# A simplified version of the Psychogenic Movement Disorders Rating Scale: The Simplified Functional Movement Disorders Rating Scale (S-FMDRS)

Glenn Nielsen, BSc(Hons)1,2, Luciana Ricciardi, MD, PhD3 , Anne Marthe Meppelink, MD, PhD4, Kate Holt, BSc(Hons)3, Tiago Teodoro, MD3,5,6, Mark Edwards, MD, PhD3

1. Sobell Department of Motor Neuroscience and Movement Disorders, UCL Institute of Neurology, Queen Square, London WC1N 3BG.
2. Therapy Services Department, National Hospital for Neurology and Neurosurgery, Queen Square, London WC1N 3BG
3. Institute of Cardiovascular and Cell Sciences, St Georges University of London, London, SW17 0RE
4. Department of Neurology, University Medical Centre Groningen, University of Groningen, Groningen, the Netherlands.
5. Instituto de Medicina Molecular, Faculdade de Medicina, Universidade de Lisboa, Lisboa, Portugal
6. Serviço de Neurologia, Hospital de Santa Maria, Lisboa, Portugal

Correspondence: Mr Glenn Nielsen

Sobell Department of Motor Neuroscience & Movement Disorders

UCL Institute of Neurology, Box 146

Queen Square

London

WC1N 3BG

Tel: +44 (0)20 344 88606

Email: [g.nielsen@ucl.ac.uk](mailto:g.nielsen@ucl.ac.uk)

Word Count Text: 2592

Word Count Abstract: 242

Key Words: Functional Movement Disorder, Psychogenic, Reliability

# Abstract

**Background:** The Psychogenic Movement Disorders Rating Scale (PMDRS) has potential as a useful objective assessment in clinical research, but the current scale has limitations. We developed a simplified version (S-FMDRS) and assessed inter-rater reliability, concurrent validity and sensitivity.

**Methods:** Fifty-two videos of subjects with functional (psychogenic) movement disorders (FMD) were rated according to the PMDRS and S-FMDRS by three neurologists. Inter-rater reliability was assessed using intraclass correlation coefficient (ICC). Agreement of symptomatic body regions and movement disorder classification was assessed using Light’s kappa. Spearman’s correlation coefficient was used to assess concurrent validity. A physiotherapist also rated videos on the S-FMDRS. The simplified scale was piloted in a feasibility study of physiotherapy for FMD to assess sensitivity.

**Results:** ICC of total scores was 0.84 for the original scale and 0.85 for the simplified scale. Light’s kappa for agreement of symptomatic body regions and movement disorder classification was moderate to low. Concurrent validity was demonstrated by Spearman’s correlation between the two scales ranging from 0.84 to 0.95. The simplified scale was sensitive to change, with an effect size in the feasibility study of 0.79. Inter-rater reliability between physiotherapist and neurologist was high (ICC 0.85).

**Discussion:** Both versions of the scale had good inter-rater reliability for the total score. Low agreement on movement disorder classification and identification of symptomatic body regions support our argument for a simplified scale.

**Conclusions:** The S-FMDRS has high inter-rater reliability and good sensitivity to change. Further psychometric evaluation is warranted.

[242 words]

# Introduction

There is increasing research interest in the treatment of patients with functional (psychogenic) movement disorders (FMD). This research shows promising outcomes and includes a diverse range of treatments including physiotherapy, psychological therapy, multidisciplinary rehabilitation, novel biofeedback treatment, supported self-help and therapeutic sedation1–11. A significant limitation of this literature is a lack of consistency in the use of objective outcome measures.

Measuring outcome in FMD is problematic as the illness experience varies considerably between individuals. Patients can experience problems in physical, psychological and or social domains. Multiple comorbidities may account for differing proportions of an individual’s illness burden, such as migraine, chronic pain, chronic fatigue, bladder and bowel symptoms, anxiety and depression. In addition, the severity of functional motor symptoms are inherently variable, making ‘snap-shot’ measures potentially unreliable.

