationship and the psychologically safe treatment environment, (ii) individual readiness and active participation in therapy, and (iii) structured cognitive, behavioral, and experiential techniques. Nevertheless, variability in outcomes was evident, as some patients reported persistent symptoms and ongoing emotional challenges.

**Conclusion:** Psychotherapy experiences in FNSD are not limited to symptom reduction. Alongside improvement, multidimensional experiences such as increased self-awareness, changes in how they understand and interpret their experiences, and re-engagement in daily life were also reported. These findings provide clinically meaningful insights into how therapeutic change is experienced within psychotherapy for FNSD and the factors to which this change is attributed by patients.

**Keywords:** Cognitive behavioral therapy; functional neurological symptom disorder; multidisciplinary treatment; qualitative research.

## INTRODUCTION

Functional Neurological Symptom Disorder (FNSD) is a complex neuropsychiatric condition characterized by symptoms such as paralysis, weakness, tremor, nonepileptic seizures, sensory loss, fatigue, or cognitive impairments, which cannot be explained by structural neurological disease. These symptoms significantly impair daily functioning and social life (Edwards and Bhatia 2012, Szasz et al. 2025). The disorder is defined as "Functional Neurological Symptom Disorder" in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR), and classified as "Dissociative Neurological Symptom Disorder" in the International Classification of Diseases, 11th Revision (ICD-11) (American Psychiatric Association, 2022, World Health Organization, 2019). Functional movement disorders (FMD) represent one of the most common subtypes of FNSD and are considered clinically distinctive due to their diagnostic complexity (Edwards and Bhatia 2012, Espay et al. 2018). The present study focuses specifically on FMD as a subcategory of FNSD. Historically, FNSD has been closely associated with the concept of "conversion disorder," which has been reconsidered within contemporary classification systems through a more comprehensive biopsychosocial framework.

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The literature on conversion disorder provides an important theoretical foundation for understanding FNSD, particularly in terms of the prevalence of psychiatric comorbidities, its relationship with stressors, and its interaction with cognitive and emotional processes. Accordingly, current approaches to FNSD are interpreted in continuity with findings derived from the conversion disorder literature (Uğuz and Toros, 2003, Demir et al. 2013).

In the literature, depression and anxiety are among the most common psychiatric comorbidities in individuals with FNSD, although prevalence estimates vary considerably across studies (Espay et al. 2018). In the FMD subtype, psychiatric comorbidities, particularly depression and anxiety disorders, are also highly prevalent (Gelauff et al. 2014). These findings indicate that comorbid conditions further complicate the clinical presentation. Accordingly, current approaches to FNSD are considered in continuity with findings from the conversion disorder literature. In this regard, studies based on structured clinical interviews indicate that the majority of patients diagnosed with conversion disorder present with at least one psychiatric disorder, most commonly depression, anxiety, and dissociative disorders. Taken together, these findings suggest multilayered role of neuropsychiatric mechanisms in the emergence and maintenance of symptoms (Kaygısız and Alkın 1999).

In addition, the unpredictable course of symptoms, combined with diagnostic uncertainty, creates challenges not only for patients but also for clinicians and healthcare systems. The literature suggests that the annual excess healthcare cost associated with FNSD ranges between USD 4,964 and USD 86,722, and that accurate diagnosis and appropriate interventions may reduce this cost by 9% to 90.7% (O'Mahony et al. 2023). In the absence of effective interventions, symptoms may persist for years, and the level of disability associated with FNSD can become comparable to that observed in major neurological disorders (Gilmour and Jenkins 2021).

Following the historically dominant conversion model, contemporary cognitive and neurobiological approaches conceptualize FNSD as a multifactorial condition that cannot be reduced to a single cause and requires holistic and individualized treatment approaches. This perspective suggests that the disorder is related not only to psychological conflicts but also to multilayered mechanisms including learning processes, cognitive schemas, and bodily awareness. Although the precise mechanisms underlying FNSD have not yet been fully characterized, neurobiological research has yielded promising findings that advance the current understanding of the disorder. These studies increasingly focus on alterations in domains such as predictive processing (the brain's generation of perceptual predictions to interpret environmental stimuli), attention, emotion regulation, sense of agency (the subjective experience of being the source of one's own actions), and interoception (the awareness and interpretation of bodily sensations). (Haggard 2017, Espay et al. 2018, Pick et al. 2020). Accordingly, from a historical perspective, neuropsychological research has demonstrated that individuals diagnosed with conversion disorder exhibit performance patterns in cognitive domains—such as attention, executive functions, memory, and visuospatial processing—that differ from those of healthy controls and are considered to be characteristic of the disorder. These findings suggest that symptoms in FNSD may be associated not only with subjective experiences but also with alterations in cognitive functioning (Demir et al. 2013).

