

Phobic Orthostatic Insecurity

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Background and objectives: The authors attempt to expand knowledge about a subjective balance disorder they have called Phobic Orthostatic Insecurity, a condition representing the second cause of medical visits (22.3%) to their ENT & Neuro-otology clinic, and attempt to identify relationships with similar conditions described in psychiatry (agoraphobia, somatoform vertigo, and space-phobia) and in neurology (phobic postural vertigo). They also propose a simple diagnostic method and present their therapies and results.

Patients and method: A total of 151 patients with an indefinite symptomatology of "dizziness," "vertigo," or "insecurity" were evaluated (from 1999 to 2005) by means of a full medical history and an appropriate neurological examination, pharmacological treatments with anxiolytics-antidepressives, a measurement of the degree of depression with the Beck test (a kind of psychiatric benchmark), and with a specific standardized test.

Results: Three symptoms and 1 exploratory condition, among others, were found in all 151 patients studied; these constitute the 4 bases for a positive diagnosis. This is confirmed if the treatment achieves total remission (this occurred in 69.53% of all patients) or a sub-total remission (24.49%), according to valuation scale for insecurity in all situations.

Conclusions: The statistical analysis showed a symptomatic concordance within the group analyzed, a syndromic equivalence between patients and satisfactory results with the antidepressive treatments (94%), thus confirming the diagnostic and aetiopathogenic hypotheses for the disorder and, later, providing a logical method for diagnosis. The authors propose to assimilate this diagnostic protocol (and therapeutic when no specialist psychotherapy teams are available) to most of the psychogenic insecurity syndromes described.

Key words: Vertigo. Dizziness. Phobic orthostatic insecurity. Agoraphobia. Somatoform vertigo. Space-phobia. Phobic postural vertigo. Anxiety. Depression.

Inseguridad fóbica ortostática

Introducción y objetivos: Los autores describen y tratan de extender el conocimiento de una frecuente afección a la que denominan inseguridad fóbica ortostática que, en su unidad de otorrinolaringología-neurootología, resulta ser la segunda causa (22,3%) de consultas por vértigos reales o aparentes, así como de establecer analogías y diferencias de dicho trastorno con otras afecciones similares descritas en psiquiatría (agorafobia, vértigo somatomorfo y vértigo espacial) y en neurología (vértigo postural fóbico). Proponen para su diagnóstico un sencillo método, y exponen su tratamiento y resultados.

Pacientes y método: Se analiza a 151 pacientes con síntomas indefinidos de "mareo", "vértigo" o "inseguridad", seleccionados entre 1999 y 2005, a los que, además de una anamnesis y una exploración neurootológica adecuadas, realizaron un interrogatorio estandarizado específico, un test de Beck (de referencia psiquiátrica) y un tratamiento farmacológico ansiolítico-antidepresivo.

Resultados: Encontraron, entre otros, 3 síntomas y una condición exploratoria que se cumplen en todos los enfermos y constituyen los 4 pilares del diagnóstico positivo. Éste se convierte en seguro cuando el tratamiento consigue una remisión total (en el 69,53% de todos los pacientes) o subtotal (en el 24,49%), según su escala de valoración de la inseguridad para todas las situaciones.

Conclusiones: El estudio estadístico permite extraer una concordancia sintomática dentro del grupo analizado, una equivalencia sindrómica entre los enfermos y unos resultados satisfactorios del tratamiento antidepresivo (en el 94%), lo que permite verificar las hipótesis etiopatogénica y diagnóstica sospechadas ante el trastorno y obtener, consecuentemente, un método lógico de diagnóstico y tratamiento. Los autores proponen asimilar a este protocolo diagnóstico, incluso terapéutico—cuando no se disponga de equipos psicoterapéuticos especializados—, la mayor parte de los síndromes psicógenos de inseguridad descritos.

Palabras clave: Vértigo. Mareo. Inseguridad fóbica ortostática. Agorafobia. Vértigo somatomorfo. Vértigo espacial. Vértigo postural fóbico. Mareo oscilante fóbico. Ansiedad. Depresión.

The authors have not indicated any conflict of interest.

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Received December 29, 2006.

Accepted for publication August 30, 2007.

