Citation: McKenzie, K., Hilari, K. & Behn, N. (2024). An exploration of UK speech and language therapists' treatment and management of functional communication disorders: A mixed-methods online survey. International Journal of Language & Communication Disorders, 59(6), pp. 2752-2765. doi: 10.1111/1460-6984.13113

Received: 15 December 2023 | Accepted: 29 August 2024

DOI: 10.1111/1460-6984.13113

International Journal of Language & Communication Disorders

RESEARCH REPORT

An exploration of UK speech and language therapists' treatment and management of functional communication disorders: A mixed-methods online survey

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Funding information
HEE/NIHR ICA Programme Pre-doctoral Clinical Academic Fellowship, Grant/Award Number: NIHR302725

ABSTRACT

Background: Functional Communication Disorders (FCDs) are one specific presentation of Functional Neurological Disorder (FND). FND is characterised by neurological symptoms, such as sensory and motor symptoms, which are not explained by neurological disease. Speech and language therapists (SLTs) have expertise in managing communication disorders, including FCDs, though is not known is what clinicians do in practice to treat and manage FCDs.

Aim: To explore the clinical practices of SLTs who regularly manage FCDs in the UK, including the assessment and intervention approaches taken.

Methods & Procedures: An online survey was developed using Qualtrics software and piloted before dissemination. Participants were experienced SLTs working in the UK who managed at least three FCD referrals a year. The survey was developed with a mix of qualitative and quantitative questions. The survey was disseminated via social media and professional networks.

Outcomes & Results: There were 73 completed responses to the survey. Participants reported working with a range of FCDs clinically, with functional stuttering and articulation disorders seen most frequently. SLTs reported working with a wide range of multidisciplinary professionals when managing patients with FCDs, though lack of access to mental health professionals was raised as an issue. SLTs reported using a combination of formal and informal communication assessments. Interventions varied, with a wide range of psychological approaches informing treatment. Lack of specific training, evidence base and negative attitudes around functional neurological disorder (FND) were raised as ongoing issues.

Conclusions & Implications: Therapists encountered a wide range of FCDs as part of their clinical practice, though there was a significant disparity in the service and interventions offered. SLTs feel their input can be effective, but lack the resources, training and evidence-based interventions to provide adequate care.

KEYWORDS
acquired, adults, assessment, intervention, neuropsychology, speech and language therapists

WHAT THIS PAPER ADDS

What is already known on the subject

- FCDs are one manifestation of FND and can present as a wide range of communication disorders. SLTs encounter FCDs as part of clinical practice, but report feeling unsure and underprepared to manage these disorders. Consensus recommendations have provided some guidance on how to manage these disorders, though what was not known was what practising SLTs are doing in practice with FCD patients: what assessment, intervention and management strategies they use, and what they feel are the facilitators and barriers to effective management.

What this study adds to the existing knowledge

- This is the first UK-wide survey of FCD SLT clinical practice. The survey found that SLTs are seeing a range of FCDs as part of their clinical practice. SLTs reported that they feel their input is effective, that they had confidence in their ability to provide assessment and intervention, and that SLT for FCDs should be routine. SLTs reported using a wide variety of approaches to assessment and intervention. Barriers to effective management included a lack of resources, training, negative staff attitudes towards FND, and lack of research and evidence-based interventions.

What are the practical and clinical implications of this work?

- This survey has found that SLTs working across the UK are providing input for patients with FCDs, but frequently reported feeling isolated and lacking clinical peer support. This shows the potential for networking groups to support SLTs to learn and share resources. There is a training need for SLTs and other healthcare professionals to tackle pervasive negative attitudes towards FND. Common themes in intervention approaches were found, but there was variability in the specific approach taken. This requires further research to guide SLTs on the best evidence-based practice.

INTRODUCTION

Functional neurological disorder (FND) describes the presentation of neurological symptoms including motor and sensory disturbances, with no known structural organic disease (Espay et al., 2018). Previously termed psychogenic or conversion disorder, FND is a common condition; it is the second most frequent diagnosis made in neurology outpatient appointments (Stone et al., 2010). The incidence rate of FND is estimated at 4–12/100,000 population per year, and the reported population prevalence is 50/100,000 (Aybek & Perez, 2022). There is a significantly female preponderance (60–80%), which undoubtedly interacts with existing historical and societal gender inequalities and exacerbates the stigma and disbelief that patients endure (Hallett et al., 2022; McLoughlin et al., 2023). Patients with FND have been found to have higher levels of disability distress, unemployment and be more likely to be receiving disability benefits compared with those whose disability is explained by neurological disease (Carson et al., 2011). The prognosis for those with FND is poor; disability typically persists or worsens over time (Espay et al., 2018; Gelauff et al., 2014). However, the prognosis for FND occurs in the context of a historical lack of effective evidence-based treatments and clinician's poor understanding and negative attitudes about the condition (Barnett et al., 2022; Espay et al., 2018).

FND can present with a wide range of symptoms such as dissociative seizures, functional motor disorders and functional cognitive symptoms. Functional communication disorders (FCDs) are a specific manifestation with an overlap between motor and cognitive symptoms. It is estimated that 25–50% of people with FND present with abnormal speech as part of their clinical presentation (Utianski & Duffy, 2022). FCDs can present as voice, speech and/or language disorders. Though a range of FCDs exists, including problems with articulation, language, reading and writing, and cognition, these are poorly represented in the literature, with the most evidence for the assessment and treatment of FCDs focusing on functional voice disorders (FVDs) (Baker et al., 2021; Barnett et al., 2019). Voice disorders (functional and organic) are a common condition, one in three people will experience a voice disorder in their lifetime (Nelson et al., 2004). FVDs occur where dysphonia is observed in patients with apparent normal vocal fold movement and anatomy (Andrea et al., 2017). Anecdotally, the prevalence of FVD is thought to be much higher than that of organic voice disorders (Baker, 2016). Incidence and prevalence data of other specific FCDs are lacking, and are convoluted in previous research as terminology has been used inconsistently.