The Psychogenic Movement Disorders Rating Scale (PMDRS) is one of very few outcome measures specifically designed for FMD12. It aims to provide a snap-shot symptom severity score and provide information on phenomenology, anatomical distribution, duration and functional impact of abnormal movement. The creators of this scale found it to have excellent inter-rater reliability, good sensitivity and good construct validity12. Scoring works by identifying the movement abnormality in 14 body regions; classifying the abnormal movement as one of 10 movement disorder phenomena (resting tremor, dystonia, chorea, athetosis, etc.); then scoring the movement according to perceived severity, duration and incapacitation. Gait and speech are also scored according to severity, duration and incapacitation. Scoring is based on 0-4 ordinal scales. Scores are added together with a global incapacitation and severity score. See figure 1 for PMDRS scoring table.

We believe that a number of features limit the usefulness of the PMDRS. The scale excludes functional weakness, one of the most common functional neurological symptoms. This may be a pragmatic decision based on the difficulty assessing weakness by observation, or related to a purist definition of ‘movement disorder’ that does not include weakness. However, we would argue that patients with functional weakness as the dominant symptom share a common aetiology with other functional motor symptoms and that weakness is part of the symptom burden of many with FMD. The PMDRS assumes high level expertise in movement disorders in order to classify movement phenomena. It is therefore likely that the high inter-rater reliability reported by Hinson et al may not be generalisable to health professionals other than experienced movement disorder specialists, while treatment (and therefore objective assessment) is likely to be performed by physiotherapists, occupational therapists and psychologists. In any case, the categories of movement disorder used in the scale are defined by their association with neurological disease and are therefore arguably not very relevant to movement impairment due to FMD. Symptoms of FMD may resemble movement disorder due to organic disease, however repeated kinematic analysis of FMD has shown inconsistency in the movement pattern13, which throws into question the usefulness and reliability of highly specific categorisation. The symptom severity score ranges from 0-4 (none, minimal, mild, moderate, severe), but the difference between minimal and mild is unclear in our opinion. We also question the usefulness of the incapacitation score. Incapacity was defined as “how functionally relevant the observed abnormal movement is”. It is not clear how this can be differentiated from severity, nor judged by a discrete observation without observation of performance during functional tasks.

To address some of these concerns with the PMDRS, we developed a simplified version, and compared the inter-rater reliability and criterion related validity to the original scale. In addition, we piloted the simplified scale in a feasibility study of physiotherapy for FMD. In line with recent suggested changes in terminology14 we have named our simplified version of the PMDRS the Simplified Functional Movement Disorders Rating scale (S-FMDRS).

# Method

## Participants

Participants for the reliability study were drawn from subjects enrolled in a randomised feasibility study of physiotherapy for FMD15. The inclusion criteria were: a clinically established diagnosis of FMD according to the Fahn-Williams criteria16; age 18 years or older; completed diagnostic investigations; acceptance of the diagnosis; symptom duration of at least six months; and symptoms severe enough to cause distress or impairment in social or occupational functioning. The exclusion criteria were: unable to understand English; pain or fatigue that we judged to be the primary cause of the patient’s disability; prominent dissociative seizures for which the patient required assistance to manage; clinically evident anxiety or depression that we felt required assessment before starting physiotherapy treatment; and high level of disability that prevented participation in an outpatient/day hospital environment. Approval was obtained from the National Research Ethics Service Committee London – City Road & Hampstead (14/LO/0572). All participants gave written informed consent.

## Procedures

Each participant completed a battery of assessments including a standardised video of movement, 10 metre timed walk and Short Form 3617 at baseline (prior to treatment) and six months follow up. In the standardised video of movement, participants were filmed according to a protocol based on that reported by Hinson et al 200512. Filming starting with a full body view of the participant sitting in a chair with arm rests (15 seconds); close up of face and neck (15 seconds); the participant was then asked to recite the months of the year; full body view sitting with hands supine resting on thighs (15 seconds); arms extended at shoulder height with hands in pronation (10 seconds); finger-nose test (5 repetitions); thumb and index-finger finger taps (15 seconds); heel taps (15 seconds); moving from sitting to standing; standing with posture uncorrected (10 seconds); standing feet touching (10 seconds) and finally walking 5 metres, turn and walking back to the starting position (using aids if necessary). All video was filmed in a frontal view. A sample of 52 videos were randomly selected (from the feasibility study data) using an online randomisation application, for the reliability and validity assessment. Three neurologists with clinical experience in movement disorders (LR, AM and TT) independently rated each video according to the PMDRS and a simplified version (S-FMDRS). The original PMDRS was scored according to the instructions in the manuscript12. The order of scoring for each scale was alternated between videos. In addition, a physiotherapist rated the videos using the S-FMDRS only. The rater was instructed to watch each video in full, and they were then permitted to re-watch relevant sections as required.