In line with the need for a comprehensive understanding of the disorder, the biopsychosocial model emphasizes the roles of genetic predispositions, neurobiological changes, and social/environmental factors in the onset, triggering, and maintenance of FNSD (Sireci et al. 2024). Within this integrative framework, the expression of symptoms, pathways to help-seeking, and meanings attributed to treatment are strongly influenced by cultural norms. Discourses surrounding psychological distress, such as "conversion," are known to vary across societies (Kirmayer and Sartorius 2007, Canna and Seligman 2020). Similarly, clinical studies on conversion disorder have shown that symptoms often emerge in the presence of identifiable stressors, sociocultural factors, and comorbid psychiatric conditions. The rate of comorbidity has also been reported to increase as the duration of the illness extends. These findings support the view that FNSD has a multifactorial structure closely associated not only with neurological mechanisms but also with psychosocial processes. Therefore, examining patient experiences in the Turkish context is relevant not only for understanding clinical trajectories but also for informing culturally sensitive adaptations of treatment models.

## Cognitive Behavioral Therapy Interventions in FNSD

Due to its multidimensional nature, psychotherapeutic approaches—particularly Cognitive Behavioral Therapy (CBT)—have gained increasing importance in the treatment of FNSD. Cognitive behavioral therapy primarily targets cognitive distortions, attentional processes, and avoidance behaviors that contribute to the maintenance of FNSD symptoms (Sharpe and Carson 2001). Within this framework, therapy aims to help patients identify dysfunctional beliefs about their symptoms, reinterpret bodily sensations, and develop more adaptive coping strategies (Espay et al. 2018). The core therapeutic objectives of CBT in FNSD include a) enhancing bodily awareness, b) strengthening the sense of control and self-efficacy over symptoms, c) disrupting behavioral avoidance cycles, and d) restoring social and occupational functioning (Stone 2016, Goldstein et al. 2020). Recent studies have demonstrated that CBT contributes to reductions in symptom severity,

decreased healthcare utilization, and improvements in daily functioning among patients with FNSD (Jordbru et al. 2014, Goldstein et al. 2020). For these reasons, CBT is considered an evidence-based, structured, and effective psychotherapy option within multidisciplinary treatment approaches for FNSD. Consistent with this multifactorial etiology, treatment approaches have increasingly shifted towards multidisciplinary models integrating neurology, psychiatry, psychotherapy, physiotherapy, and rehabilitation components (Nielsen et al 2015). On the other hand, in line with this complex etiology, treatment efforts have increasingly focused on multidisciplinary programs. These programs integrate interventions from neurology, psychiatry, psychology/psychotherapy (including CBT), physiotherapy, and occupational therapy. Meaningful improvements in symptoms have been observed even in short-term multidisciplinary protocols. For example, in a notable study, following a one-week multidisciplinary rehabilitation program, 86.7% of patients reported improvement in their symptoms, and this improvement was maintained at a rate of 69.2% at the six-month follow-up. These findings were based on both patients' self-reports and clinicians' observations (Jacob et al. 2018). In particular, psychological interventions—especially CBT-based approaches—have been shown to reduce symptom severity and improve quality of life among patients with psychogenic nonepileptic seizures and FMDs (Goldstein et al. 2020, Gutkin et al. 2021).

Despite these advances, significant challenges remain. Although quantitative research has expanded our understanding of the prevalence, clinical determinants, and treatment outcomes of FNSD, considerably less is known about patients' subjective experiences of treatment and therapeutic change. Qualitative methods are considered particularly valuable in capturing these experiential dimensions, which are often overlooked by quantitative analyses, and thus offer important contributions to the field (Rezaei and Stanley 2025). Qualitative studies examining psychotherapy experiences in FNSD remain limited (Rezaei and Stanley 2025, Szasz et al. 2025). A review of the existing qualitative literature indicates that these studies have predominantly focused on patients' experiences related to the disorder itself, including diagnostic processes and psychosocial impacts (Szasz et al. 2025). For example, the study by Staton et al. (2024) explored the experiences of individuals diagnosed with FNSD in relation to access to psychological treatments and their experiences of the psychotherapeutic relationship through qualitative interviews. These findings provided important insights, particularly regarding difficulties encountered during referral to psychotherapy and perceptions of mental health services. However, this study did not systematically explore therapeutic change processes, emotion regulation capacities, or patients' lived experiences of cognitive-behavioral techniques. In this respect, to the best of our knowledge, no qualitative study has systematically examined how patients with FNSD evaluate their psychotherapy experiences within the context of multidisciplinary treatment. Such qualitative investigations are considered valuable for providing insight into who benefits from treatment and who encounters difficulties in the recovery process.

The aim of this study was to qualitatively examine the multidisciplinary treatment experiences of patients diagnosed with FNSD who received short-term psychotherapy (CBT). Specifically, the study sought to understand 1) the changes experienced by patients during or after the psychotherapy process and 2) the factors to which they attributed these changes. In this way, both universal and culture-specific aspects of psychotherapy experiences in FNSD are intended to be addressed in an integrated manner. Through this approach, the study aims to contribute to the development of patient-centered and culturally sensitive multidisciplinary care for individuals with FNSD.