FCDs can occur because of sensory, motor and/or cognitive dysfunction. Though dysfunction may be occurring in different neuro-networks depending on the presentation, the fundamental pathophysiology of FND symptoms is thought to be occurring in a similar way. Hallett et al. (2022) have presented a model of the neural mechanisms of FND which describes how emotion, attention, and intro- and exteroception, impact the intention, planning and generation of movements (or sensation, or cognitive functions). The model explains that when there is a mismatch between the brain's predictive coding and the subsequent feedback, dysfunction can occur, and this is reinforced by over-attention and hyperactivity in the amygdala (emotional response).

Speech and language therapists' (SLTs) skills and experience could be considered as well suited to manage a condition which lies between neurology and psychiatry. SLTs are experts in communication which incorporates other attributes as part of the profession's skillset: counselling, listening and empathy. SLTs also routinely consider patients holistically: what is important to them, what do they want to achieve. When working with patients who have routinely been ignored and not believed, SLTs may be well suited to alleviate and address these issues. However, research into effective interventions and guidance for SLTs on how to manage FCDs has been lacking (Barnett et al., 2019). The lack of research has contributed to SLTs reportedly feeling unsure and under-prepared to manage functional disorders (Barnett et al., 2022). A systematic review on this topic has found only seven papers which describe interventions for FCDs. The quality of most of these papers was poor, and the majority focused on FVDs (6/7) with the remaining paper describing functional stuttering (McKenzie et al., 2024). Baker et al. have recently attempted to address the lack of guidance by producing SLT consensus recommendations: a modified Delphi approach was used to develop the consensus recommendations with an international panel speech and language professionals with expert knowledge of functional swallowing disorders and FCDs (Baker et al., 2021). This document has provided SLTs, globally, with the most holistic recommendations to date for the management of functional disorders.

The consensus recommendations have provided useful guidance for SLTs and acknowledged the broad skillset SLTs should utilise when working with FCDs: for example, SLTs should address illness belief, unhelpful thoughts and predisposing and perpetuating factors (Baker et al., 2021). This requires a skilled and considered approach, yet little is known about how practicing SLTs do this, and what resources or approaches are used to achieve this. Functional disorders can be challenging to work with, and presentation can be disparate (Aybek & Perez, 2022). Therefore, the challenges faced by SLTs clinically may not be fully realised. Nor is known what interventions SLTs use in practice, and what supports them to determine an appropriate intervention. Therefore, the aim of this study was to explore the clinical practices of SLTs who regularly manage FCDs in the UK, including the interventions and assessment approaches used when managing FCDs.

METHODS

A survey methodology was used to explore the practices of SLTs in the UK. The survey is reported according to The Checklist for Reporting Results of Internet E-Surveys (CHERRIES) to ensure good conduct in reporting (Eysenbach, 2004) (see Appendix 1 in the Supporting Information section).

Survey development

A 29-item self-administered online open survey included demographic questions ($n = 9$), which were developed using existing surveys (Behn et al., 2020; Chang et al., 2018). The main part of the survey comprised of questions specifically about SLT management of FCDs ($n = 6$). These were developed by the research team as there are no published studies on this research question to develop survey questions on. Development drew on similar FND clinician interview and survey studies (Morton et al., 2022; Nicholson et al., 2022). Qualitative open-text questions were kept to a minimum to promote ease of completion ($n = 6$).

To explore behaviour change facilitators and barriers the COM-B model was used as the basis for the survey's final Likert questions ($n = 8$). The model considers three key factors that influence whether behaviour change can occur (B): the individual's psychological and physical capability (C) to participate in an activity; the social and physical opportunity (O) to make a behaviour possible; and whether the individual has the conscious and unconscious motivation (M) to inspire behaviour (Michie et al., 2011). The COM-B question comprised eight subquestions displayed in a Likert table, which were adapted from a previous survey on SLTs' clinical practice (Behn et al., 2020). An exhaustive list of questions covering the entire COM-B framework was avoided to promote ease of survey completion. Questions deemed to be most significant to the subject area were chosen with at least two questions from each of the three domains (capability, motivation and opportunity).

The survey was initially piloted by a group of SLTs known to the lead researcher, who are part of a FND specialist interest group ($n = 4$). The survey took a mean time of 24 min to complete. Comments and suggestions were gathered from the pilot group and amendments to the survey were discussed between authors (KM and NB). Changes were largely minor wording edits or question order. Two COM-B questions were replaced with a different question from the same domain based on pilot suggestions. This was due to issues raised about the relevance and clarity of the original questions.

For the full survey, see Appendix 2 in the Supporting Information section.

Eligibility and consent

Participants were HCPC-registered SLTs working in the UK at an NHS agenda for change band 6 salary or above (or equivalent). Participants required experience in managing adults (18+) with FCDs, stipulated as at least three referrals a year. This number was discussed and agreed to be sufficient with the FND networking group. The survey received ethical approval from the university's proportionate review committee. Informed consent was required to participate in the survey and further optional consent was gained to use anonymised quotes. Incentives were not offered to participate in the survey.

