**Supplemental Text Box 1**

**The Mind-Body Program: Historical Origins and Family Systems Underpinnings**

The Mind-Body Program was founded in 1994 at The Royal Alexandra Hospital for Children by child and adolescent psychiatrist Dr. Kenneth Nunn. The hospital, initially called The Sydney Hospital for Sick Children, had been founded in 1880. It changed names to The Royal Alexandra Hospital for Children in 1904, and it became The Children’s Hospital at Westmead—its current name—when it moved west of Sydney in 1995.

KEY GUIDING PRINCIPLES DEVELOPED IN 1998

In a 1998 book chapter, Dr. Nunn outlined the key principles guiding the treatment process with the child with functional neurological disorder—then called conversion disorder—and the child’s family.27 Because family systems theory was very influential at that time, family systems thinking pervades the 1998 principles. After listing the guidelines, we discuss the key ways in which systems thinking shaped the Mind-Body Program.

Nunn’s 1998 principles relating to assessment and inpatient treatment were as follows:27(p 276)

1. Re-assess the evidence for conversion disorder [now called FND], prior to admission where possible:
   1. The evidence that there is no medical disorder
   2. The evidence that there are psychological contributors. [Note: psychological contributors are no longer required under DSM-5.]
2. Always assess *before* agreeing to admit.
3. Establish clear expectations about the goals of treatment and what treatment will require by way of consent, *prior to admission*.
4. Parental restrictions to no more than two hours’ visiting can be helpful to assess alliances and to treat enmeshment. Where this is accomplished easily, consider covert rejection and abandonment. Enmeshment is the rule and extrusion is the exception.
5. A physical rehabilitation approach is usually the most helpful, especially with motor deficit.
6. The least affected parts are rehabilitated first. Keep that which is well, well. The most impaired functions such as paralysed limbs should be focussed on least to begin with and only recruited passively or by default such as in hydrotherapy.
7. Move from passive to active with school involvement, physical rehabilitation and social encounter; school attendance without expectation of academic activity, physical rehabilitation without expectation of performance and social encounter without demand to interact.
8. Focus on what the child *can* do rather than on what they *cannot* do.
9. Keep short-term expectations low and long-term expectations high. When things go well emphasise potential complications. When things go badly emphasise the long-term positives. This smooths out ‘roller coaster’ reactions.
10. Keep communications centralised and highlight the dangers of the team becoming split or fragmented.
11. Do not rush and do not allow programme drift. Allow more time at the beginning of each new phase of treatment so that small achievements can lead to positive generalisation. Avoid becoming clinically *becalmed* with no short-term plans.
12. Avoid termination phenomenon. Long-term follow-up even if widely spaced is more desirable than intensive therapy followed by abrupt terminations.

DESIGNATING A CLEAR BOUNDARY BETWEEN THE ASSESSMENT PROCESS AND THE TREATMENT PROCESS

Drawing on the structural interventions of Salvador Minuchin28—in which boundaries were especially important—the guidelines addressed the need to manage the transition from the biomedical model of pediatrics (the assessment and diagnostic process) to the biopsychosocial rehabilitation model (the treatment process) in a careful and explicit way. This first step created—and continues to create—a clear boundary. It helps families make the necessary conceptual shift from the process of looking for a diagnosis and explanation to the process of implementing treatment interventions that would help the child recover from the illness.

PROVIDING STRUCTURE TO THE PROGRAM: THE DAILY TIMETABLE

Also drawing on the structural interventions of Minuchin,28 the guidelines suggested an overarching structure for the program, all of which were timetabled into program: daily attendance at school; daily physical therapy; daily psychotherapy; therapeutic group activities; limited family visiting times; and weekly family meetings. The daily timetable created—and continues to create—a clear, predictable, and recurring daily rhythm that provided not only structure and therapeutic focus, but rhythm, to the child’s hospital stay and the treatment intervention.

SHAPING AND RESHAPING THE THERAPEUTIC PROCESS

Process issues necessary for maintaining therapeutic momentum—change and movement over time—were highlighted in the guidelines. Key issues included the following: management of the child and family’s expectations; goal setting in the here and now (vs. the future); the importance of noticing small gains and achievements to maintain hope; cohesion within the multidisciplinary treating team (to avoid splitting); and the need for strong clinical leadership, or what our team refers to as driving the ship in a slow and steady way to move the therapeutic process slowly but relentlessly in the right direction.

USING PARADOXICAL INTERVENTIONS

Paradoxical interventions came from the Milan school of family therapy.29 In physical therapy, indirect physical therapy approaches were favored—for example, working with the least-affected body parts first or recruiting the impaired body parts indirectly, as by working in the hydrotherapy pool. In work with the family, the therapist downplayed short-term expectations and emphasized long-term expectations. When things were going badly, the therapist emphasized positive long-term expectations and goals, and when things were going well, the therapist emphasized potential complications.

THERAPEUTIC USE OF POSITIVE SUGGESTION

The guidelines also drew on the work of Milton Erickson, an American psychiatrist and family therapist, who highlighted the therapeutic use of positive suggestions, stories, and metaphors in conversations with patients. Erickson’s goal in using suggestions, stories, and metaphors was to steer the patient (and family) toward healthy actions and future outcomes.30,31 In the guidelines for the Mind-Body Program, these themes are evident in the overall emphasis on hope, mastery, and positive expectations, with the therapist always focusing on small gains, on what the child can, rather than cannot, do, and on the expectation of good long-term outcomes.

LIMITATIONS: WHAT THE GUIDELINES DID NOT COVER

The guidelines also had significant limitations. They did not provide fine-grained detail about the specific therapeutic content of each of the treatment components that made up the Mind-Body Program. What interventions should make up the individual psychotherapy with the child? What model of family therapy might be a good match for this group of families? What specific physiotherapy interventions should the physiotherapist use? In 1998, this fine-grained detail was missing because the evidence base about FND—both its etiology and treatment—was just beginning to be established. That evidence base is now much more robust.