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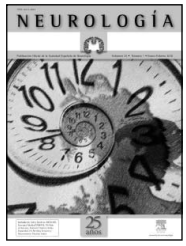

REVIEW ARTICLE

Psychogenic tremor: a positive diagnosis

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Abstract
Psychogenic movement disorders are a daily challenge for the neurologist. A mistake in its recognition may have important consequences for the patients. As a result, the diagnosis must be considered very carefully in clinical practice. However, psychogenic movement disorders are not unusual, are mainly tremors, and a wrong diagnosis is common. Psychogenic is an unspecific term that usually masks the real mental disorder, and should be called somatoform disorders, factitious disorders, malingering, depression, anxiety and histrionic personality disorder, although the absence of a psychiatric diagnosis does not preclude a psychogenic cause. The diagnosis may often be difficult and should be made by an expert neurologist. Organic movement disorders must be excluded after a detailed neurological history, examination, and appropriate diagnostic studies. Psychogenic tremor is not only a diagnosis of exclusion, it can be diagnosed positively by its neurological signs, mainly: variability in frequency and amplitude, bilateral and sudden onset, non-progressive with frequent remissions, absence of finger, tongue or face tremor and coactivation of antagonistic muscles. Several tests can be useful in diagnosis, such as: accelerometry, EMG and response to placebo or suggestion. The treatment requires close cooperation between the medical team and patient. The problem must never be minimised and early diagnosis and treatment must be attempted.

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PALABRAS CLAVE
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Depresión

Temblor psicógeno: un diagnóstico en positivo

Resumen
Los trastornos del movimiento psicógenos constituyen un reto cotidiano para el neurólogo. Un reconocimiento erróneo puede tener importantes consecuencias, por consiguiente este diagnóstico debe considerarse con mucha cautela en la práctica clínica. Sin embargo, los trastornos del movimiento psicógenos no son raros, especialmente el temblor y los errores diagnósticos frecuentes. El término psicógeno es inespecífico y oculta el verdadero trastorno mental que suele ser un trastorno somatomorfo, facticio, simulación, depresión, ansiedad o un trastorno histriónico de la personalidad, aunque la ausencia de un diagnóstico psiquiátrico no descarte la causa psicógena. El diagnóstico es difícil y debe realizarlo un neurólogo experto. Los trastornos del movimiento orgánicos deben excluirse tras una historia detallada, el examen clínico y las pruebas complementarias. El temblor psicógeno no es sólo un diagnóstico de exclusión, se puede diagnosticar en positivo por sus signos clínicos: variabilidad en frecuencia y amplitud, comienzo súbito y bilateral, no progresivo con frecuentes remisiones, nunca afecta a los dedos, lengua o cara y por la coactivación de los músculos antagonistas. Diversas pruebas pueden ser útiles en el diagnóstico, como: acelerometría, electromiograma y respuesta al placebo o la sugestión. El tratamiento requiere una estrecha comunicación entre el equipo médico multidisciplinario y el paciente. Nunca hay que minimizar el problema y siempre intentar un diagnóstico y un tratamiento precoces.

Introduction

Psychogenic movement disorders are a daily challenge for neuroscientists in both diagnostic and therapeutic approach. The confusion of labelling an organic movement disorder as psychogenic is considered a serious diagnostic error because it deprives the patient of adequate treatment, implies a certain personal stigma for the patient and exposes the physician's skill set; caution should therefore be exercised in the diagnosis. Reciprocally, classifying a movement disorder as organic when in reality it is psychogenic may indicate that the clinician is not familiar with the mechanisms that generate organic movements and does not adequately assess neurological inconsistencies; this may involve an endless series of useless additional tests and subject the patient to treatments that only serve to accentuate the features of the conduct disorder he presents.

However, diagnostic confusion is common in daily practice. It is estimated that 6-30% of organic movement disorders are regarded and treated as psychogenic[1], and this is especially common in the case of dystonia (25-52%)[2]. Alternatively, 25-30% of psychogenic movement disorders are diagnosed as organic. To complicate matters further, it is relatively frequent for an organic movement disorder to coincide with a psychogenic one[3], similar to what occurs with epileptic seizures and pseudoseizures.

Movement disorders are one of the most common modes of presentation of psychogenic neurological disorders. A retrospective analysis of clinics specialising in movement disorders, with a certain bias towards underestimation, indicates that 2-3% have a psychogenic origin[4]. They can be manifested as dystonia, parkinsonism, gait and static disturbance, chorea, myoclonus, tics, hemiballism and tremor[5]. The most frequent are tremor (50%) and dystonia, postural and walking changes and myoclonus[4,6,7].

This article reviews the psychopathology underlying psychogenic disorders, aims to increase diagnostic rigor based on positive clinical criteria and complementary tests, and emphasises the importance of early, rational treatment.

Development

Although psychiatric assessment is essential, the diagnosis of a psychogenic movement disorder should and must be carried out by a neurologist and based on clinical observation, since the coexistence of a movement disorder with a mental disorder does not prove that its origin is psychogenic. The key point for its diagnosis is to assess the current inconsistencies and clinical incongruities with the recognised patterns of abnormal movements; hence, once a detailed history, a thorough examination and appropriate complementary techniques have reasonably excluded an organic basis, certain diagnostic keys indicative of a psychogenic origin have to be considered[5,8] (Table 1): acute onset and rapid progression towards its maximum severity, static course with spontaneous remissions and paroxysmal exacerbations, variability in amplitude, frequency and distribution, selective disability for certain tasks, lack of response to standard treatments, surprising and dramatic response to psychotherapy and placebo, variability in amplitude and worsening with attention and the existence of a clearly diagnosed psychopathology.