Sample size

The survey aimed to recruit at least 20 participants. This is an emerging field in SLT and there are no figures for how many SLTs are regularly working with FCDs in the UK. There are no known published UK surveys of SLTs specifically on functional disorders. Participation estimates were based on attendance of specific clinical excellence network (CEN) study days (e.g., there were over 200 attendees at the East Midlands Progressive Neurology CEN in March 2022) and discussion with the FND special interest group.

Recruitment

The survey was distributed via the Qualtrics XM survey platform between 27 April and 19 June 2023. The survey was advertised on social media (Twitter, LinkedIn, ResearchGate) and disseminated through the FND Networking group and adult neuro CE s across the UK.

Data analysis

Survey responses were exported from Qualtrics to a Microsoft® Excel® spreadsheet and screened to identify and remove responses from participants who declined to participate and were not eligible, or where responses were incomplete. Responses which were included for analysis were then uploaded on to IBM® SPSS® Statistics and analysed using descriptive statistics. Graphs and visualisations were created using the Qualtrics report function.

Open-text responses were exported into NVivo 12 and analysed using content analysis by the first author (Hsieh & Shannon, 2005). Responses were coded and grouped into categories and subcategories by topic. The analysis was verified by all co-authors. The main themes, with greater frequency count, were prioritised in the survey findings. These findings were used to supplement the quantitative survey findings.

RESULTS

Participants

In total, there were 104 responses to the survey. Of the total responses, nine did not meet the eligibility criteria (9.4%) and five did not give consent to participate (5.2%). Of the remaining 90 responses: there were 52 complete responses (54%); and 38 incomplete responses (39.5%). Of the incomplete responses, 17 provided no information beyond SLT demographic questions (17.7%), these were excluded from the analysis as it was deemed insufficient information to ensure they had the relevant experience. The other 21 incomplete responses did complete FCD experience questions (21.8%) and were included in the analysis. Therefore, a total of 73 responses were included in the analysis (75.9%).

Participants represented all UK regions, except Wales, with the greatest proportions working in London (20.5%) and South West England (17.8%). The majority worked in urban settings (80.8%). Most participants had 6–10 years of experience working as an SLT (26%), but there was a relatively even spread between 5 and 20+ years of experience. The majority of participants only worked in the public sector: NHS (84.9%), with a further 9.6% working in both private and public settings. Participant characteristics are displayed in Table 1.

FCD clinical experience

The primary work setting participants predominantly saw patients with FCD was community or domiciliary settings (39.7%), followed by outpatient settings (27.4%), inpatient acute hospital (20.5%) and inpatient rehabilitation (9.6%). FND was most frequently reported to be on participant's typical caseload (n = 58, 79%), followed by dementia and other progressive disorders (n = 51, 69%), non-traumatic acquired brain injury, that is stroke (n = 49, 67%), general acute/medical (n = 26, 35.6%), voice/dysphonia (n = 18, 24.6%), dysfluency (n = 18, 24.6%), psychiatric/mental health (n = 14, 19%), head and neck cancers (n = 6, 8%) and adults with learning disabilities (n = 4, 5%). Other diagnoses reported included long covid, upper airways, trans and gender diverse voice, critical care and paediatric dysphagia. The majority had less than 10 years of experience managing FCD patients. See Table 1 for further information.

There was a large disparity in the estimated number of FCD referrals seen in the previous year, the mean was 18.9 (50 SD). Figure 1 shows what FCD participants had seen clinically over the last year, functional swallowing disorders were included for comparison. FCDs seen by the largest number of participants were functional stuttering (n = 53), functional language symptoms (n = 50) and functional articulation symptoms (n = 48). Yet these were reported almost as often as functional oropharyngeal dysphagia (n = 49) and globus pharyngeus (n = 43). Few clinicians reported having seen foreign accent syndrome (FAS) in the last year (n = 9). 'Other' text responses given included social communication disorders and selective mutism.

Participants then ranked the functional disorders they had seen in the last year from most to least frequently seen. The most frequently seen FCD was functional stuttering, followed by functional articulation symptoms; but more participants reported seeing functional oro-pharyngeal dysphagia, followed by globus pharyngeus as their most frequently seen functional disorders (Figure 2). Overall, there was a relatively even spread of conditions from most to least frequently seen.

Multidisciplinary working

SLT input typically involved lone SLT providing assessment and intervention with 64.5% selecting 'often' or 'always'. Participants rarely provided an assessment only service both for lone working (46.8% selected 'never' or 'rarely') and interdisciplinary working (59.2% selected 'never' or 'rarely'). However, most participants reported that standard practice involved providing advice or liaising with other healthcare professionals (73.6% selecting 'often' or 'always').

Participants selected which members of the multidisciplinary team they worked with when managing patients with FCDs. This indicated that a wide range of professionals are involved in the management of FCDs, most frequently with neurologists (n = 37), occupational therapists (n = 34) and psychologists (n = 31). A total of 14 participants also selected the 'other' free text option, responses given included: gastroenterology, case managers, talking therapies, ENT and respiratory, and Dietitians. See Figure 3 for further breakdown.

Participants also reported in open-text responses the importance of multidisciplinary team working. Responses highlighted that joint working with other healthcare professionals was crucial to the effective management of FCDs but is hindered by a lack of multidisciplinary team services. The main issues identified were the lack of and need for established pathways, long waiting lists for key services, particularly: neuropsychology, neuropsychiatry and other mental health services. As a result, some participants highlighted the SLT role as one that provides support and guidance in the absence of other psychological services.

> I feel very strongly that the people I am seeing with FCDs deserve to be able to access adequate psychological support.