INTRODUCTION

Patients frequently tell us: "I'm walking around as if I were drunk" or "I am always nauseous." Many complain indefinitely of "nausea," "dizziness," or "instability," and upon questioning they describe it as a sensation of losing their minds or not maintaining balance, without a real rotating sensation or actually falling. Leaving aside true vertigo, or a rotating sensation of vestibular origin, organic neurological disequilibrium (objective), true nausea or "sea sickness" from boat travel, currently extended to the sufferer by other forms of transport (motion sickness), other categories generically understood as "undefined nausea" that create difficulties in making a diagnosis and adequate treatment frequently correspond to a condition that for years has been called psychogenic and is currently known, with a term we consider more precise, as phobic orthostatic insecurity (POI). But such disorders could also be ascribed to other known conditions, such as agoraphobia, somatoform vertigo, spatial phobia, or phobic postural vertigo, which obliges us to review these concepts.

Agoraphobia. Etymologically originating from the Greek words *agora* (public square) and *phobos* (fear), Westphal applied it in 1871 to the state of anxiety, insecurity, fear of falling or of some event that some sufferers feel when traversing a free and open space,¹ and it is thus recognized by Bartual,² Marks et al,³ and other authors. According to Marks et al, in its original genuine concept, agoraphobia could be related to a loss or distancing of the visual reference of verticality represented by walls, columns, and other related structures that from the "agora" may remain distant, obliging the agoraphobic not to pass through these plazas by the centre but along the archways. However, some agoraphobics also manifest claustrophobia and many have phobia of crowds. This, in comparison with the previous concept, seems counterintuitive, which led Marks et al³ to segregate a variety they called space phobia. Despite the contradiction deriving from its etymology, current psychiatry (DSM IV⁴ and CIE-10⁵) extends the definition of agoraphobia to include crowds, as well as a real constellation of spaces that are not empty or open, such as public places, closed spaces like theatres and restaurants and public transport like buses or planes, that cause anxiety in the sufferer and an urgent desire to escape. Perhaps this can be justified by arguing another different meaning for *agora* (from *agieren*, to join, gather) that applied to the plaza during celebrations or assemblies (*forum* in Latin), including the market, or for us the supermarket. In these situations, sufferers find themselves off-balance and are afraid of suffering a major incident, such as a fall or a faint, remaining unprotected and "wanting to escape immediately" (2 new concepts, fear and flight), which obliges them to avoid finding themselves in such situations that, moreover, tend to be generalized (conduct of avoidance and generalization). Moreover, a sensitization to certain symptoms or bodily reactions may occur if they resemble or evoke symptoms of a panic attack (tachycardia, palpitations, or dyspnea, whatever the origin) and these may act as triggers for similar attacks.

Cognitive behavioural treatment with progressive exposure is proposed. But given its psychological pathogenesis, many authors prefer the appropriate use of medication,⁶ specifically anxiolytics and anti-depressants.

Somatoform vertigo. In a review by Brandt et al,⁷ this condition is described as a very complicated and persistent set of symptoms constituted by "vague or variable dizziness" (sensations of elevation, inclination, and emptiness in the head, insecurity when walking), at times also a rotating vertigo crisis with palpitations, nausea, and sweating, as well as symptoms derived from the causal psychiatric illness (belonging to the group of dissociative disorders classified in CIE-10 F-44, somatoform F-45, or depressive F-31 to 34) and its psychosomatic repercussions: difficulty in concentration, indecision, loss of productivity, weight loss, dream and fear disorders, as well as true panic attacks. Neurological alterations are not present upon examination. The treatment proposed is similar to that for agoraphobia.

Phobic postural vertigo. The true, primitive term, incorporated in 1986 by Brandt et al⁸ is *Phobischer-Attaken Schwankschwindel* later simplified to *Phobischer Schwankschwindel* (PSS),⁷ which could be translated as an attack of oscillating "dizziness" of phobic origin in which, in addition to short bouts of oscillation or swaying, non-rotational, as specified by the authors of the original definition, the sufferer feels instability (floating insecurity). All this occurs when the sufferer is standing or walking and most frequently when facing specific situations similar to those cited in agoraphobia. The fact that symptoms may appear spontaneously and the subclinical manifestation of fear by the patient ("which must be discovered by specific probing"⁸), as well as presentation at later ages and having identified vertigo or conflictive situations as triggers, all constitute arguments for its differentiation from agoraphobia. The treatment that the cited authors and Holmberg et al⁹ recommend is based on techniques of educational information and behavioural cognitive focus, with self-controlled exposure, that appears perfectly described by Amorim-Gaudêncio et al,¹⁰ as well as in the use of anxiolytics and antidepressants in the case of insufficient response to specialized psychotherapy.

