

# Psychogenic Disorder Survey Shows Differences

BY JEFF EVANS

WASHINGTON — Neurologists vary widely in their practices and beliefs when it comes to diagnosing and managing patients with psychogenic movement disorders, and those ranges might be indicative of the absence of practice guidelines, according to results from more than 500 Movement Disorder Society members.

The findings revealed a range of approaches in the use of diagnostic testing in making and delivering the diagnosis, and low confidence in the effectiveness of any therapy.

"This is a starting point to determine areas of weaknesses in the diagnostic process and in treatment strategies," said Dr. Alberto J. Espay, one of the investigators.

Psychogenic movement disorders (PMDs) are mostly generated by conversion or somatoform disorders in which psychological stressors unconsciously produce abnormal movements. They have no known "organic" etiology and may occur in association with underlying psychiatric disease.

Estimates put the number of PMD patients at about 1%-2% of the patient population at general neurology practices, but tertiary movement disorder referral centers have reported as many as 25% of their patients have a PMD, said Dr. Espay, a movement disorders specialist at the University of Cincinnati.

PMDs have been a neglected area of study "because it's so hard to have patients accept the psychological underpinnings of their problem [while] at the same time not stigmatizing them," said Dr. Espay, who presented the survey results at the Second International Conference on Psy-

chogenic Movement Disorders and Other Conversion Disorders, which was sponsored by the Movement Disorder Society, the National Institute of Neurological Disorders and Stroke, and the National Institute of Mental Health.

He and his colleagues sent the 22-question, online survey to 2,104 members of the Movement Disorder Society and asked that those who did not have experience

in managing or diagnosing PMDs not fill it out. Of 519 (25%) neurologists who responded, 43% practice in the United States, 32% in Europe or Canada, and 25% in other countries. Most of them practiced in an academic setting (55%).

In reaching a diagnosis, 74% of the respondents said they ask psychiatrists or other mental health professionals to assess a patient for underlying psychopathology before they discuss the diagnosis with the patient. A majority (52%) said they diagnose and attempt to secure expert management, 40% reported diagnosing and coordinating interdisciplinary long-term management, 5% said they diagnose and personally manage, and 3% diagnose only.

Nearly a quarter said they have no access to an electrophysiology laboratory, but most of those who do use them to confirm PMD only when clinical examination alone is insufficient. Many (40%) said they never or rarely use test results to explain the diagnosis to the patient



Dr. Alberto J. Espay says a psychogenic motor disorder diagnosis can be based on clinical evidence alone.

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and 21% said they often or always do so.

The clinical findings of incongruent movement, psychogenic signs, and inconsistency over time were each thought to be essential for a clinically definite diagnosis of PMD by more than half of the respondents and only 8% thought that an obvious psychiatric disturbance was essential for a clinically definite diagnosis.

Fifty-one percent of the respondents said that even when the patient shows clinically definite evidence of PMD, they request a battery of tests such as brain MRI, EEG, and carotid ultrasound, and then present the diagnosis.

In an interview, Dr. Espay called this the "most damning aspect of the survey," because a PMD diagnosis can be established on clinical evidence alone. Even if such tests produce positive results, they will not explain the problem, because PMDs are not associated with any detectable physiologic or anatomic abnormalities. This approach suggests a many PMD experts "still treat psychogenic movement disor-

ders as a diagnosis of exclusion."

The respondents indicated that an excessive loss of function or disability relative to what was found in the clinical examination is the greatest predictor of a PMD diagnosis. U.S. respondents were more likely than their overseas counterparts to give a PMD diagnosis if a patient had spontaneous remissions and cures, associated nonphysiologic deficits, a history of mental health problems or psychological stressors, or ongoing litigation related to the patient's condition.

About two-thirds of the respondents reported that they refer PMD patients to a psychiatrist or a mental health specialist while also providing personal follow-up. But about half said mental health professionals at least sometimes question their original diagnosis and recommend that the neurologic basis for the disorder should be reconsidered.

