Functional Disorders and Associated Challenges in Diagnosis and Communication with Patients

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I read with great interest the article by Joseph H. Friedman, MD, "Functional Disorders," in the February 2026 issue of the *Rhode Island Medical Journal*.[1] Dr. Friedman highlights the challenges in the diagnosis of functional disorders and in the communication of these diagnoses to patients.

"Functional" disorders are typically described as those which manifest with symptoms but do not ultimately derive from an organic etiology.[2] They are some of the most commonly encountered disorders across specialties, and frequently cause significant distress for patients. Often, extensive testing is completed and resources expended, but ultimately without identification of an organic disease process. Providers face the challenge of clearly communicating the functional diagnosis to their patient, while patients are often frustrated by the lack of a seemingly "tangible" diagnosis, and can feel dismissed by their providers or seek out second, third, or fourth opinions.

Dr. Friedman's observations about functional neurological disorders are highly relevant to other specialties as well. As a pediatric gastroenterologist, one of the most common entities I routinely diagnose is some kind of functional gastrointestinal (GI) disorder, such as functional abdominal pain, irritable bowel syndrome (IBS), functional dyspepsia, etc. The exact pathophysiology behind these disorders is not clearly understood, and research is ongoing. However, what is known is that there is a brain-gut interaction that leads to the inextricable link between the brain and the GI system. Optimal management of these conditions typically involves a multidisciplinary approach and, importantly, usually involves a mental health provider to address underlying anxiety or stress that may be contributing to symptoms. The latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR), which categorizes functional gastrointestinal (GI) disorders, notes that, if a functional GI disorder is suspected, unless there are alarm signs/symptoms or other concerning features, testing should be limited to that which is deemed necessary, as excessive or repetitive testing can actually lead to more anxiety for patients, thereby exacerbating symptoms further, and can also lead to unnecessary healthcare costs.[3]

Of course, in clinical practice, this ideology can fall to the wayside. There are multiple reasons for this, including: (1) patients/families understandably wanting to ensure that the patient is receiving the correct diagnosis, sometimes advocating for extensive testing that may not always be necessary; (2) providers sometimes feeling bound by a medical-legal environment in which they feel they must "rule out" other common, organic pathologies, even if the likelihood of diagnosing such organic processes is low, based on the individual patient's history and presentation; and (3), as Dr. Friedman notes, the diagnosis of a functional disorder is often mistakenly perceived by the patient/family as being told that they are "crazy,"[1] when, in fact, this is not the case at all. Similarly, one of the most important aspects of managing functional GI disorders is understanding and conveying to patients that the symptoms involved in functional GI disorders are, in fact, real and distressing, and not "in one's head." However, in the process of reaching this understanding, extensive testing is often undertaken.

Given the prevalence of functional GI disorders and the possibility, for many of these disorders, of significant relief with appropriate management, it is important to diagnose functional conditions appropriately, as Dr. Friedman suggests in his piece. While some patients will be receptive to the diagnosis and others will not, it is imperative that medical providers continue to listen to patients, complete the appropriate amount of investigation into the reasons for their symptoms, and, if a functional disorder is ultimately suspected, ensure that they clearly and openly communicate with patients and families about what this means and how best to approach the management.

References

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Disclosures/Conflicts of Interest

None

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