Another reoccurring issue raised by participants was the impact of misconceptions and negative attitudes held by some members of the multidisciplinary team:

> A patient's previous poor experiences with health care professionals. Limited societal understanding and empathy of FCD, including from other health care professionals.

TABLE 1 Participant characteristics: Personal biographical, SLT clinical practice and clinical experience managing FCDs.

Participant characteristics	*N*	%	SLT biographical information	*N*	%	FCD clinical experience	*N*	%
Age			**Years of SLT practice**			**Years of experience managing FCDs**		
21–30 years old	9	12.3%	≤ 5 years	12	16.4%	≤ 5 years	32	43.8%
31–40 years old	34	46.6%	6–10 years	19	26.0%	6–10 years	25	34.2%
41–50 years old	19	26.0%	11–15 years	13	17.8%	11–15 years	6	8.2%
51–60 years old	10	13.7%	16–20 years	13	17.8%	16–20 years	7	9.6%
≥ 61 years old	1	1.4%	> 20 years	16	21.9%	> 20 years	3	4.1%
Gender			**UK region**			**Primary work setting where FCDs predominantly seen**		
Female	71	97.3%	England: East Midlands	2	2.7%	Community/domiciliary based care or rehabilitation	29	39.7%
Male	2	2.7%	England: East of England	2	2.7%	Hospital outpatient	20	27.4%
Ethnicity			England: London	15.0	20.5%	Inpatient acute/hospital	15	20.5%
Asian	1	1.4%	England: North East	6	8.2%	Inpatient rehabilitation unit	7	9.6%
Asian British	1	1.4%	England: North West	6	8.2%	University outpatient community clinic	1	1.4%
White	21	28.8%	England: South East	8	11.0%	Virtual rehabilitation team	1	1.4%
White British	50	68.5%	England: South West	13	17.8%			
			England: West Midlands	1	1.4%			
			England: Yorkshire and the Humber	6	8.2%			
			Northern Ireland	5	6.8%			
			Scotland	9	12.3%			
			Setting type					
			Metropolitan/urban	59	80.8%			
			Rural/remote	14	19.2%			
			SLT funding					
			Private/independent	3	4.1%			
			Public sector: NHS	62	84.9%			
			Public sector: NHS, private/independent	7	9.6%			
			University clinic	1	1.4%			

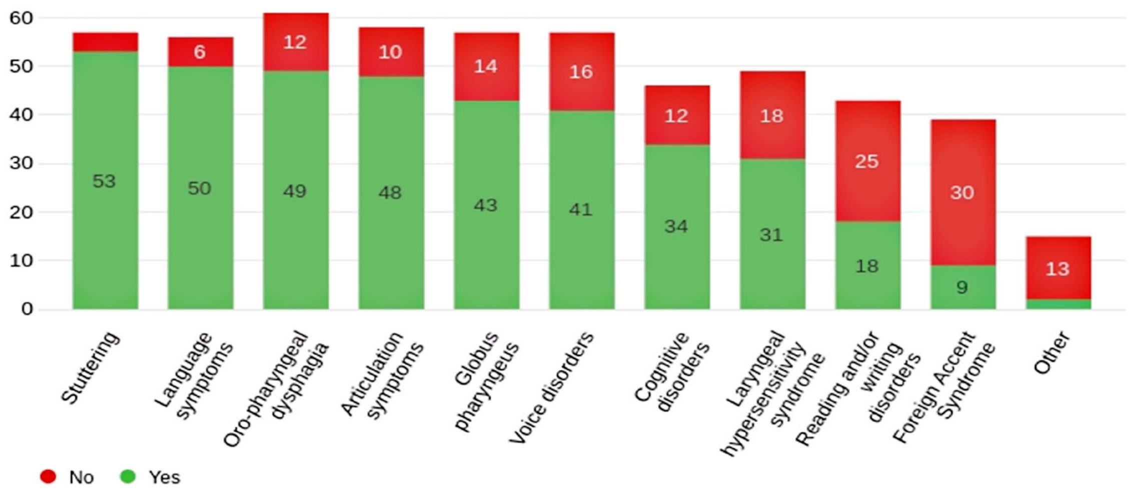

FIGURE 1 Functional disorders seen by participants in clinical practice over the last year.

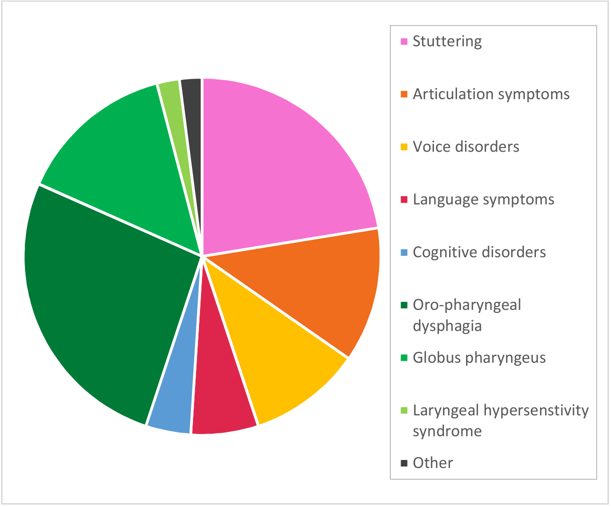

FIGURE 2 Most frequently seen functional disorders.