## METHODS

### Research Design

This study was conducted using a qualitative phenomenological approach to examine the experiences of individuals diagnosed with FNSD regarding psychotherapy sessions implemented as part of a multidisciplinary treatment program. The research was designed within a phenomenological framework aimed at understanding the essence of individuals' lived experiences (Moustakas 1994, Giorgi 2009). In this context, the data obtained were analyzed using thematic analysis in order to systematically identify patterns within the dataset (Braun and Clarke 2006). Thematic analysis enabled the organization of phenomenological data into main and subthemes and allowed the findings to be presented in a holistic manner, thereby contributing methodologically to the study's phenomenological perspective. Since the changes experienced during psychotherapy and the factors to which these changes were attributed constitute meaningful experiences that affect patients' lives, the topic was considered appropriate for phenomenological inquiry.

### Participants and Setting

The study included 12 inpatients diagnosed with FMD who were receiving treatment in the Neurology Department of Hacettepe University Hospital. This subtype was selected because the majority of patients diagnosed with FNSD within the hospital's multidisciplinary program consist of FMD cases, and the clinic has substantial experience in this area. Participants were selected using a purposive sampling method. Within this framework, criterion-based and homogeneous sampling strategies were employed (Patton 2015). The

participants consisted of individuals diagnosed with FMD who had participated in the same multidisciplinary inpatient treatment program and were evaluated using a comparable semi-structured interview protocol. During the process, some patients within the identified sampling pool could not be reached, while others declined participation. As participation was voluntary, the data collection process was conducted with patients who met the study criteria and agreed to take part in the interviews. Sampling was terminated when data saturation was achieved. Individuals who did not provide informed consent were excluded from the study. This approach ensured sample homogeneity and yielded a participant group consistent with the aim of the study. Consequently, consistency was achieved in terms of diagnosis, treatment context, and data source (the demographic characteristics of the participants are presented in Table 1).

**Table 1.** Demographic Characteristics of the Participants

| General Characteristics | Number of Participants |
|---|---|
| **Gender** | |
| Male | 5 |
| Female | 7 |
| **Age** | |
| 30–40 | 6 |
| 41–50 | 3 |
| 51–60 | - |
| 61–70 | 3 |
| **Education Level** | |
| Primary School | 2 |
| Middle School | 1 |
| High School | 2 |
| Undergraduate | 5 |
| Graduate (Master's or PhD) | 2 |
| **Marital Status** | |
| Married | 6 |
| Single | 2 |
| Divorced | 1 |
| Widowed | 3 |
| **Employment Status** | |
| Employed | 9 |
| Unemployed | 2 |
| Retired | 1 |
| **Duration of FND Symptoms** | |
| Less than 1 year | 3 |
| 1–2 years | 3 |
| 3–10 years | 3 |
| 11 years and more | 3 |
| **Comorbid Psychiatric Diagnosis** | |
| None | 2 |
| Mood Disorders | 5 |
| Anxiety Disorders | 4 |
| Obsessive Compulsive Disorder | 1 |

## Procedure

In Türkiye, the clinical approach to FNSD has increasingly shifted toward a multidisciplinary treatment framework in recent years. Patients are typically diagnosed during neurology outpatient consultations and subsequently referred to collaborative programs involving psychiatry, physiotherapy, and clinical psychology services. Diagnosis is established by a specialist neurologist based on positive neurological signs identified during a comprehensive clinical assessment, and the diagnosis is explained to the patient following evaluation. Although there is no nationally standardized treatment algorithm for FNSD, an institutional treatment protocol has been implemented at Hacettepe University Faculty of Medicine through collaboration among the departments of neurology, psychiatry, physiotherapy, and clinical psychology. This protocol is based on internationally validated criteria (Stone and Edwards 2012, Jacob et al. 2018). Individuals diagnosed with FNSD are typically referred to the psychiatry department within the same clinical setting following neurological evaluation, and the treatment plan is determined by the multidisciplinary team. Within this program, CBT is implemented concurrently with pharmacotherapy and physiotherapy components. During the participant selection process, 37 patients diagnosed with FMD who had been hospitalized in the Neurology Department of Hacettepe University Hospital between 2019 and 2025 were evaluated. The inclusion criteria were being over 18 years of age, having a diagnosis of FMD, having completed the CBT component of the multidisciplinary treatment program, and being willing to participate in an online semi-structured interview. In June 2025, it was planned to contact 21 patients who had been hospitalized within the previous 36 months via telephone through their attending neurologists, and the process was completed with 12 interviews. The sample size was determined based on the principle of data saturation. The data collection process was terminated when responses began to recur and no new findings emerged. Participants attended short-term CBT sessions consisting of 7–11 meetings as part of the multidisciplinary treatment program conducted at the university hospital. The CBT intervention was planned in accordance with structured short-term protocols commonly used in the treatment of functional movement disorders (Jacob et al. 2018).