## Simplified Functional Movement Disorders Rating Scale (S-FMDRS)

The following developments were made to create the simplified scale (see figure 2). First, and most importantly, the nature of the movement disorder phenomenology was removed, and raters were simply required to note the presence or absence of abnormal movement in each body region. Second, the number of body regions was condensed from 14 to seven. Third, symptom severity at each body region was rated from 0-3 (0=none, 1=mild, 2=moderate, 3=severe). Fourth, a duration score was assigned to each body region (estimated amount of time during the video that symptoms are observed at the body region), rated from 0-3 (0=none; 1=symptomatic movement spotted at least once or only a few times; 2=symptom is intermittent but frequent, so there are periods where it is absent or does not affect purposeful movement; 3=the symptom is there all the time)..Gait and speech were also rated according to severity and duration. Fifth, the incapacitation score was removed. All severity and duration scores were added to give a total score.

## Feasibility Study Procedures

The feasibility study procedures have been reported in full elsewhere15. In summary, 60 patients with FMD were randomised to receive a specialised intensive 5-day intervention (intervention group) or referral to standard community neurophysiotherapy (control group). Video was taken at baseline and at six months following treatment.

## Analysis

A sample size of 52 was chosen using a sample size calculation based on an estimated intraclass correlation coefficient (ICC) of 0.8, for 2 raters with a 95% confidence interval width of 0.218.

Interrater reliability was assessed using ICC (2 way random effects-absolute agreement, ICC(2,1)) for score totals and Light’s kappa19 for agreement on classification of movement disorder (PMDRS) and the presence of symptoms at each body region/function (both scales). Concurrent validity was explored using Spearman’s correlation, comparing total S-FMDRS scores to the PMDRS scores, SF36 Physical Function domain scores and 10 metre walk times. To assess sensitivity of the S-FMDRS, the mean difference between the intervention and control groups of the feasibility study was assessed using a linear regression model, adjusting for the baseline scores of the measure20. A treatment effect was calculated using Cohen’s *d* 21. Statistical analysis was conducted using SPSS version 22.

# Results

The mean age of participants in the reliability assessment sample was 43 (SD 13.4), 73% were female, the mean symptom duration was 5.6 years (SD 6.7). Participants presented with primary complaints of gait disturbance (25%), tremor (20%), weakness (12%), jerks (4%), and mixed movement disorder symptoms (39%). Reliability values are presented in table 1.

## Intraclass Correlation Coefficient

ICC(2,1) for the neurologists was 0.84 (95% CI 0.75, 0.90) for the PMDRS total score, and 0.85 (95% CI 0.77, 0.90) for S-FMDRS total score. ICC(2,1) for the neurologist-physiotherapist S-FMDRS total score comparison was 0.85 (95% CI 0.76, 0.91).

## Light’s kappa

Light’s kappa for PMDRS movement disorder classification (phenomenology) ranged from no agreement for functional tics, athetosis and cerebellar-like incoordination to high agreement for resting tremor (ICC 0.80, 95% CI 0.73, 0.87). Agreement for PMDRS symptomatic body regions ranged from 0.10 for the jaw (95% CI 0.09, 0.11) to 0.66 for the trunk (95% CI 0.57, 0.75). Agreement for S-FMDRS body regions ranged from 0.36 for left lower limb (95% CI 0.32, 0.41) to 0.63 for the trunk (95% CI 0.55, 0.71). Agreement on the presence of symptoms during gait was 0.70 (95% CI 0.62, 0.78) and speech 0.66 (95% CI 0.57, 0.76) for both scales.

## Validity

Spearman’s correlation between PMDRS and S-FMDRS total scores was 0.86 (p<0.001) for neurologist one; 0.95 (p<0.001) for neurologist two and 0.84 (p<0.001) for neurologist three. Spearman’s correlation between S-FMDRS and SF36 Physical Function domain was -0.56 (p=0.001) for neurologist one; -0.39 (p=0.031) for neurologist two; and -0.33 (p=0.073) for neurologist three. Spearman’s correlation between S-FMDRS and 10 metre walk time was 0.53 (p<0.004) for neurologist one; 0.41 (p<0.032) for neurologist two; and 0.25 (p=0.212) for neurologist three.

