

# Psychogenic Gait Disorder After a Stressful Life Event: Case Report

## Stresli Bir Yaşam Olayı Sonrası Gelişen Psikojenik Yürüme Bozukluğu

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**ABSTRACT** Psychogenic or functional movement disorders (PMDs) may occur at almost any age, particularly those affecting vulnerable populations. Mostly, that are not explained by a specifiable organic disease and that especially related to psychiatric underlying cause. Psychogenic gait disorders (PGDs) may be fluctuations during a physical exam-particularly an increase of movement following attention, and a decrease when the person is distracted. Useful clues suggesting psychogenic gait problems are acute onset, selective disability, false weakness, bizarre tremor, astasia-abasia (a lurching gait with repeated near falls). If one or more of these features were present, the diagnosis of psychogenic gait disturbance could be made on phenomenological grounds alone with over 90% certainty. But, as with other pseudoneurologic signs, normal underlying neurological function must be demonstrated. Here, we describe a 54-year-old case who had suffered from postural instability, unusual gait disturbance with excessive slowness for about 7 years before, following a stressful life event.

**Key Words:** Gait; conversion disorder; movement disorders; stress, psychological

**ÖZET** Psikojenik ya da fonksiyonel hareket bozuklukları, özellikle yatkınlığı olan kişileri etkilemek üzere hemen her yaşta ortaya çıkabilir. Bu durum, genellikle spesifik bir organik bozuklukla açıklanamaz, çoğunlukla altta yatan psikiyatrik nedenlerle ilişkilidir. Psikojenik yürüme bozuklukları, özellikle fizik muayene esnasında, dikkatle incelendiğinde belirginleşen, kişinin dikkati dağıldığında ise daha belirsiz olan dalgalı bir seyir gösterir. Psikojenik yürüme bozukluklarının tanınmasında en önemli ipuçları, ani başlangıç, seçici yetersizlik, sahte güçsüzlük, tuhaf titreme, astazi-abazi (neredeyse düşecekmiş gibi yalpalayarak yürüme) görülmesidir. Bu özelliklerden bir veya daha fazlası mevcut ise %90'ın üzerinde fenomenolojik gerekçelerle, tek başına psikojenik yürüme bozukluğu tanısı kesinlik kazanabilir. Ancak, diğer sahte nörolojik bulgularda olduğu gibi, altta yatan normal nörolojik bulgular gösterilmelidir. Biz burada yaklaşık 7 yıl önce stresli bir yaşam olayından sonra, postural dengesizlik ve yavaşlamış tuhaf yürüme bozukluğu şikayetleri başlamış olan 54 yaşında bir olgudan bahsedeceğiz.

**Anahtar Kelimeler:** Yürüyüş; konversiyon bozuklukları; hareket bozuklukları; stres, psikolojik

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The psychogenic movement (functional) disorder (PMD) with conversion disorder (CD) is defined as a movement disorder that cannot be explained by a specifiable organic disease to the nervous system and that mostly related to psychiatric underlying cause.<sup>1,2</sup> As we all know, stressful life events exacerbated PMD including the gait problems, particularly in psychiatric patients.<sup>1</sup> Anxiety, depression, conversion, somatization and malingering are the commonest psychological accompaniments of psychogenic gait disorder (PGD) in contemporary practice.<sup>3,4</sup>

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Conversion disorder (Functional Neurological Symptom Disorder) is a neurological symptom complex originating from psychological factors.<sup>5</sup> PGD may occur at almost any age, particularly manifests itself most commonly as a conversion disorder.<sup>1,4</sup> According to previous literature data, it is believed that some neurological and general medical abnormalities finally develop in 25-50% of the patients with conversion disorder diagnosis.<sup>1,3,4</sup> Useful clues suggesting psychogenic gait problems are acute onset, selective disability, relation to minor trauma and improbable longitudinal courses, false weakness, bizarre tremor, astasia-abasia (a lurching gait with repeated near falls).<sup>2</sup> If one or more of these features were present, the diagnosis of PGD could be made on phenomenological grounds alone with over 90% certainty.<sup>1,3</sup>

We present here report of a 54-year-old male who suffered from postural instability, unusual gait disturbance with excessive slowness, for about 7 years before.

## CASE REPORT

A 54-year-old man presented at our outpatient psychiatry clinic with complaints of postural instability, and bizarre gait, during the last 7 years. When he walked, his body swayed from side to side but with a narrow base, sudden knee buckling without falling and bizarre gait present, which was worse in the crowded places. He became increasingly slowed in his movement and began to have problems initiating movements gait. He was dragging his feet while walking. Although, the symptoms never occurred during sleep. Previously, he had tried multiple medications without relief of his involuntary movements and other symptoms, for unknown periods. He had been off of medication, for about 2 years.

He reported that, having experienced persisting stressful life event due to the marital conflict, but he had not accepted any medical assistance. In the context of these psychosocial stressors and after divorce his wife, he complained of increasing bizarre gait pattern with the postural instability. Also, before onset of his symptoms, he had never seen a psychiatrist and never been diagnosed

with a psychiatric disorder, including the substance abuse. He was only a social smoker. There was no family history in terms of the psychiatric illness and any neurological disorders.