In the initial sessions, patients were presented with a formulation illustrating the cyclical relationship between symptoms, anxiety, and avoidance behaviors. Through this formulation, it was explained that symptoms involve not only physiological components but also learned elements. Behavioral interventions targeted the avoidance behaviors commonly observed in individuals with FMD. Behavioral experiments were conducted collaboratively with participants in order to retest motor functions in safe contexts and to reduce movement-related fears. In addition, efforts were made to support patients in reorganizing their daily activities and enhancing their everyday functioning.

During the cognitive restructuring process, participants' dysfunctional beliefs related to their symptoms, loss of control, and fears of permanent damage were addressed, and alternative patterns of thinking and behavior were developed. Body awareness exercises were implemented to strengthen emotion regulation skills. In the final sessions, emphasis was placed on the generalization of therapeutic gains and the prevention of potential relapses. Individualized relapse prevention plans were collaboratively developed with the participants. Homework assignments were given at the end of each session and were subsequently reviewed. The psychotherapy process was conducted by a psychotherapist with graduate-level training in clinical psychology and 18 years of experience in psychotherapy. Cognitive behavioral therapy sessions were implemented in an integrated and coordinated manner with the physiotherapy and pharmacotherapy components of the multidisciplinary program (Macías-García et al. 2024).

### Data Collection and Analysis

Ethical approval for the study was obtained from the Hacettepe University Health Sciences Research Ethics Committee on January 13, 2025 (Decision No: SBA 24/1194). Participants were informed about the purpose of the study, principles of confidentiality, and the voluntary nature of participation, and written informed consent was obtained from all participants. To protect participants' identities, pseudonyms (e.g., P1, P2) were used in quotations. Participants who required additional support during the interviews were referred to appropriate services. Data were collected using a semi-structured interview form developed by the research team. The semi-structured interview guide was designed to systematically explore psychotherapy experiences and perceived changes through participants' narratives (Creswell and Poth 2018). Consistent with phenomenological research, the interview form consisted of a limited number of questions, specifically two core questions. These questions focused on the changes experienced during the process and the areas to which participants attributed these changes. Participants were asked the following: "When you focus specifically on the psychotherapy component of the multidisciplinary treatment, what kinds of changes did you experience during or after the psychotherapy process?" and "To what do you attribute these changes?" Prior to the study, a pilot implementation of the interview form was conducted, and regular supervision meetings were held throughout the data collection process to ensure consistency.

The interviews were conducted online, lasted an average of 20–30 minutes, were audio-recorded, and transcribed verbatim. Following transcription, the texts were anonymized and all identifying information was removed. Participants' demographic information (e.g., age, gender, education, marital status, employment status, comorbid psychiatric diagnoses, duration of diagnosis, and number of therapy sessions) was collected through a separate information form. The interviews were conducted by two clinical psychologists with experience in qualitative research. All interviews were audio-recorded and transcribed verbatim. Data analysis was carried out using the thematic analysis approach described by Braun and Clarke (2006). The coding process was conducted independently by two researchers trained in qualitative analysis. Prior to the main analysis, the coders worked together on a pilot transcript to achieve conceptual alignment and subsequently coded the entire dataset independently. Following the independent coding, the codes were compared, and themes and subthemes were developed through discussion until consensus was reached. In cases where agreement could not be reached, a third senior researcher was involved in the process in an advisory role and the final decision was made accordingly. This multi-stage coding and consensus process aimed to enhance the consistency of the analysis and the trustworthiness of the findings. Data were analyzed using thematic analysis (Braun and Clarke 2006). This process involved the following stages: 1) familiarization with the data through repeated readings, 2) generation of initial codes, 3) identification of potential themes, 4) review of themes, 5) defining and naming themes, and 6) reporting the findings. During the reporting phase, particular attention was paid to ensuring that representative quotations reflected both diversity and strong discriminative value. Data collection was terminated after the twelfth interview, as no new codes or themes emerged. Microsoft Excel was used to organize and manage the codes and themes.

## RESULTS

### Experiences related to change

Participants' experiences related to change during the treatment process were grouped under three main themes. In this section, the main themes, subthemes, and representative quotations concerning changes in symptoms, emotional changes, changes in thinking, and behavioral changes are presented (see Table 2).

### Main Theme: Experiences related to changes in symptoms

The subthemes under this main theme were grouped as increased physical capacity and recurrence of symptoms.

### Subtheme: Increased physical capacity

Eight participants reported experiencing changes in their symptoms and expressed satisfaction with these improvements.