## Sensitivity - Difference between Intervention and Control Groups

Sensitivity analysis was conducted using the data from the sample of 60 participants enrolled in a feasibility study.15 The mean intervention group S-FMDRS score at six months (post treatment) was 10.6 (SD 9.1) and the mean control group score was 16.6 (SD 8.6). After adjusting for baseline scores, the difference between groups was 7.4 (95% CI 3.8, 11.0), Cohen’s d=0.79.

# Discussion

We assessed the inter-rater reliability of the PMDRS and a simplified version of the scale. Scores for both scales were found to have high inter-rater reliability with ICC’s ranging from 0.84-0.85. These values are comparable to the ICC for the PMDRS reported by Hinson et al12 of 0.88 and compare favourably to other clinical outcome measures in neurology; for example the Berg Balance Scale in stroke (ICC: 0.9522); Modified Ashworth Scale (ICC: 0.64-0.8723); Unified Parkinson’s Disease Rating Scale motor score (ICC: 0.8224).

Agreement on the classification of movement disorder and the presence of symptoms in body regions was assessed with Light’s kappa and found to be highly variable, with values ranging from no agreement to 0.80. It has been suggested that a kappa value below 0.60 indicates inadequate agreement and little confidence should be placed in the measure25. In the present study, all movement disorder classifications in the PMDRS except resting tremor and the presence of symptoms at many body regions for both scales had insufficient agreement according to this cut-off value.

The low agreement of movement disorder classification supports our argument for removing this from step from our revised scale. The results also support our move to condense the number of body regions in the revised scale as there were no observed symptoms (or a negligible number) in 4 out of 13 regions of the PMDRS. Reducing the number of body region categories in the S-FMDRS appeared to improve agreement, though in our sample only 4 of 7 body regions had a kappa value greater than 0.60. A number of changes could be employed to improve agreement on symptomatic body regions in future studies. This might include stricter standardisation of the scoring procedure, scoring calibration with an experienced scale user, improving quality or length of video footage and requiring the rater to double check each score.

Concurrent validity is the extent to which a measure corresponds to a previously established measure. Concurrent validity was demonstrated with a significant high correlation between the S-FMDRS and the original scale and a significant moderate correlation with other measures of disability: SF36 Physical Function domain and a timed 10 metre walk.

When we tested the S-FMDRS in the randomised feasibility study, it proved to be a sensitive measure of change. The effect size of 0.79 compared favourably to other measures tested in this study, including SF36 Physical function domain (*d=*0.70), 10 metre timed walk (d=0.72) and the functional mobility scale26 (d=0.79).

The S-FMDRS performed similarly to the original scale, but had certain advantages. It was quicker to complete. It does not require specialist movement disorder training in order to categorise movement disorder phenomena, allowing use by non-neurologists. This is an important issue in its utility, as those administering treatment (and therefore wishing to assess outcome) in patients with FMD are often not movement disorder neurologists, but are other health professionals such as physiotherapists. In this regard we found high inter-rater reliability between the physiotherapy and movement disorder specialist raters. Lastly the revised scale allows the rating of observed movement impairment due to weakness; in the original scale functional weakness of the lower limbs or trunk may be accounted for in the gait score, however there is no equivalent for scoring upper limb weakness within the scoring matrix of the original scale. Further psychometric assessment is recommended to refine the S-FMDRS and highlight limitations, including assessment of construct validity and test-retest reliability.

There are a number of limitations to this study. Although the sample size was sufficient to determine inter-rater reliability of total scores, there were insufficient observations of some of the movement disorder categories to adequately assess agreement. Our analysis only compared agreement of three neurologists. We did not assess each video recording for quality, a factor that may have impacted on reliability of scoring. The results can only be generalised to patients meeting the inclusion criteria and therefore do not necessarily extend to patients with significant psychopathology, more extreme disability and those with a primary complaint of pain or fatigue in addition to functional motor symptoms. These patients were excluded from the current study as they were not considered appropriate candidates for the feasibility study intervention. Finally, both the original and simplified scales are ‘snap-shot’ measures, which may have low test-retest reliability due to the variable nature of FMD severity.