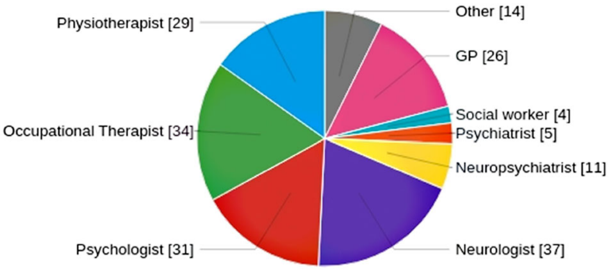

FIGURE 3 Members of the multidisciplinary team participants reported working with when managing FCD patients.

> I'm aware that some colleagues feel dread when they encounter a patient with FCD, but if it's done well, I genuinely think that SLT have something to offer patients with FCD.

Management of FCDs

Assessment and diagnosis

Participants reported that prior to SLT input a formal FND diagnosis is required, this would typically be made by a neurologist or other medic. Some participants reported they work alongside the multidisciplinary team to make a functional diagnosis, by providing a differential diagnosis and highlighting this to the medical team.

Participants reported using a combination of standardised and informal communication assessments with patients with FCDs. The most frequently reported standardised assessments were the Boston Naming Test (Kaplan et al., 1976), Mt Wilga High Level Language Test (Simpson et al., 2006), and Comprehensive Aphasia Test (Swinburn et al., 2022). Observations made during preliminary discussion with the patient was described as the approach mostly frequently taken in informal assessment. Many participants also highlighted the importance of gathering a thorough case history as part of their assessment. Diagnosis of FCDs was often reported as a diagnosis made on positive features, that is, inconsistencies between assessment tasks and function, and improved presentation when patient distracted.

Therapy approach

Participants often gave a multitude of psychological approaches they apply when managing patients with FCDs. Participants most frequently mentioned using mindfulness strategies such as grounding techniques, breathing exercises and body scans. Specific psychological interventions commonly reported were acceptance and commitment therapy (ACT), cognitive behavioural therapy (CBT), solution focused brief therapy (SFBT) and motivational interviewing. The use of counselling skills, showing compassion, empathy and understanding were also often reported as core to management.

> Counselling approaches; a range of tools and techniques based on the theory of personal construct psychology aiming to understand the role of the symptoms for the patient.

Many participants reported taking an explorative, curious and non-judgemental approach to their management approach.

> … I am not looking for a cause to explain away the symptoms I am trying to address, that would be a big mistake; it's more that achieving rapport, which has such a good effect on symptoms, is better accomplished when you know the person you're working with, and when they feel accepted for who they are, including the totality of their life experience). I often feel that modelling that acceptance of who the person is, is the one of the most important things I can do.

Participants acknowledged that intervention needs to address the patient's attitudes and beliefs about their condition, as part of the therapeutic process:

> I also then explore their thoughts and ideas around the symptoms to gather information about belief sets, wider systemic influences and what strategies that are in place that are helpful or unhelpful and why these strategies have stuck (when all else may have failed).

Speech and language therapy interventions

In terms of SLT interventions offered, participants reported a wide and varied range of approaches. Common themes included providing education to the patient about their functional diagnosis and explaining typical function. Individualised goal setting and intervention were acknowledged as particularly important when working with FCDs due to the variability of presentations.

Participants reported using approaches that encourage the patient to self-reflect and increase interoception:

> Activities that encourage the client to become aware of, or rate the effect of various external or internal stressors and acknowledging that we can't be in control of these, but might be able to modify them.

Relaxation and breathing techniques were reported to be commonly used:

> I also use a lot of breathing, body scans and mindfulness. I use strategies to support self-talk, slowing down, and tolerating sensations.

Distraction and redirection activities were also frequently reported as used as an intervention method:

> divert attention through other physical movements such as finger/foot tapping/hand slides or using an item to calm down unwanted movements (helpful for lingual dystonia) ….

Knowledge, skills and training

The lack of training and teaching on functional disorders was a recurring theme. Participants reported frustration that it was not covered in their SLT degrees, and that this was highlighted as an ongoing issue for current SLT students:

> The single most frustrating thing about the label of FND is the disempowerment the SLTs, including our SLT student can feel as it feels unknown and is not linked to a specific condition like stroke. Therefore it's treated like 'I don't know what to do', instead of focusing on all of our SLT skills. It does begin with taught content on degree programmes.

Others highlighted the wider issues to taught and institutional healthcare philosophy:

> We are not taught about the holistic and embodied nature of communication in our degrees. There is a very Cartesian approach to the teaching and learning that separates things off from each other in much the same way that medicine as a whole does. This is a huge failing. It has taken me all my working experience to learn, develop and hone my understanding and skills of working

> emotionally with patients in a way that isn't dangerous or damaging, or ineffective.

Participants reported having to develop their understanding of functional disorders by taking initiative in their own learning: reading around the topic, seeking out study days or training and applying training that is relevant but not specifically about FND for example, interoception and CBT.

> It has taken a lot of time to build up the skills and I have done much of it in my own time.

Participants reported that one of the most valuable sources of knowledge and development of skills when working with people with FCDs was their own clinical experiences and drawing from other areas of knowledge. Participants often reported using skills and experience from a wide range of clinical caseloads and integrating this with training in psychological approaches:

> I have a wide range of experience with a variety of client groups including (but not limited to) adults with mental health problems, adults in a high secure forensic setting, teens at risk of being excluded, young offenders, teens with autism, ALD, children with SEMH, adults in the community, neurorehab. Of these I'd say I draw *least* on my experience working in neurorehab. The experience I draw most from would be ALD, teens at risk, autism, women with PD (forensic).