"I went from being unable to even write my name and unable to walk to now being able to run." (Participant 1)

**Table 2.** Main Themes, Sub-themes, and Representative Quotations.

| Main Theme | Subtheme | Representative Participant Quotation |
|---|---|---|
| **I. Experiences Related to Change** | | |
| Experiences of Changes in Symptoms | Increased physical capacity | "I went from not being able to write my name or walk to being able to run now." (P1) |
| | Recurrence of symptoms | "Sometimes good, sometimes bad — it's been the same for the last three years." (P4) |
| Experiences of Emotional Change | Ability to regulate emotional reactions | "I used to be much more aggressive… now I'm not that aggressive." (P6) |
| | Continued difficulties in emotion regulation | "My emotions are trying to grab the steering wheel — none of them are in their place." (P4) |
| Experiences of Cognitive Change | Change in perspective | "It really expanded me — my body, my thinking, my whole outlook on myself." (P1) |
| | Sense of self-worth | "I became someone who can say, 'I deserve this.'" (P1) |
| Experiences of Behavioral Change | Increased social participation and boundary setting | "Saying no is such a great freedom." (P2) |
| | Increased functionality | "I've returned to life again." (P2) |
| | Continued avoidance of social environments | "I still don't want to go to weddings." (P8) |
| **II. Factors Attributed to Change** | | |
| Related to the Psychotherapist and Therapeutic Setting | Therapist's verbal interactions | "They would ask me what would help me, and I would tell them." (P3) |
| | Supportive and safe therapeutic environment | "I could tell even my most private experiences with peace of mind." (P2) |
| Related to the Individual | Feeling ready for treatment | "I think being ready for this treatment had a big effect." (P9) |
| | Integrating treatment into daily life | "This process didn't just stay in that room." (P1) |
| | Not believing in psychological treatment | "I don't believe a psychologist can offer extraordinary help." (P8) |
| Related to Techniques | Cognitive techniques | "I noticed my thinking errors about myself." (P1) |
| | Experiential techniques | "I wrote a letter to my arm — it helped." (P6) |
| | Behavioral techniques | "They gave me homework — that helped." (P6) |

P: Participant

### Subtheme: Recurrence of symptoms

Five participants reported that they were generally not satisfied with their therapy processes, that their expectations were not met, and that they did not experience improvement.

"Yes, for a few weeks at that time. Then the same process continued. Sometimes good, sometimes bad—it's been the same for the past three years." (Participant 4)

## Main Theme: Experiences related to emotional change

The subthemes under this main theme were grouped as the ability to control emotional reactions and the persistence of difficulties in emotion regulation.

### Subtheme: Ability to control emotional reactions

One participant reported a reduction in anger and aggressive responses following therapy and stated that they had adopted a calmer attitude:

"I used to be more aggressive and got angry very quickly. Now I'm not that aggressive. I'm a bit calmer. I could say that I've started to let life flow more, and I'm moving forward in that direction now." (Participant 6)

### Subtheme: Persistence of difficulties in emotion regulation

One participant stated that, despite the therapy process, they continued to experience difficulties in controlling and regulating their emotions:

"I'm sitting in the driver's seat. I'm about to drive. There's anxiety in the passenger seat. Regrets in the back. Anger on one side. I'm trying to drive the car with my mind. My emotions are trying to grab the steering wheel. None of them are in their proper place." (Participant 4)

## Main Theme: Experiences related to changes in thinking

The subthemes under this main theme were grouped as perspective change and sense of self-worth.

### Subtheme: Perspective change

Eight participants reported that the therapy process provided them with a new perspective on themselves and on the symptoms related to their illness, fostering insight and awareness. They stated that it helped them develop a more flexible and accepting attitude toward their difficulties and their environment.

"As I said, it had a great impact on how I see myself—as a person, as a body—and on how I look at events around me, whether they affect me or not. I'm more aware now. As I said, Professor A helped me grow as a person." (Participant 1)

"It contributed to my awareness of my complaints and my condition." (Participant 7)

"For example, when you enter a market, all the eyes turn toward you. At first, I felt very uncomfortable. Now I don't feel uncomfortable at all. In the beginning, I felt like turning around

and saying something—like 'What are you looking at?' Now I don't care. They look, but I don't even look back at them. I don't let them feel that I've noticed it. Actually, I do notice their gaze, but I don't show it. I don't turn around. I don't say anything like 'What are you looking at?' " (Participant 8)

### Subtheme: Sense of self-worth

Three participants reported an increase in their sense of self-worth following the therapy process and stated that, as a result, they felt more comfortable expressing their rights and needs.

"For example, I wasn't someone who could express my needs. I wasn't someone who could say 'I deserve this.' That was it. Now I can say, 'This is my right.' " (Participant 1)

## Main Theme: Experiences related to behavioral change

The subthemes under this main theme were grouped and presented as increased social participation and boundary setting, improvement in functional capacity, and continued avoidance of social environments.

### Subtheme: Increased social participation and boundary setting

Six participants reported that, as a result of the therapy process, their avoidance of socialization decreased, their engagement in social interactions increased, and they developed the ability to establish interpersonal boundaries in their relationships.

"For example, I didn't really have a social circle before—because of my illness. Now I can enter social environments." (Participant 11)

"For instance, I didn't know how to say no. Being able to say no is a great sense of freedom." (Participant 2)

### Subtheme: Increased functioning

Three participants reported noticeable improvements in their daily lives and social functioning and stated that they were able to maintain a more autonomous way of living.