# Conclusion

Scores obtained from the S-FMDRS have high inter-rater reliability when used by experienced neurologists and physiotherapists. The limitations of the S-FMDRS include low agreement on the presence of symptoms at some body regions and unknown test-retest reliability. With acknowledgement of these limitations, the S-FMDRS enables a blinded, clinician rated assessment of overall symptom severity in FMD for research purposes that is sensitive to change. We would recommend that if using either rating scales (PMDRS or S-FMDRS), results are considered alongside other measures, including patient reported outcomes with a set recall period to account for symptom variability, and measures of physical, psychological and social function. Further work to develop valid and reliable outcome measures for FMD is required.

# Author Roles

Research project conception and organisation: Glenn Nielsen and Mark Edwards. Execution of assessments: Lucia Ricciardi, Anne Marta Meppelink, Tiago Teodoro and Kate Holt. Statistical Analysis design and execution: Glenn Nielsen. All authors reviewed the analysis. Manuscript preparation: Glenn Nielsen wrote the first draft, Mark Edwards revised the first draft and all authors reviewed and critiqued the final draft and later revisions.

# Disclosures

## Funding Sources and Conflict of Interest

This report is independent research supported by the National Institute for Health Research (NIHR/HEE Clinical Doctoral Research Fellowship, Mr Glenn Nielsen, CDRF-2013-04-034). The views expressed in this publication are those of the authors and not necessarily those of the NHS, the National Institute for Health Research or the Department of Health. The authors have no conflicts of interest to declare.

## Financial Disclosures for the previous 12 months

Mark Edwards reports a research grant from Medical Research Council; financial support for educational activities from Merz Pharma and a lecture honorarium from UCB. No other financial disclosures to report.

Tiago Teodoro receives funding from the grant ‘‘SFRH/SINTD/95267/2013’’, awarded by ‘‘Fundação para a Ciência e a Tecnologia’’.

**Ethical Compliance Statement**

We confirm that we have read the Journal’s position on issues involved in ethical publication and affirm that this work is consistent with those guidelines.

Approval for this study was obtained from the National Research Ethics Service Committee London – City Road & Hampstead (14/LO/0572). All participants gave written informed consent.

# References

1 Matthews A, Brown M, Stone J. Inpatient physiotherapy for functional (psychogenic) gait disorder: a case series of 35 patients. *Mov Disord Clin Pract* 2016; **28**: 93–6.

2 Nielsen G, Ricciardi L, Demartini B, Hunter R, Joyce E, Edwards MJ. Outcomes of a 5-day physiotherapy programme for functional (psychogenic) motor disorders. *J Neurol* 2015; **262**: 674–81.

3 Jordbru AA, Smedstad LM, Klungsøyr O, Martinsen EW. Psychogenic gait disorder: A randomized controlled trial of physical rehabilitation with one-year follow-up. *J Rehabil Med* 2014; **46**: 181–7.

4 Czarnecki K, Hallett M. Functional (psychogenic) movement disorders. *Curr Opin Neurol* 2012; **25**: 507–12.

5 Espay AJ, Edwards MJ, Oggioni GD, *et al.* Tremor retrainment as therapeutic strategy in psychogenic (functional) tremor. *Park Relat Disord* 2014; **20**: 647–50.

6 Sharpe M, Walker J, Williams C, *et al.* Guided self-help for functional (psychogenic) symptoms: a randomized controlled efficacy trial. *Neurology* 2011; **77**: 564–72.

7 Demartini B, Batla A, Petrochilos P, Fisher L, Edwards MJ, Joyce E. Multidisciplinary treatment for functional neurological symptoms: a prospective study. *J Neurol* 2014; **261**: 2370–7.

8 McCormack R, Moriarty J, Mellers JD, *et al.* Specialist inpatient treatment for severe motor conversion disorder: a retrospective comparative study. *J Neurol Neurosurg Psychiatry* 2013; **85**: 895–900.

9 Hubschmid M, Aybek S, Maccaferri GE, *et al.* Efficacy of brief interdisciplinary psychotherapeutic intervention for motor conversion disorder and nonepileptic attacks. *Gen Hosp Psychiatry* 2015; **37**: 448–55.

10 Kompoliti K, Wilson B, Stebbins G, Bernard B, Hinson V. Immediate vs. delayed treatment of psychogenic movement disorders with short term psychodynamic psychotherapy: randomized clinical trial. *Park Relat Disord* 2014; **20**: 60–3.

11 Stone J, Hoeritzauer I, Brown K, Carson A. Therapeutic sedation for functional (psychogenic) neurological symptoms. *J Psychosom Res* 2014; **76**: 165–8.