Participants also mentioned specific research papers which have been valuable resources when working with FCDs. The SLT consensus recommendations were most frequently mentioned, followed by the work of Joseph R. Duffy (Baker et al., 2021; Duffy, 2016). Nevertheless, limited research evidence on effective interventions was also highlighted as a barrier to effective management of FCDs.

Behaviour change

Capability

Participants had low agreement on access to adequate training (54%, strongly or somewhat agreed). There was high agreement in their confidence to provide SLT assessment and intervention for FCDs (85%, strongly or somewhat agreed), and there is good evidence that SLT is effective in patients with FCDs (77%, strongly or somewhat agreed) (Figure 4).

Motivation

There was strong agreement that managing FCDs should be part of routine SLT practice (94% strongly or somewhat agreed). However, participants responded negatively when asked if SLT input does not always result in improved communication for patients with FCDs (75% strongly or somewhat agreed). There was a mixed response to whether SLTs feel stressed at the thought of providing input for FCDs, a small majority disagreed with the statement (61% strongly or somewhat agreed) (Figure 5).

Opportunity

There was a mixed response to whether participants felt they had adequate resources to work with people with FCDs, there was a slightly more positive response (55% strongly or somewhat agreed) though the majority (74%) selected a 'somewhat' option. Participants strongly agreed that they felt supported by their management to provide SLT input for patients with FCDs (80% strongly or somewhat agreed) (Figure 6).

DISCUSSION

This survey aimed to explore current practice for SLTs working with people with FCDs in the UK. The survey gathered the views from 73 practising SLTs working in a range of clinical areas with this patient group. A mixed picture has emerged of current practice, which on one hand demonstrates how SLTs are using intuitive, explorative practice when working with this challenging and heterogeneous patient group. Yet, on the other hand it highlights the variability and inconsistency between services and clinicians. These two perspectives will be explored in terms of what guidance currently exists and what the further challenges are for the profession.

SLTs: Intuitive and explorative FCD clinicians

This survey has found that SLTs feel working with this patient group should be routine, that it can be effective and reported confidence in their ability to help. However, SLTs reported that input does not necessarily result in improved communication. This finding may be

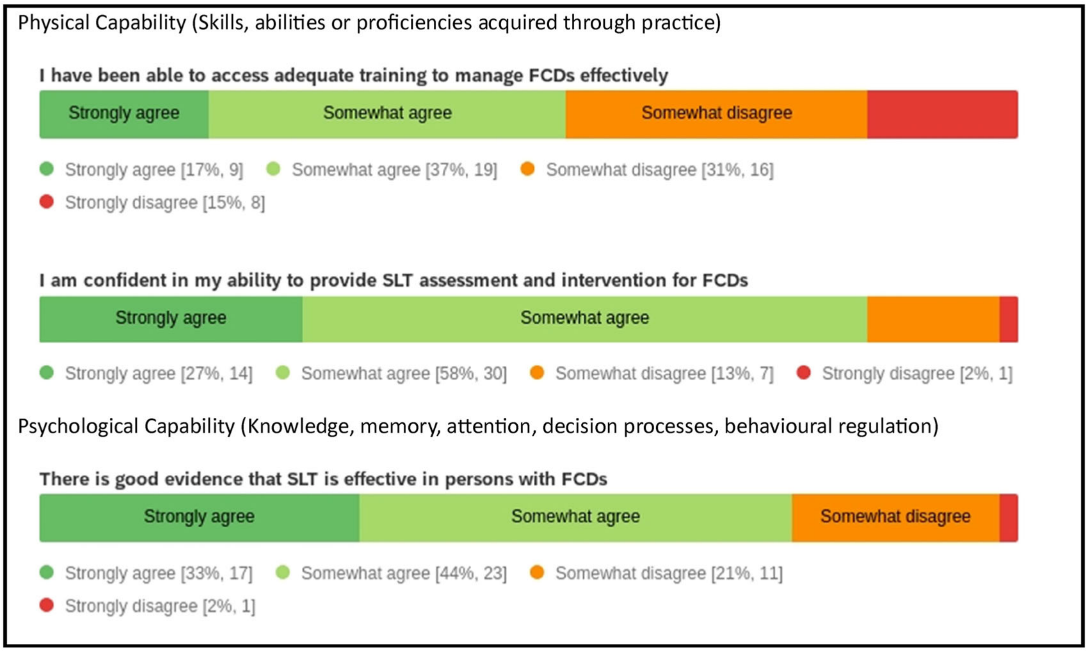

FIGURE 4 COM-B capability.