"I came back to life, so to speak." (Participant 2)

### Subtheme: Continued avoidance of social environments

One participant stated that she/he continued to experience difficulty participating in crowded environments that require social interaction and therefore tended to avoid such settings.

"I still don't want to go to weddings. I don't really want to meet with relatives. I also have to say that I don't want to go to crowded places." (Participant 8)

## Issues/Factors attributed to change

The factors to which participants attributed the changes they experienced during the treatment process were grouped under three main themes. In this section, the main themes related to the psychotherapist and the psychotherapy setting, individual-related factors, and technique-related factors are presented.

## Main Theme: Factors related to the psychotherapist and the therapeutic environment

The subthemes under this main theme were organized as the psychotherapist's verbal interactions and the supportive and safe nature of the therapeutic environment.

### Subtheme: The psychotherapist's verbal interactions

Three participants, when describing factors that contributed to change, specifically emphasized the questions asked by the psychotherapist.

"She/he would ask me things like, 'Would this help you? Would this kind of situation be helpful for you?' and I would tell them what worked for me." (Participant 3)

### Subtheme: The supportive and safe nature of the therapeutic environment

Five participants reported that the supportive and reassuring nature of the therapy environment facilitated their ability to express themselves openly and contributed to therapeutic change.

"I was able to share even my most private experiences with the psychotherapist comfortably, and I felt relieved when I talked about them." (Participant 2)

## Main Theme: Factors related to the individual

The subthemes under this main theme were organized as feeling ready for treatment, integrating therapy into daily life, and not believing in psychological treatment.

### Subtheme: Feeling ready for treatment

According to two participants, feeling ready for treatment facilitated benefiting from the therapeutic process.

"I think it definitely had a big impact that I accepted this treatment and came prepared for it." (Participant 9)

### Subtheme: Integrating therapy into daily life

One participant stated that what they learned during therapy was not limited to the sessions, but could be transferred to daily life and implemented independently.

"This process didn't stay only within that room. I was able to continue improving myself after leaving the sessions. It didn't make me dependent on going there. I could follow these practices on my own, without constantly needing to attend, and I was able to deal with this issue on my own feet." (Participant 1)

### Subtheme: Not believing in psychological treatment

One participant stated that she/he did not believe psychotherapy would contribute to the process of change.

"As I said, this is just my personal view—I don't believe that a psychologist can provide anything beyond listening and letting me talk, anything extraordinarily helpful." (Participant 8)

### Main Theme: Technique-related factors

The subthemes under this main theme were organized as cognitive techniques, experiential techniques, and behavioral techniques.

### Subtheme: Cognitive techniques

Eight participants reported that the cognitive techniques used during therapy helped them identify patterns of thinking, become aware of and work through dysfunctional beliefs, and reflect on their inner experiences. This process supported a re-evaluation of their experiences and thoughts.

"Yes, what I mostly remember are things like how to structure my sentences, where the mistakes are, cognitive distortions—especially those related to myself. I remember all of these." (Participant 1)

### Subtheme: Experiential techniques

According to two participants, experiential techniques implemented during the therapy process facilitated the expression of emotions and thoughts. This contributed to improvements in well-being and to the reduction of certain symptoms.

"At that time, Professor A told me to think of my arm as if it were a separate individual. Let me put it this way: I had distanced my arm from myself. To help me reconnect with it, he suggested that I talk to my arm. I wrote a letter to my arm. I received a response from it. I asked my arm questions and received answers. It was something like that. But it really helped. It was very beneficial." (Participant-6)

### Subtheme: Behavioral techniques

Two participants pointed to the role of behavioral techniques implemented during the therapy process in facilitating change.

"For example, the psychotherapist would give me homework. That was helpful." (Participant-6)

## DISCUSSION

This study is one of the few qualitative investigations examining the psychotherapy experiences—particularly those related to CBT—of patients diagnosed with FNSD within the context of multidisciplinary treatment. The findings offer original contributions to the understanding of psychotherapy processes in this population, which are largely consistent with both the broader psychotherapy literature and research specific to FNSD, while also reflecting certain cultural nuances specific to the Turkish context. The findings reflect two closely linked dimensions—participants' experiences of therapeutic change and the processes and factors through which these changes were understood and attributed. Most participants reported marked positive changes during and following the psychotherapy process. These included reductions in functional neurological symptoms, improvements in emotion regulation skills, increased self-worth and self-confidence, enhanced social functioning, and shifts in patterns of thinking. For example, many participants stated that they developed an understanding of the relationship between their symptoms and the stress and emotions they experienced. Therefore, this awareness seems to contribute to a greater sense of control. Some participants reported that they began re-engaging in social and physical activities they had previously avoided and became more active and effective in their daily lives. The primary factors contributing to change during the psychotherapy process were grouped into three main categories: i) factors related to the therapist and the therapeutic environment, ii) individual-level factors, and iii) factors related to the techniques used. Regarding the first group, participants reported that the therapist's questions and guidance prompted reflection, and that a safe and supportive therapeutic environment provided a foundation for change. The presence of a trusting relationship was emphasized as a critical component of the process. At the individual level, elements such as "being ready for recovery" and "integrating treatment into daily life" appeared to facilitate the change process. In relation to the techniques used, cognitive restructuring, recognizing dysfunctional thought patterns, and developing alternative perspectives were among the most frequently mentioned components. In addition, experiential techniques (e.g., writing letters to bodily parts) and behavioral techniques (e.g., homework assignments, note-taking) also emerged as factors contributing to change. In this respect, it was notable that participants expressed a marked sense of insight into the changes they experienced, even following brief psychotherapy sessions.