12 Hinson VK, Cubo E, Comella CL, Goetz CG, Leurgans S. Rating scale for psychogenic movement disorders: scale development and clinimetric testing. *Mov Disord* 2005; **20**: 1592–7.

13 Merello M, Ballesteros D, Rossi M, *et al.* Lack of maintenance of gait pattern as measured by instrumental methods suggests psychogenic gait. *Funct Neurol* 2012; **27**: 217–24.

14 Edwards MJ, Stone J, Lang AE. From psychogenic movement disorder to functional movement disorder: It’s time to change the name. *Mov Disord* 2014; **29**: 849–52.

15 Nielsen G, Buszewicz M, Stevenson F, *et al.* Randomised feasibility study of physiotherapy for patients with functional motor symptoms. *J Neurol Neurosurg Psychiatry* 2016; **online first**: jnnp-2016-314408.

16 Fahn S, Williams DT. Psychogenic dystonia. *Adv Neurol* 1988; **50**: 431–55.

17 McHorney CA, Ware JE, Raczek AE. The MOS 36-Item Short-Form Health Survey (SF-36): II. Psychometric and clinical tests of validity in measuring physical and mental health constructs. *Med Care* 1993; **31**: 247–63.

18 Bonett DG. Sample size requirements for estimating intraclass correlations with desired precision. *Stat Med* 2002; **21**: 1331–5.

19 Hallgren KA. Computing inter-rater reliability for observational data: an overview and tutorial. *Tutor Quant Methods Psychol* 2012; **8**: 23–34.

20 Vickers AJ, Altman DG. Statistics notes: Analysing controlled trials with baseline and follow up measurements. *BMJ* 2001; **323**: 1123–4.

21 Sedgwick P. Effect sizes. *BMJ* 2012; **345**: e7370.

22 Mao H-F, Hsueh I-P, Tang P-F, Sheu C-F, Hsieh C-L. Analysis and comparison of the psychometric properties of three balance measures for stroke patients. *Stroke* 2002; **33**: 1022–7.

23 Mutlu A, Livanelioglu A, Gunel MK, *et al.* Reliability of ashworth and modified ashworth scales in children with spastic cerebral palsy. *BMC Musculoskelet Disord* 2008; **9**: 44.

24 Richards M, Marder K, Cote L, Mayeux R. Interrater reliability of the unified Parkinson’s disease rating scale motor examination. *Mov Disord* 1994; **9**: 89–91.

25 McHugh ML. Interrater reliability: the kappa statistic. *Biochem Medica* 2012; **22**: 276–82.

26 Graham HK, Harvey A, Rodda J, Nattrass GR, Pirpiris M. The Functional Mobility Scale (FMS). *J Pediatr Orthop* 2004; **24**: 514–20.

# Figure Legends / Abbreviations

Figure 1. The Psychogenic Movement Disorders Rating Scale (Hinson et al 2005)

