Psychogenic Movement Disorders

**Definition**
Abnormal movements occurring from psychiatric cause

**Epidemiology**
As many 4% of patients seen in a movement disorders center
Women > men
Risk factors include trauma, surgery, stressful events

**Pathophysiology**
Unknown
May be similar to conversion disorder – neurological symptoms inconsistent with disease
Often comorbid with psychiatric disease
Distinct for somatization and malingering

**Clinical Features**
Abrupt onset, often around a triggering event
Rapid progression and can wax and wane
Requires careful clinical exam for consistency with neurological disease
Bizarre, incongruent movement that is inconsistent over time
Can modulate movements with nonphysiological intervention (tuning fork)
EMG can be helpful, and DAT scan can r/o PD
Disability out of proportion to exam

**Psychogenic tremor**
Most common – complex resting / action tremor that often presents with maximal severity, often spares fingers but involves wrist
Completely distractable
Restraining tremor may precipitate increase force or tremor in other regions

**Psychogenic dystonia**
Doesn’t respect known muscle groups, fixed posture or incongruous dystonic movements with excessive slowness, marked resistance to pavement, incongruous dystonic postures.

**Psychogenic gait**
Walking does not conform to known gait patterns with maintenance of postural control

**Psychogenic myoclonus**
Inconsistent jerks or spasms

**Startle syndromes**

**Management**
No specific treatment
Diagnosis needs to be explained, but sensitively, and needs to be stressed that patient is not making this up, and it is not ‘in their head’,
Needs a neurologist and a psychiatrist for co-management
May be role for CBT, antidepressants,