When the "positive" aspects of the findings are considered together, they appear to be largely consistent with the category of "helpful events," which has long been discussed in the psychotherapy literature. For example, Timulak's (2007) seminal qualitative meta-analysis grouped clients' helpful experiences into the following meta-categories: Awareness/Insight/Self-understanding, Behavioural change/Problem solution, Empowerment, Relief, Exploring feelings/Emotional experiencing, Feeling understood, Client involvement, Reassurance/Support/Safety, and Personal contact. Similarly,

in a more recent qualitative meta-analysis, Ladmanová et al. (2022) identified multiple helpful impact meta-categories, including gaining a new perspective on the self, feeling heard, understood, and accepted, and feeling engaged in the therapeutic process. In the present study, the observed changes—such as perspective shifts, increased self-worth, reduced avoidance, the development of trust in the psychotherapist, participants' reports of feeling understood through the psychotherapist's empathic stance, and their attribution of change to personal readiness and the integration of therapy into daily life—closely parallel these mechanisms. This convergence supports the cross-cultural relevance of therapeutic change mechanisms and underscores their potentially universal characteristics. In addition to explanations provided in the broader psychotherapy literature, findings specific to FNSD also align with the positive aspects observed in the present study. Evidence from randomized and controlled studies indicates that cognitive-behavioral interventions—particularly when delivered within multidisciplinary treatment programs—are associated with reductions in symptom severity, improvements in emotional regulation and functional outcomes, and the acquisition of adaptive coping strategies, with these gains maintained at follow-up (Goldstein et al. 2020, Macías-García et al. 2024). Similarly, CBT has been reported in some studies to have moderate effect sizes in reducing FNSD symptoms, improving comorbid psychological symptoms such as anxiety and depression, and enhancing patients' quality of life (Gutkin et al. 2021).

At this point, the concept of sense of agency becomes particularly salient. Defined as the experience of initiating one's own actions and having control over their consequences (Haggard 2017), the sense of agency has been reported to be frequently disrupted in FNSD (Voon et al. 2010). In this context, many CBT intervention domains are thought to help restore a sense of control and influence, and may therefore be associated with the strengthening of agency. A strengthened sense of agency may be linked to the individuals' ability to perceive themselves as the source of change and to engage more actively with CBT techniques. In addition, although the present study did not directly examine this construct, the literature consistently emphasizes that trust in healthcare professionals and the therapeutic alliance play a critical role in the process of change among patients with FNSD. There is also evidence indicating that a safe therapeutic relationship is instrumental in helping patients overcome experiences of stigma (Staton et al. 2024). These findings further suggest that the absence of trust and a weak therapeutic alliance may hinder engagement with treatment. The findings of the current study also seem to support this framework, highlighting the central role of a safe therapeutic environment as a foundation for change.

On the other hand, when the findings are examined in terms of "negative" outcomes, it becomes evident that change did not occur at the same level for all participants. A small number of participants reported that psychotherapy did not meet their expectations, that their belief in psychological treatment remained limited, and that they were unable to fully accept psychological explanations. Consequently, they indicated that they did not benefit substantially from psychotherapy and that their symptoms did not completely resolve. Accordingly, they perceived little benefit from psychotherapy and reported that their symptoms did not fully resolve. These findings are also consistent with the existing literature. According to qualitative meta-analytic evidence, some patients report feeling that they do not make progress during therapy, experience difficulty establishing a sufficient connection with the therapist, and perceive disruptions in the trust relationship. These experiences are sometimes accompanied by perceptions of insufficient guidance from the therapist and disappointment at the termination of therapy (Ladmanová et al. 2022, Vybíral et al. 2024). Consistent with the literature, a proportion of individuals with FNSD perceive the psychological explanations offered to them as insufficient and report feeling that their symptoms are invalidated by healthcare professionals (Foley et al. 2024). Moreover, qualitative and meta-ethnographic studies have demonstrated that patients may experience internalized stigma, refrain from disclosing their symptoms when trust in the psychotherapist is lacking, and consequently fail to engage fully in treatment (Foley et al. 2024, Staton et al. 2024). These findings suggest that stigma in FNSD has the potential to undermine the therapeutic alliance and that, in the absence of a trust-based therapeutic relationship, the process of change may be constrained.