Psychiatric evaluation was done our department by the experienced psychiatrists. The psychiatric examination revealed, he looked older than his stated age, was shabbily dressed with a partially overgrown beard. His conversational speech was fluid and non-phasic, and also his attention and concentration were normal. The patient had symptoms of anxiety, la belle indifference (lack of emotional concern about the disorder) and overflow of emotion during the exam (such as, painful expression, etc). After then, the patient had been administered an (Minnesota Multiphasic Personality Inventory) MMPI-2 to classified personality traits.<sup>6</sup> The results of the neuropsychological tests were considered to be invalid because of his excessive endorsement of symptoms. He was a cooperative man but had immature and dependent features.<sup>6</sup>

He was consulted by a trained neurologist (A.B). His neurologist ordered an magnetic resonance imaging (MRI) of the brain and electromyography (EMG), which were normal. Also, neurologic function in the lower extremity was intact on careful examination as well as the routine laboratory investigations and vital signs were completely normal.

Based on these clinical observations, we determined the diagnosis of PGD with CD.<sup>5</sup> The neurologist emphasized that at that time there was no evidence of nervous system disease, concurred with a diagnosis of conversion disorder. After then obtaining informed consent, we initiated treatment with paroxetine 10 mg/day and the dosage increased by 20 mg/day, within ten days. Subsequently, he was given clonazepam for anxiety, which resulted in partial elimination of the postural instability and involuntary movements. In addition, we used the supportive therapy coupled with cognitive behavioral therapy (CBT) (e.g., psychoeducation, cognitive restructuring) for the stress management, activity regulation, emotional awareness, cognitive restructuring, and interpersonal com-

munication. The patient was scheduled for a follow-up appointment by the psychiatry outpatient clinic. He was seen in follow-up every 2 weeks, in all 10-session CBT. On follow up, he had reduced anxiety as well as the increased the insight and emotional awareness. At 14 months, the patient continued the same medical treatment and he was satisfied with the results. At the end of 17 months, his symptoms completely improved.

## DISCUSSION

Most movement disorders begin insidiously.<sup>3</sup> The diagnosis of psychogenic gait disorders (PGDs) are often incorrect and must be made with great caution, in clinical practice.<sup>1,2</sup> The slow gait, knee buckling and astasia-abasia were most common with PGDs.<sup>3,4</sup> It may be fluctuations during a physical exam-particularly an increase of movement following attention, and a decrease when the person is distracted.<sup>3</sup> Physical symptoms can mimic the full spectrum of abnormal involuntary movements.<sup>1,4</sup> Therefore, a careful history and physical examination can often reveal the psychological etiology of such symptoms.<sup>3,7</sup>

As in our case, PGD is characterized by high multiple psychiatric comorbidity.<sup>1,2</sup> In some cases, the people seems to be ignoring an obvious abnormality which defined to “la belle indifference”.<sup>2</sup> While some patients may clearly demonstrate secondary gain, determining the motivation for secondary gain can be quite difficult, if even possible.<sup>2,3</sup> Organic movement disorders must be excluded after a detailed neurological history, examination, and appropriate diagnostic studies.<sup>3,4</sup>

PMDs were previously defined in Diagnostic and Statistical Manual of Mental Disorders (DSM)-

Fourth Edition as “conversion disorders of motor subtype”.<sup>1,3</sup> On the other hand, DSM-Fifth Edition classifies it under “functional neurological symptom disorders” diagnoses.<sup>5</sup> It should be noted that, the correct diagnosis of the psychogenic movement disorder is made by the a neurologist with the psychiatrist.<sup>1</sup>

Most previous studies have reported, psychogenic disorders can be very difficult to treat. Although, some authors concluded that antidepressants may be beneficial for PMD.<sup>2,3,8</sup> In our opinion, multi-disciplinary approach to the treatment of psychogenic gait disorder is very beneficial.<sup>3,4</sup> CBT is a major concern to treatment of these patients with functional neurological symptoms in general.<sup>3,7</sup> CBT is addresses cognitive distortions and promotes behavioral changes.<sup>7</sup> According to a study made by Keane (1989) who described 60 patients with conversion gait disorder, dramatic recovery is a major sign directing towards a conversion origin.<sup>4</sup> Similarly, another study reported a single case of a patient with functional generalized dystonia and facial twitching who had complete resolution of symptoms after 12 weeks of CBT.<sup>7</sup>

We emphasize the importance of bizarre-looking gait evaluation might be the key, during psychiatric examination in every patient suspected to have a PMD. Nevertheless, it should be remembered that mental health professionals providing services should be aware of the potential for malingering during medical evaluations. At the end, current pharmacological and non-pharmacological approaches to treatment focus on therapy of underlying comorbid psychiatric issues. The role of psychiatrist is to identify the underlying psychiatric disorder and help treat it.

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