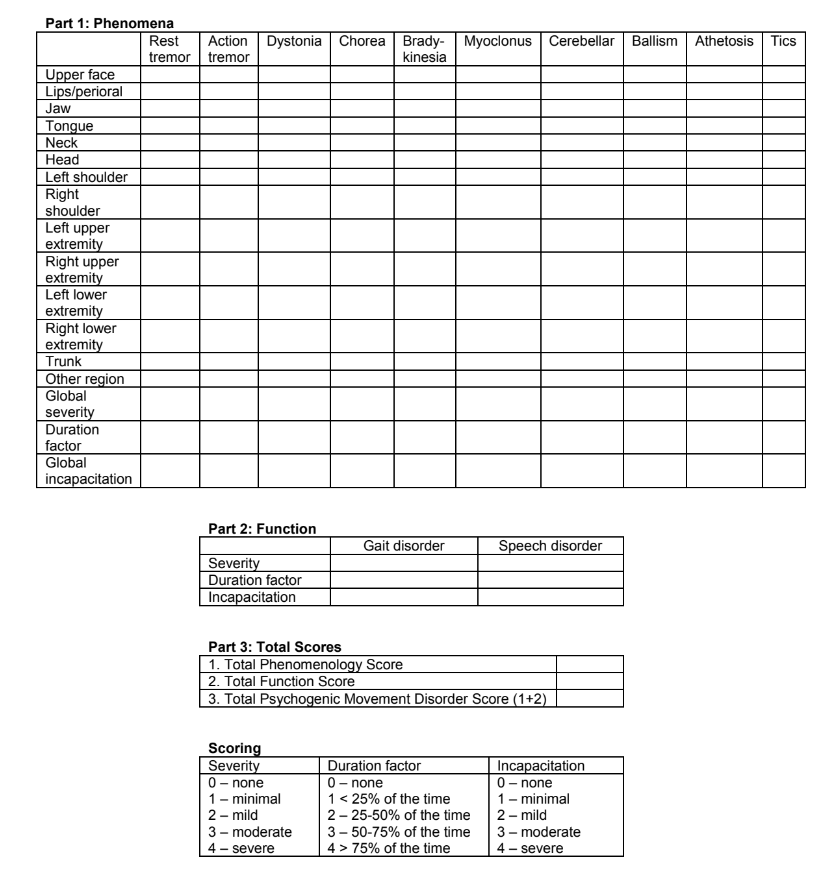
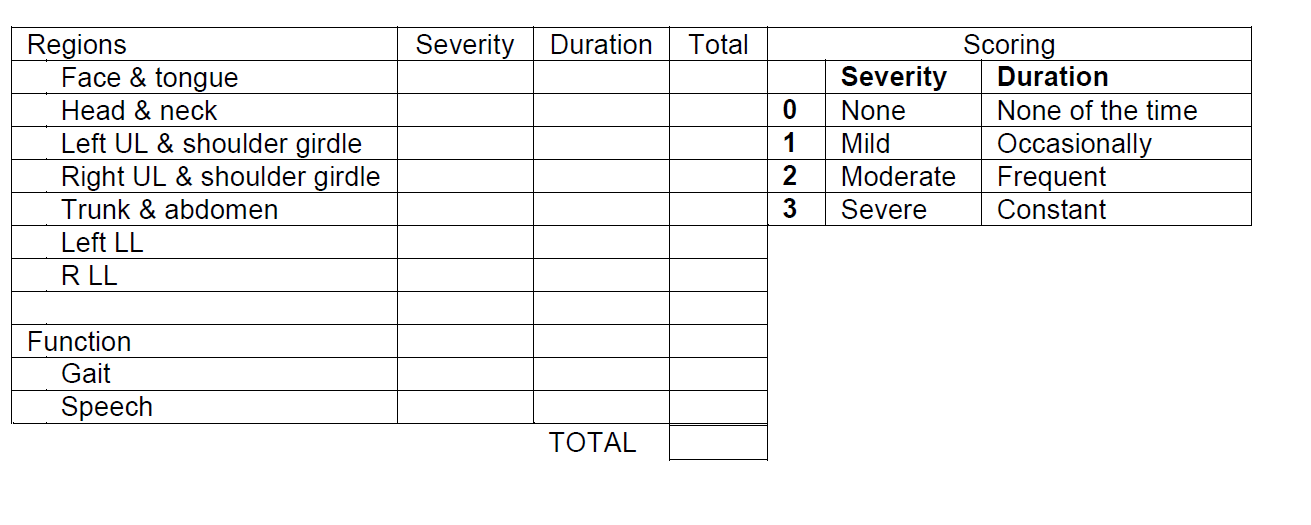


Figure 2. The Simplified Functional Movement Disorders Rating Scale (S-FMDRS)  
Abbreviations: UL=Upper limb; LL=Lower limb



