Phobic postural vertigo: a first follow-up

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Abstract Seventy-eight patients with phobic postural vertigo (PPV) and 17 patients with psychogenic disorder of stance and gait (PSG) were asked to evaluate their condition 6 months to 5.5 years after their original referral and short-term psychotherapy. Two results seem most important: (1) PPV had a favourable course with a 72% improvement rate (22% of patients becoming symptom free), whereas the majority of patients with PSG (52%) remained unchanged; (2) the majority of patients with PPV experienced complete remission or considerable improvement even if their condition had lasted between 1 and 20 years prior to diagnosis. Complete remission of PSG was observed only if the disorder had been present less than 4 months; there was no improvement if it had lasted longer than 2 years. PPV can be defined as a distinct clinical entity with a relatively benign course. It can be reliably diagnosed on the basis of typical features.

Key words Phobic postural vertigo · Psychogenic disorders · Postural balance · Panic disorder · Conversion

Introduction
Phobic postural vertigo (PPV) [5, 6] has been described as a syndrome that is distinguishable from agoraphobia, acrophobia, and the pseudo-agoraphobic syndrome “space phobia” [20]. Closely related to locomotion, it is characterised by a combination of non-rotational vertigo with subjective postural and gait instability, mainly in patients with an obsessive-compulsive personality.

The monosymptomatic disturbance of balance manifests with superimposed attacks that occur with and without recognisable provoking factors in the same patient and are experienced with and without accompanying excess anxiety, misleading both patient and physician to a false diagnosis of organic disease.

PPV has become the second most common cause of vertigo in our dizziness unit since we began diagnosing it as a clinical entity. Of 768 consecutive neurological inpatients and outpatients presenting with vertigo between 1990 and 1992, 158 (21%) were found to suffer from benign paroxysmal positioning vertigo and 129 (17%) from PPV, whereas less than 10% were diagnosed as having other well-known disorders such as Menière’s syndrome and vestibular neuritis. Although our experience has shown that a positive diagnosis of the condition (as opposed to diagnosis by exclusion) can be established mainly by appropriate interview techniques and clinical neurological tests, some neurologists may doubt the reliability of this psychiatric labelling. However, as holds true for all psychogenic disorders in neurology, diagnosis is not made or refuted by a psychiatrist. The patient rarely consults a psychiatrist but instead seeks the advice of a specialist in the field associated with the relevant physical symptom.
In the present study 78 patients diagnosed as PPV were followed up 6 months to 5.5 years after their original referral. The aims of this first follow-up investigation were to check our original diagnosis and to determine the course of PPV. The course and particularly the prognosis of the disorder were compared with that of a psychogenic disorder of stance and gait (PSG) without vertigo in a smaller sample of 17 patients.

**Patients and methods**

Self-evaluation by the patient was obtained by means of a questionnaire inquiring about the past and current status of the condition, including the degree of improvement with regard to work and social activities, history of medical evaluation and diagnosis and treatment within the follow-up period. Patients allocated their condition of PPV to one of three categories: 1 = symptom free; 2 = considerably improved; 3 = no change or worsened.

Of 131 patients, a total of 95-78 with PPV (41 women, mean age 46 years; 37 men, mean age 43 years) and 17 with PSG (12 women, mean age 52 years; 5 men, mean age 48 years) – could be contacted and were willing to complete the questionnaire for inclusion in the study. All had been diagnosed and treated with a similar approach by the authors themselves between 1987 and 1992.

**Phobic postural vertigo**

The diagnosis of PPV was based mainly on the following six characteristic features:

1. Dizziness and subjective disturbance of balance in the upright posture and during gait, despite normal clinical balance tests.
2. Postural vertigo described as fluctuating unsteadiness, often taking the form of attacks or sometimes the perception of illusory body perturbations for mere fractions of seconds.
3. Anxiety and distressing vegetative symptoms accompanying and subsequent to the vertigo elicited by direct questioning, although most patients experience vertigo attacks both with and without excess anxiety.
4. Vertigo attacks that can occur spontaneously but upon specific questioning are found to be almost invariably associated with particular constellations of perceptional stimuli (bridges, staircases, empty rooms, streets, driving a car) or social situations (department store, restaurant, concert, meeting, reception) from which the patients have difficulty in withdrawing and which they recognize as provoking factors. There is a tendency for rapid conditioning, generalisation and avoidance behaviour to develop.
5. Typically, an obsessive-compulsive type personality in patients often found to have affective lability and mild (reactive) depression.
6. Frequently, onset of the condition following periods of particular stress or after the patient has experienced an illness, usually a vestibular disorder.

Normal findings on neuro-ophthalmological and neuro-otological evaluation (with the exception of a centrally compensated unilateral vestibular hypofunction) were a precondition for the inclusion of patients in this study.

Our therapeutic regimen consists mainly of releasing the patients of their fear of an occult organic disease by providing them with a detailed explanation of the mechanism that causes and the factors that provoke PPV attacks. This is usually achieved in two to three sessions. We do not subject the patients to long-term psychotherapy. We attempt to guide the patient by suggestion, assuring him or her during the discussion that the nature of the disease is known and that self-controlled therapy is possible. We advise the patient against dwelling on the illness too much (decoupling of catastrophic thoughts), provided the obsessional symptoms are not too severe. We recommend a self-controlled “desensitisation” – within the context of behavioural therapy – by repeated exposure to situations that evoke the patient’s vertigo. We advocate regular but not overly strenuous physical activity in order to improve the patient’s sense of diminished fitness.

**Psychogenic disorder of stance and gait**

Six features proved most valuable for diagnosis of PSG, since they occurred alone or in combination in more than 97% of patients [16]:

1. Momentary fluctuations of stance and gait, often in response to suggestion.
2. Excessive slowness or hesitation of locomotion incompatible with neurological disease.
3. “Psychogenic” Romberg test with a build-up of sway amplitudes after silent latency or with improvement by distraction.
4. Uneconomic postures with wastage of muscular energy.
5. The “walking on ice” gait pattern, which is characterised by small cautious steps with fixed ankle joints.
6. Sudden buckling of the knees, usually without falls.

Normal findings on neurological evaluation were a precondition for the diagnosis of PSG. Psychiatric findings were heterogeneous in patients presenting with PSG and included conversion disorder and depression.

Our therapeutic regimen was symptom-oriented and aimed at an improvement of stance and gait by use of suggesting positive reinforcement supported by placebo infusions and physical therapy. Most patients did not demand further psychotherapy once they had regained postural stability. There was a negative correlation of short-term improvement with symptom duration, and four of the patients with PSG left the hospital without improvement.

![Fig. 1](image-url) Course of phobic postural vertigo (PPV) and psychogenic disorders of stance and gait (PSG) at follow-up 5 months to 5 years (mean 2.5 years) after diagnosis. Of 78 patients with PPV, 72% were considerably improved or symptom-free (black). Of 17 patients with PSG, 47% were considerably improved or symptom-free (black).