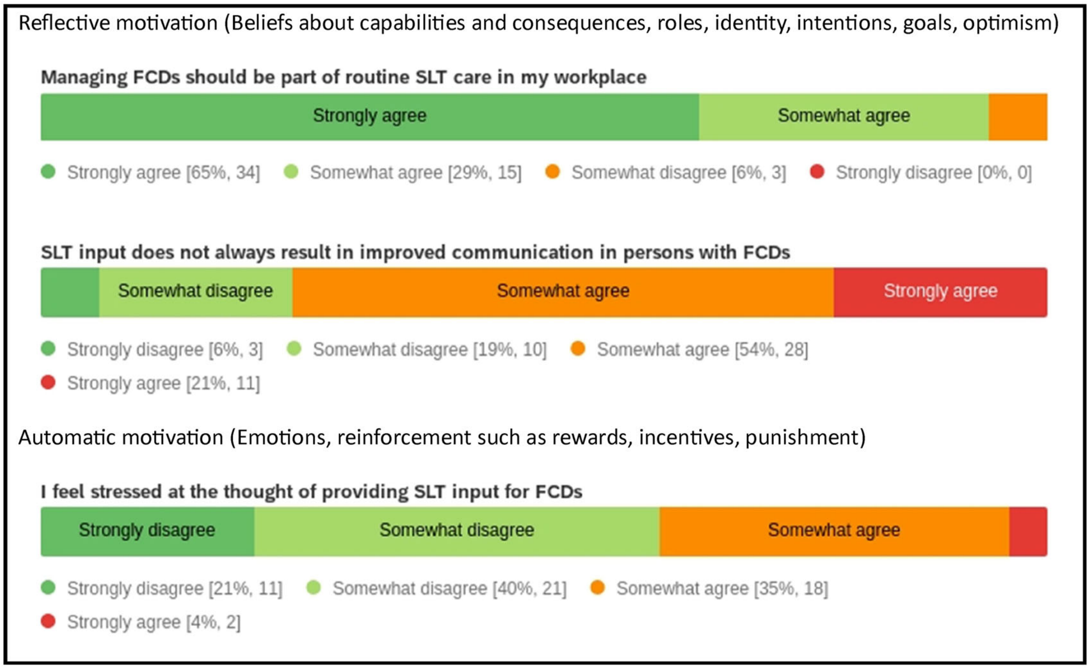

FIGURE 5 COM-B motivation.

related to the complex nature of FCDs: that improved intelligibility or communication behaviours is too reductive as a primary outcome. Perhaps, outcomes need to consider constructs beyond communication, such as interpersonal relationships and participation in society. This has been supported by the literature, where psychological and interpersonal factors, and not just symptom reduction, have been found to be important for FND quality-of-life measurement (Jones et al., 2016; Pick et al., 2020).

The survey found that SLTs feel a tailored and individualised approach for the initial assessment is important. This finding is consistent with the consensus recommendations which advise SLTs to take a thorough case history and conduct a psychosocial assessment to better understand the individual's personal history as part of the initial

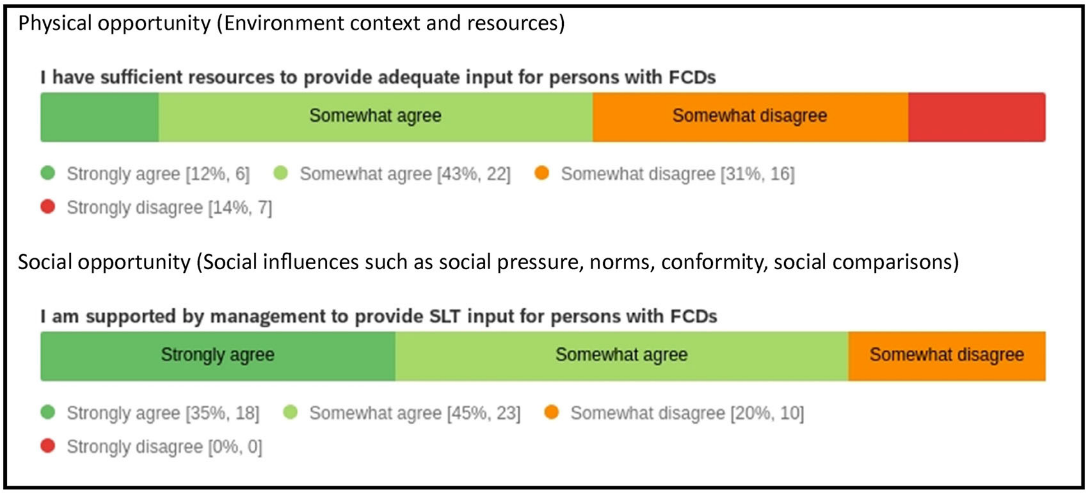

FIGURE 6 COM-B opportunity.

assessment (Baker et al., 2021). This process supports the SLT to tailor treatment to the individual. Personalised treatment may be particularly important in the management of functional disorders due to the heterogeneity and variability of symptoms, and is supported by other disciplines, such as psychotherapy (Myers et al., 2021; Pick et al., 2020). This process of individualising care encourages SLTs to consider the patient's needs holistically and tailor them to their circumstances and goals.

A theme that emerged from the survey was the breadth of experience SLTs are incorporating into their practice when working with FCDs. This included learning from clinical experiences of working with patients with functional disorders, but also a broad range of other clinical groups. A wide range of psychological approaches and models were also reportedly applied to clinical practice. This suggests that FND is a complex condition, which requires clinicians with a wide range of skills and experience to draw on. Though the majority of respondents (57.5%) had over 10 years of experience working as an SLT, only 21.9% reported more than 10 years of experience managing FCDs. The data seemed to suggest that SLTs with greater clinical experience were more confident, though further research including interviews and/or focus groups of clinicians with a range of skills and experience may help to further understand the connection between clinician experience and skills with clinical outcomes and clinician confidence.

SLPs: The inconsistencies in FCD management

The survey highlighted a huge range of approaches and experiences SLTs apply to their work with patients with FCDs. The inconsistency in management approach may indicate a professional failing due to the lack of professional guidelines for FND, a symptom of a lack of literature, lack of support, and SLTs feeling unsure about what approach to take. These issues will be explored further.

Psychological approaches such as Mindfulness, CBT, ACT and SFBT were frequently mentioned, though other specific approaches, mentioned by a single participant, included: empowerment behaviour management approach, compassion focused therapy and personal construct psychology. Apart from CBT (Deary et al., 2018), there is no research evidence supporting the use of these specific psychological approaches by SLTs with a FCD population. Nevertheless, SLTs are encouraged to use a 'psychotherapeutic mindset' when working with this patient group (Freeburn & Baker, 2023: 5). The range of approaches reported could demonstrate the resourcefulness and creativeness of clinicians using whatever is in their toolbox. The reasons for this are explored through the survey findings.