Few respondents rated common treatment strategies such as avoiding iatrogenic harm, patient education, psychotherapy with or without drug therapy, rehabilitation services, and drug therapy for a specific movement impairment as "very" or "extremely" effective.

Slightly more than half of the respondents thought that the identification and management of a concurrent psychiatric disorder or psychological stressor are important predictors of prognosis. Another 60% thought that "acceptance of the diagnosis by the patient" is an extremely important predictor of prognosis.

Dr. Espay said it might be time to survey PMD patients to "determine what happens to them while in psychiatric or psychological care and their odds of following with a treatment strategy. ■

## Revisions Needed to Streamline Diagnostic Criteria for PMDs

BY JEFF EVANS

WASHINGTON — Psychogenic movement disorders could be classified with greater simplicity and possibly diagnosed with greater accuracy in a system that expands the ways in which patients can meet criteria for the disorders, according to Dr. Anthony E. Lang.

The original classification scheme for psychogenic movement disorders (PMDs) proposed by Dr. Stanley Fahn and Dr. Daniel Williams (Adv. Neurol. 1988;50:431-55) subdivided the diagnosis based on the level of diagnostic certainty. The original two categories of "documented" and "clinically established" later merged to become clinically definite PMD (Adv. Neurol. 1995;65:231-57), which are "the majority that we see in the clinics," said Dr. Lang, professor of neurology at the University of Toronto. Other cases were classified as "probable" or "possible."

But the Fahn and Williams classification scheme does not take into account the ability to confirm the diagnosis as psychogenic using electrophysiologic testing, Dr. Lang said at an international conference sponsored by the Movement Disorder Society.

Dr. Lang proposed revising the classification scheme to define "clinically definite" PMD as documented,

clinically established plus other features (false neurologic signs or psychiatric problems), or clinically established without other features. A "laboratory-supported" definite PMD diagnosis would be made on evidence from electrophysiologic testing. "Possible" PMD could define a movement disorder that has either clinical or electrophysiologic characteristics that are suggestive of a psychogenic condition but leave room for doubt, such as patients with combined psychogenic and organic movement disorders or with organic movement disorders that have superimposed psychogenic features.

**A revision of the Fahn and Williams scheme might lead to better diagnoses of PMDs.**

DR. LANG

The Fahn and Williams classification system, which is the one most commonly used in research and clinical practice, also cannot accurately classify patients who have clinically unequivocal psychogenic features based on distractibility or entrainment but lack false neurologic signs or multiple somatizations that are required for a clinically-established PMD diagnosis; they can only be diagnosed as probable although they meet all the clinical criteria for a "nonorganic" movement disorder, he said.

The classification system insists that probable or possible PMD can be diagnosed with patients who have movement disorders that are consistent and congruent with an organic counterpart, but many of those patients may have an organic movement disorder with a great deal of functional overlay or a combination of organic and nonorganic movement disorders, Dr. Lang said.

"It's very common to see patients with mixed [movements]. They may have some bizarre movement disorder or a phenotype that's difficult to classify but then also have a prominent tremor or dystonia," he said.

"One of the biggest problems is that we don't have any gold standards in establishing the diagnosis of a psychogenic movement disorder, and the converse is that many organic movement disorders lack similar defining laboratory abnormalities, such as Tourette syndrome or essential tremor."

Certain clinical phenotypes strongly suggest a PMD, although this is a somewhat controversial area, Dr. Lang said. These include tremors that never vary in amplitude in rest, postural, and action states and certain types of leg tremor, such as prominent thigh tremors. Certain dystonic postures are characteristic of PMDs, such as hemifacial dystonic posture. A lack of arm swing in a patient with hemiparkinsonism may be characteristic of a PMD, because Parkinson's disease patients will bring both arms up in front of them and swing nearly symmetrically despite pronounced bradykinesia. ■