Another dimension of the findings pertains to cultural and structural factors specific to the Turkish context. Some participants reported that they began therapy with the belief that psychotherapy would not be beneficial and that their confidence in psychological treatment was limited. Research conducted in Türkiye indicates that negative emotional reactions toward psychotherapy—such as anxiety, fear, and confusion—may weaken patients' motivation at the outset of treatment (Çetinkaya and Yavuz Güler 2023). In addition, there is evidence suggesting that societal perceptions of psychotherapy may be shaped by environmental and familial pressures. Furthermore, studies have shown that individuals who experience stigma may develop more negative attitudes toward psychotherapy (Coşan 2015, Dinar and Yalçınkaya-Alkar 2021). While studies conducted in Western contexts often emphasize issues related to insurance coverage and access to services (Rezaei and Stanley 2025), in the Turkish context these challenges were more commonly manifested in patients' experiences of "doctor shopping" and efforts to cope with a persistent sense of unresolved illness. This situation highlights structural differences related to the healthcare system. Accordingly, prolonged and repetitive help-seeking trajectories

may undermine trust in treatment and reduce motivation in the Turkish context. These findings suggest that beliefs and attitudes toward psychotherapy cannot be understood independently of the cultural context. In turn, engagement with treatment appears to be shaped not only by individual factors but also by broader social and structural dynamics.

These findings are generally consistent with recent meta-analyses in the literature. For instance, Thomas et al. (2025) reported that although the chronic nature of symptoms in FNSD may partially limit treatment response, significant improvements can still be achieved in both motor symptoms and quality of life. Considering the chronic symptom profiles of the patients included in the present sample, the findings of this study appear to be in line with the existing literature. Similarly, Varley et al. (2023) and Radin et al. (2025) emphasized the importance of clinical management and multidisciplinary treatment programs, highlighting the need for standardized protocols and high-quality evidence. Within this context, qualitative studies are considered among the elements that deepen our understanding of the effectiveness of multidisciplinary programs. In terms of its methodology and findings, the present study may be regarded as one of the contributing efforts aimed at enhancing the effectiveness of multidisciplinary treatment programs.

### Limitations and Implications

In this study, it was observed that participants' responses to the first question occasionally also encompassed the content of the second question. In qualitative interviews, participants' narratives not fully aligning with the thematic distinctions anticipated by the researcher is a natural consequence of data production as a co-constructed process shaped through researcher–participant interaction (Mishler 1991, Holstein and Gubrium 1995). In addition, the sample consisted of 12 participants and was limited to a single center. The findings were based on subjective narratives, and long-term effects were not assessed. Therefore, the generalizability of the results is limited. Moreover, as the psychotherapy process was conducted as part of a multidisciplinary treatment program, it is difficult to isolate the specific effects of psychotherapy from other treatment components. Consequently, the observed changes should be attributed not only to psychotherapy itself but also to the broader treatment context and the nature of the patient-therapist relationship. Change in FNSD has previously been conceptualized as a multilayered process occurring across biological, psychological, and social domains (Espay et al. 2018). Consistent with this conceptualization, the findings of the present study further support this multidimensional model of change.

Future research should examine psychotherapy experiences among individuals with FNSD using larger samples and longitudinal, mixed-method designs. In particular, it would be valuable to identify which specific components of CBT (e.g., cognitive restructuring, exposure-based interventions) contribute most strongly to symptom improvement. Additionally, given the heterogeneous nature of FNSD, comparative investigations across different subtypes are warranted. Furthermore, in addition to patient experiences, incorporating the perspectives of psychotherapists and other healthcare professionals may provide a more comprehensive understanding of the multidimensional dynamics of the treatment process.

### Clinical Implications

These findings offer important practical implications for clinicians and psychotherapists working with individuals diagnosed with FNSD. First, the perception of change appears to be strongly shaped by a trust-based therapeutic relationship. Therefore, strengthening the therapeutic alliance early in the process is of critical importance. Second, even brief CBT interventions seem to contribute to meaningful improvements in symptom perception and functional outcomes, which support the effectiveness of the psychotherapy component within multidisciplinary treatment programs. Finally, considering patients' expectations regarding therapy and their level of acceptance of psychological explanations prior to multidisciplinary treatment may represent an important factor in enhancing treatment effectiveness.

## CONCLUSION

In conclusion, this study represents one of the first investigations in Türkiye to focus on the experiences of individuals with FNSD undergoing brief psychotherapy. The findings reveal both the universal aspects of therapeutic change mechanisms and the cultural and structural dynamics specific to the Turkish context. The themes identified in participants' experiences of change were largely consistent with the common factors described in the broader psychotherapy literature. At the same time, initial reluctance toward psychotherapy, concerns about stigma, and healthcare system–related experiences emerged as noteworthy context-specific contributions within the Turkish setting. These results support the universal principles underlying therapeutic change while also highlighting the importance of understanding how cultural and structural contexts shape the psychotherapy process.

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