**Table 1. Intraclass correlation coefficient and Light’s kappa values**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Rater 1**  **mean (SD)** | **Rater 2**  **mean (SD)** | **Rater 3 mean (SD)** | **ICC(2,1)** |
| **PMDRS** |  |  |  |  |
| Phenomenology score | 24.6 (18.0) | 25.6 (19.9) | 21 (17.2) | 0.80 (0.70, 0.87) |
| Function score (gait & speech) | 8.2 (5.7) | 6.8 (5.1) | 7.2 (4.9) | 0.89 (0.81, 0.93) |
| Total Score | 32.8 (21.2) | 32.4 (22.8) | 28.4 (20.3) | 0.84 (0.75, 0.90) |
| **S-FMDRS** |  |  |  |  |
| Body region score | 9.1 (6.7) | 9.5 (7.1) | 9.8 (6.9) | 0.78 (0.68, 0.86) |
| Function score (gait & speech) | 4.3 (2.8) | 3.6 (2.7) | 4.2 (2.6) | 0.86 (0.78, 0.91) |
| Total Score | 13.4 (8.5) | 13.1 (8.7) | 14.0 (8.6) | 0.85 (0.77, 0.90) |
|  | **Rater 1**  **mean (SD)** | **Physiotherapist mean (SD)** |  | **ICC(2,1)** |
| **S-FMDRS** |  |  |  |  |
| Body region score | 9.1 (6.7) | 9.9 (8.5) |  | 0.81 (0.70, 0.89) |
| Function score (gait & speech) | 4.3 (2.8) | 4.3 (2.9) |  | 0.93 (0.88, 0.96) |
| Total Score | 13.4 (8.5) | 14.2 (10.6) |  | 0.85 (0.76, 0.91) |
|  | **Rater 1, No. observations** | **Rater 2, No. observations** | **Rater 3, No. observations** | **kappa (95% CI)** |
| **Phenomenology (PMDRS)** |  |  |  |  |
| Resting tremor | 21 | 16 | 16 | 0.80 (0.73, 0.87) |
| Action tremor | 24 | 7 | 28 | 0.41 (0.37, 0.45) |
| Dystonia | 27 | 28 | 26 | 0.41 (0.36, 0.46) |
| Chorea | 2 | 1 | 2 | 0.14 (0.12, 0.17) |
| Bradykinesia | 27 | 43 | 30 | 0.38 (0.34, 0.43) |
| Myoclonus | 4 | 12 | 4 | 0.21 (0.18, 0.24) |
| Cerebellar | 0 | 3 | 9 | 0 |
| Ballism | 1 | 2 | 0 | 0.22 (0.20, 0.24) |
| Athetosis | 0 | 1 | 1 | 0 |
| Tics | 1 | 7 | 0 | 0 |
| **Functions (PMDRS)** |  |  |  |  |
| Gait | 41 | 37 | 43 | 0.70 (0.62, 0.78) |
| Speech | 8 | 7 | 11 | 0.66 (0.57, 0.76) |
| **Body Region (PMDRS)** |  |  |  |  |
| Upper face | 6 | 9 | 12 | 0.33 (0.28, 0.38) |
| Lips | 6 | 11 | 10 | 0.55 (0.47, 0.56) |
| Jaw | 1 | 0 | 5 | 0.10 (0.09, 0.11) |
| Tongue | 0 | 0 | 0 |  |
| Neck | 7 | 14 | 13 | 0.36 (0.31, 0.41) |
| Head | 7 | 13 | 10 | 0.63 (0.54, 0.71) |
| Left Shoulder | 0 | 2 | 0 |  |
| Right Shoulder | 0 | 1 | 1 |  |
| Left Upper Extremity | 22 | 26 | 34 | 0.54 (0.49, 0.60) |
| Right Upper Extremity | 24 | 26 | 38 | 0.52 (0.46, 0.57) |
| Left Lower Extremity | 29 | 32 | 24 | 0.29 (0.25, 0.32) |
| Right Lower Extremity | 23 | 25 | 28 | 0.54 (0.48, 0.60) |
| Trunk | 7 | 12 | 12 | 0.66 (0.57, 0.75) |
|  |  |  |  |  |
| **Body Region (S-FMDRS)** |  |  |  |  |
| Face & tongue | 11 | 14 | 17 | 0.48 (0.42, 0.55) |
| Head & neck | 12 | 23 | 16 | 0.54 (0.48, 0.61) |
| Left upper limb & shoulder girdle | 19 | 28 | 34 | 0.50 (0.45, 0.55) |
| Right upper limb & shoulder girdle | 21 | 26 | 38 | 0.53 (0.48, 0.58) |
| Trunk & abdomen | 7 | 13 | 14 | 0.63 (0.55, 0.71) |
| Left lower limb | 28 | 28 | 24 | 0.36 (0.32, 0.41) |
| Right lower limb | 22 | 25 | 28 | 0.49 (0.43, 0.55) |
| **Functions (S-FMDRS)** |  |  |  |  |
| Gait | 41 | 37 | 43 | 0.70 (0.62, 0.78) |
| Speech | 8 | 7 | 11 | 0.66 (0.57, 0.76) |

Abbreviations: ICC(2,1)=Intraclass correlation coefficient; PMDRS=Psychogenic Movement Disorders Rating Scale; S-FMDRS=Simplified Functional Movement Disorders Rating Scale.