Spatial phobia. Marks³ described pseudoagoraphobia or SP in 1982, due to the patients not suffering in crowds, but when standing or walking in empty spaces (one patient commented: "my fear is of the space that surrounds me"; on the other hand, they could dance if the place was packed with people, as they had nearby support structures). The patients involved are older than the agoraphobics, with an average age of 55, against 25 for the agoraphobics, and Marks presented 4 reasons to separate it from agoraphobia: greater age, spatial specificity, insufficient response to exposure psychotherapy, and that 10 of the 13 patients had an organic cerebral, cardiovascular, or cervical condition. Brandt et al,⁸ comparing it with PSS, state that SP, "more than oscillating vertigo (nausea) attacks," entails a "permanent postural insecurity upon walking" and

standing, due to a "lack of visual-spatial support," but they consider it very similar to PSS.

Orthostatic phobic insecurity. With this term we refer to a set of symptoms that we can define as an insecurity (in its 2-fold physical and psychological sense) that arises when standing or walking and courses chronically for over a month without interruption, lacks organic signs of vertigo or imbalance and is pathogenetically related to an anxiety-depressive disorder. The situation that most generally favours the disorder is being outside the house, especially far from it and without company, while there are many other phobic situations shared with those described in any of the previous sets of symptoms. With respect to the treatment of POI, on the basis of its anxiety-depressive origin and the clinical, and pathogenic relationship with agoraphobia, we have followed the opinion of Bousoño,⁶ using a pharmacological treatment that we always associate with non-specialized psychotherapy. The medications used have been anti-depressants (selective serotonin reuptake inhibitors such as sertraline, paroxetine, or fluoxetine), sometimes combined with noradrenergic inhibitors, all this for a minimum period, when possible, of 6 months counted from the remission of symptoms. A few times, and only in the first 3-9 weeks, we have added benzodiazepinic anxiolytics. To obtain positive results in depression, we believe it necessary to inform the patient with optimism that their nausea is really a somatization of depressive origin that can almost always be cured, but the patient needs to persevere and trust in the prescribed treatment.¹¹

PATIENTS AND METHOD

We have studied 201 patients coming from our otorhinolaryngology service (neurotology unit) between the years 1997 and 2006, that suffered, according to the cases: *a)* chronic insecurity, without any history of vertigo or objective imbalance, *b)* chronic insecurity, with current or preceding vestibular alterations, and *c)* chronic insecurity, whether or not associated to vestibular vertigo, preceded by anxiety or panic attacks.

Fifty-one patients with a positive diagnosis of POI were excluded from the study: *a)* mild cases not requiring treatment, only information for the patient and his or her doctor, *b)* referrals with information to the psychiatrist who previously treated them due to being severely depressed or at risk of suicide, or having other sets of concomitant psychiatric symptoms, *c)* voluntary withdrawal by the patient, and *d)* because POI appeared in the context of other serious organic and multimedicated disorders by internists or other specialists and the patient was subject to frequent therapeutic changes that could incur incompatibilities, for which they were referred to the internal medicine department with a diagnosis of POI and suggested treatment.

These patients have been statistically analyzed in terms of the comparative frequency of POI with the other conditions of vertigo and imbalance noted in our unit, but not in terms of treatment results, as these remained outwith our control.

The protocol used with the patients studied was as follows:

1. Complete and detailed anamnesis, considered the most important part of the diagnostic process, with special attention on complaints of "insecurity," "nausea," "instability," or "ill-defined vertigo," that were minutely analyzed in terms of their personal significance for the patient; this showed that the patient nearly always selected the term insecurity among those offered to express the personal sensation of their complaint. All the morphological, temporal, and circumstantial characteristics of the disorder were analyzed, especially in relation to bipedestation and deambulation, whether they were at home or out of doors, and, secondly, the exposure to various phobic situations. The patient was asked whether the insecurity was daily with no days of complete normality, if it was fluctuating and if it was subjective (not perceived as disequilibrium by any witnesses present).
2. Specific standardized questioning that we have laid out for POI can be seen with all the items in the results table (Table).
3. Otorhinolaryngeal, neurotological, and audiological physical examination: we followed the system of Bartual et al,² as shown in Chapter 9 and developed further in Chapters 8-16. Our protocol, in summarized form, is as follows:

- Habitual otorhinolaryngeal study
- Neurotological physical examination: spontaneous nystagmus, with and without Frenzel goggles; vestibulospinal segmental deviation tests: extended arms and dynamic Barany test with vertical movements, general Romberg deviation test, Unterberger test walking with the eyes closed and basic neurological study of the cranial pairs, general movement, and cerebellar tests
- Upon suspicion of spontaneous or positional vestibular alteration, we studied: provocation of nystagmus through cephalic agitation, pneumatic test, Halmagyi test, examination of positional nystagmus through the Dix-Hallpike test, just like others, when this was negative and there was suspicion of positional or postural vertigo. For the study and for the video-oculo-nystamographic register we followed the technique of Freyss et al,¹² Guillemant et al,¹³ and others, search saccade according to Freyss, ocular search, nystagmus with and without fixation, optokinetic nystagmus, and nystagmus induced by a caloric test. The rotating induction tests (progressively muffled pendulum test, and express sinus protocol) were only performed exceptionally in the POI study, especially if a calorigram with water could not be done
- Basic systematic audiological examination through tone threshold audiometry and tympanometry with stapedial reflex. Only in the case of alterations or vestibular conditions did we use speech audiometry and supraliminal recruitment and fatigue tests, and

Table. Diagnosis of Phobic Orthostatic Insecurity (POI)

	Score
Standardized questionnaire	
Insecurity* regularly when standing or walking (100%)	5
Chronic course,* at least 1 month (100%)	5
Absence of continuity,* almost always with fluctuations but rarely with gradual worsening (100%)	4
Scant or no insecurity when seated or lying down	1
Subjective symptoms of pseudovertigo: if the patient does not express them spontaneously, questioner should probe for at least the following: sense of being in the air, of floating, of drunkenness, empty-headed with confusion, of being "absent" (69%)	R
Inexplicable symptoms, in cases of true vertigo or objective insecurity and contradictory symptoms	R
6-1-Worse in the street than at home (89%)	R
6-2-Worse when standing still than when walking, in the street (86%)	R
6-3-Afraid to go out unaccompanied, even near home (62%)	R
6-4-Intolerance when standing, in queues, public places, at church (89%)	R
6-5-Habitual intolerance to remaining in places with excessive auditory and visual sensorial stimuli (supermarkets, fairground, etc) (82%)	R
Physical examination	
Absence of objective signs of true vertigo or objective imbalance (100%)	10
With elaborate signs of neurotic expression, such as for example: Trembling – continuous blinking in nystagmoscopy and when closing eyes	2
Alternating up-down or right-left oscillations in the outstretched arms test. Exaggerated deviations in the indices, without latencies, with or without accompanying lateral flexions of the head and body	
Deviations in the Romberg test starting even before closing eyes, "as soon as the patient enters trance." Striking Romberg test or with exaggerated gestures of being about to fall, but never actually falling	
Fast, striking and changing deviations in gait, unexpected and decisive after a few normal steps, to either side or backwards and forwards, that the patient corrects when alerted	2

The symptoms and signs investigated are shown on the left. The percentage values accompanying them correspond to the percentage of patients in which each one was positive. On the row for each item, the figure on the right is the score given to its positivity for the calculation of the diagnosis of phobic orthostatic insecurity. Some cells include an R (reinforcement) that re-affirms the diagnosis.

Positive diagnosis: if the sum is ≥ 23 , even without "R" symptoms. With 20-23 points, if there is any "R," it will be necessary to repeat the questionnaire evaluation.

Certain diagnosis: if, in addition to the above, the effects of the treatment were highly favourable and persist for at least 6 months.

the Tullio test. In cases of unilateral hypoacusia, masking by Hood and/or Rainville techniques (to test bone conduction), and, afterwards, conventional tests on the new levels for air conduction

– In the case of findings of ataxia of any origin or suspicion of neurological organicity, in principle we excluded the patient from the POI study, repeated the preceding tests and completed a neurological examination with a study of deep and superficial sensitivity, tone and motility, tendinous periosteal and exteroceptive reflexes, or we requested the assistance of a neurologist or ophthalmologist

With these examinations of the patient affected by daily insecurity, we tried to note organic signs of vertigo or disequilibrium. But the fact that patients have had prolonged vertigo previously or are affected by recurrent vertigo (spontaneous or positional), prior or subsequent to the time of the examination, does not contraindicate the diagnosis of POI, as long as they have been correctly identified and have not manifested activity during the diagnostic phase (minimum, 1 month). Less frequently, the absence of organic signs during the examination may be replaced by theatrical, grotesque, or incoherent responses to examination (Table), that raify a neurotic-hysteric response.