SLTs reported variable capability to deliver FCD interventions, particularly in terms of access to adequate training. There was a relatively equal spread between those who felt there was good access and those who felt there was poor and inadequate access. Those who did report having accessed training mostly reported attending formal external CEN study days and conferences, and a few participants were accessing internal training within their department or institution. The ability to learn through internal training will be dependent on the skills and experience within the team. This was reported by some as an issue, some clinicians indicated that they were the only SLT who had the skills or interest in managing FCDs in their team. This scenario results in individual SLTs being the go-to recipient of functional referrals, which on one hand leads them to gain more exposure, but on the other creates an experience disparity in teams and therefore a lack of peer support. This isolation may explain why one-third of participants reported feeling stressed at the thought of providing input for this patient group. This highlights the need for peer support groups or CENs to provide opportunities for SLTs to share skills and experiences.

The approach taken by SLTs and support available are also dependant on their service, pathways, and access to other services and specialists. Access to specialists in neurology and neuropsychology, who have an interest and understanding of FND, was highlighted as integral to providing an effective service. The benefits of effective pathways and timely diagnosis of FND has been highlighted as a means of reducing service dependence and improving outcomes (Williams et al., 2022). One potential reason for the use of such a broad range of psychological approaches can be found in studies of Occupational Therapists and Physiotherapists, studies have found that therapists can take on a more psychologically supportive role where services are lacking (Edwards et al., 2012; Nicholson et al., 2022). Yet the barriers to patients accessing appropriate services are complicated, they are in part a result of a lack of services but, unlike many other neurological conditions, clinicians with negative attitudes and misconceptions about the condition have been found to delay or impede referral to appropriate services (O'Keeffe et al., 2021). This highlights a wider issue regarding how people with functional disorders are thought of by healthcare professionals (Begley et al., 2023).

Finally, SLTs ability to provide an effective service for people with FCDs is reliant on the evidence base available to them. This survey has highlighted a range of functional disorders UK SLTs are encountering in clinical practice, but these disorders are not proportionately represented in research literature. For example, FAS has received significant research attention, yet it is infrequently seen clinically. Functional voice disorders have received significantly more research attention though its occurrence is reportedly similar to or less than other FCDs. Furthermore, this paper has highlighted that SLTs are seeing many FCDs, such as functional stuttering, language symptoms and articulation symptoms, as frequently as functional oro-pharyngeal dysphagia and globus pharyngeus, yet there is a lack of formal guidance on how these conditions should be managed. The reason for the disparity in research is not known, one reason why FVDs may have received more research attention is an intrinsic understanding of the impact on emotions and stressful life experiences on voice use, this has been eloquently explored by Baker (2010). Furthermore, FAS though a rare disorder is particularly unusual and may draw research attention on this basis (McWhirter et al., 2019). This survey has highlighted the range of FCDs SLTs are encountering in the UK, research needs to address the deficits in evidence-based practice according to the conditions SLTs are actually seeing clinically.

Limitations

The limitations of this survey were due to the scope and methodology used. The aim of the survey was to determine what interventions UK SLTs are using with people with FCDs; therefore, to ensure participants had sufficient experience of managing FCDs the inclusion criteria required at least three FCD referrals to have been seen a year. Therefore, this sample is not representative of the adult SLT workforce, and the findings cannot be extrapolated to a wider population. Furthermore, the survey targeted SLTs with experience in managing patients with FCDs. Yet questions included functional swallowing disorders for comparison, however as this condition was not the focus of the survey, the responses may have been skewed towards SLTs with limited experience of functional swallowing disorders. Therefore, the findings regarding functional swallowing disorders cannot be extracted in isolation. Further research specifically targeting functional swallowing disorders should be the focus of further research. Another limitation is the use of a condensed set of COM-B questions to explore facilitators and barriers to effective management of FCDs, the survey found some response patterns which could be construed as contradictory. A more complete set of COM-B questions could have explored these issues further, but questions were limited to reduce participant burden. Finally, though there were attempts to gain a representative sample, participants from some areas of the UK were not represented, specifically Wales. Further targeted recruitment strategies should have been employed to gain a more representative sample.

CONCLUSIONS

This study has explored current UK SLT practice when managing patients with FCDs. This is the first survey conducted specifically on this topic. The survey found that UK SLTs encounter a wide range of FCDs as part of their clinical practice, that they feel SLT is important and necessary for those experiencing FCDs and can achieve good outcomes. Yet there is disparity and variety in the intervention approach SLTs are offering. This survey has highlighted the barriers SLTs are encountering when trying to provide effective intervention: the lack of research and evidence-based practice, lack of training opportunities, healthcare practitioner's negative attitudes and beliefs about functional disorders, and access to specialist clinicians and services. SLTs are motivated to provide an effective service for patients with FCDs, therefore clinicians and researchers need to work together to tackle these issues and improve services and outcomes for those with FCDs.

CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

PARTICIPANT CONSENT STATEMENT

Informed consent was required to participate in the survey and further optional consent was gained to use anonymised quotes. Incentives were not offered to participate in the survey.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

How to cite this article: McKenzie, K., Hilari, K. & Behn, N. (2024) An exploration of UK speech and language therapists' treatment and management of functional communication disorders: A mixed-methods online survey. *International Journal of Language & Communication Disorders*, 1–14. https://doi.org/10.1111/1460-6984.13113