4. Imaging tests: magnetic resonances of the brain and ear were only carried out in cases of unilateral or asymmetric sensorineural hypoacusia, and in those with current vestibular alteration, except for BPPV (understood with peripheral and benign characteristics, following the diagnostic criteria of Pérez Fernández et al,¹⁴ summarized in the "Diagnosis" sub-section).
5. Beck Test: this involves a simple self-applied questionnaire for the evaluation of depression,¹⁵ whose reliability is accredited by vast experience,¹⁶ comprising 21 questions. We should clarify that this is not necessary for the positive diagnosis of POI, and in Table we have not given it a general score. According to the sponsor organization providing the test,¹⁷ specific scores >9 are considered positive for depression: 5-9, normal; 10-18, mild to moderate depression; 19-29, moderate to severe depression; 30-63, severe depression; and 0-4, possible denial of depression or defective response. The original test can be obtained through the web page¹⁷ or by contacting the first signatory of this paper personally.
6. Course of the symptoms: we consider that a positive diagnosis of POI requires at least 1 month of evolution to avoid normal mental reactions to known or unknown unfavourable events being treated as depression, as these tend to disappear spontaneously in a few weeks or days.
7. Treatment and evaluation of response: after the performance of the first stage of treatment according to the guidelines commented on previously, we have assessed the degree of improvement at 2 months from the beginning (bearing in mind that positive results

take from 4 to 6 weeks to appear) and again at all of the follow-up visits by the patient. We have used a scale of improvement or disappearance of symptoms from 0 to 100 points, equivalent to the percentage of days with absolute absence of insecurity or dizziness, in any circumstance, and calculated in the last month ("in this last month, every 10 days, how often have you felt absolutely well?"): 0 points for no good days; 100 points for a complete absence of symptoms in the three 10-day periods in the last month.

RESULTS

Among the 151 patients selected, there is a clear predominance of women (70.2%) over men (29.8%), and the age range is 16 to 75 years (mean 52).

The distribution into the 3 groups mentioned in "Patients and Method" turned out to be: 40.39% in group 1 (without a history of vertigo or panic attacks), 52.98% in group 2 (occasional vestibular vertigo or a history of it); 6.6% in group 3 (insecurity with or without organic vertigo appeared preceded by anxiety or panic attacks).

From the biographical questioning, we have been able to observe that the patient defines their "dizziness" as a sensation of insecurity while walking and as if it required a significant effort to continue walking straight. As much as they can, they refuse to leave home unaccompanied, and when they do they seek the proximity of walls and limit their errands to nearby establishments.

Table shows the protocolized symptoms and signs in their corresponding rows alongside the percentage of patients in which they were positive and a score granted for diagnostic purposes. The items followed by an asterisk, found in 100% of the patients, allow the establishment of statistical bases for the definition of a suite of symptoms though there could be reasoned exceptions that have not been presented. The symptoms marked "R" (reinforcement) are highly indicative of POI, but do not carry scores.

It is of interest to emphasize 2 nuances of diagnostic importance in relation to the symptoms absolutely necessary: *a*) insecurity should occur daily in bipedestation and in deambulation, while away from home and unaccompanied, and subjectively (ie, not perceived as disequilibrium by any witnesses present), and *b*) the positive diagnosis of POI, with its obligatory therapeutic consequences, requires, as has been said, at least one month of evolution.

In the diagnostic evaluation by scorecard, according to our experience, we consider the diagnosis to be positive if the total score is >23 points, even with no R sign; with scores of ≥20 and if there is an R sign, it will be necessary to revise the questionnaire more thoroughly; the diagnosis was deemed confirmed if, in addition to the foregoing, the effects of treatment were very favourable and persisted for at least 6 months.

The Beck test was performed on 93 patients, and was expressive of depression in 80 (73 positive, plus 7 false negative; 86%). The mean score of those tested was 13.8. This test is not included in Table because we do not consider

it necessary for the otorhinolaryngological diagnosis of POI, even though it may be useful for a physician beginning work in this field.

The response to treatment performed on the 151 patients (Figure) was: 105 (69.53%) obtained 100 points: total disappearance of symptoms; 29 (19.2%) obtained 89-99; 8 (5.29%) obtained 79-89; 5 (3.31%) obtained 69-79; 3 (1.98%) obtained 59-69; 0 (0%) obtained 1-59; and 1 (0.66%) obtained 0 points. As we can see, there was a cure or a satisfactory improvement of 80 or more points in 94.02% of the patients.

Relapses were observed in 31 patients (20.5%); 8 were severe (scores fell by more than 20 points) and the other 23 were moderate (10-20 points) or mild (up to 10 points), stationary or secondary to therapeutic reductions, or unknown causes. All reverted when medication was adjusted and the final results were as shown in the Table.

DISCUSSION

Positive Diagnosis of POI

This is inferred from the statistical study of the symptoms and signs collected from our patients (Table), whose results

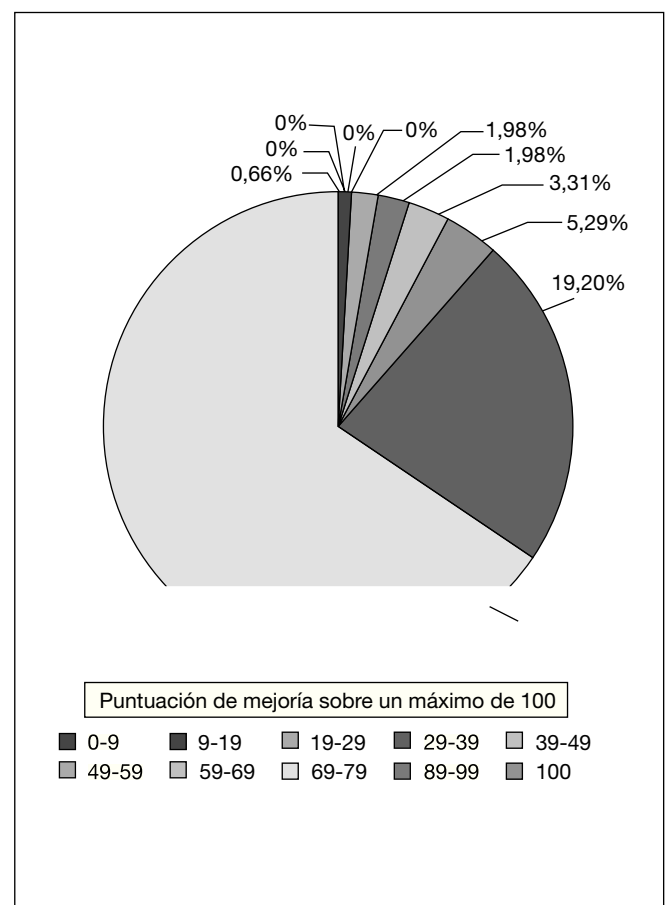


Figure. The response to treatment of the 151 patients distributed in percentages (segments) according to the degree of improvement (grey) expressed as scores from 0 to 100.

are in accordance with the condition's definition, as well as the positive result obtained with a treatment consistent with the suspected aetiopathogeny. Such an aetiopathogenic suspicion was inferred: *a)* from the success obtained with the anti-depressive treatment of the first patients arriving with the same clinical symptoms; *b)* from the onset of the condition due to vestibular vertigo, stubborn tinnitus, failure in functional otic interventions, and situations of psycho-social anguish; and *c)* from the Beck test used to consider our diagnostic progress from a psychiatric angle.

Differences and Similitudes of POI With Other Sets of Symptoms Cited

The condition we have analyzed in this study has, at first glance, many points in common with agoraphobia, SV, PPV/PSS, and SP. However, there are also differences between POI and each of the four conditions commented on, which we will now analyze with the purpose of establishing their reciprocal relationships.

Agoraphobia

Agoraphobia is almost never observed before 18 years of age or after 35,¹⁸ with an average age of 25,¹⁹ while among our 151 POI patients the average age was 52 years.

It includes a very frequent history of panic attacks, to the point where a distinction exists between agoraphobia without panic attacks (CIE-10 F40.00) and with them (F40.01). In POI we have only observed these in 10 (6.6%) of patients. On the contrary, in POI triggering by or at least comorbidity with well-classified organic vertigo reached 52.98%, which did not occur with agoraphobia.

In psychiatry the concept of agoraphobia only applies in a strict sense when daily activity is substantially reduced and avoidance behaviour basically constrains their lifestyle.¹⁸ In POI such a psychosocial repercussion has a less rigid range, and there are plenty of compatible cases with normal social and work activity, as occurs in PPV/PSS.⁸

Furthermore, the lack of any spontaneous manifestation of fear and the absence of triggering situations for symptoms to be manifested make POI similar to PPV/PSS⁸ and SP¹⁹ and distinguish it from agoraphobia.

In short, we believe that POI and agoraphobia cannot be considered the same condition, even though they coincide in various symptoms and in a similar aetiopathogenic basis.

Somatoform Vertigo

Authoritative researchers⁷ describe SV as a very complex set of symptoms, as mentioned in the introduction, including panic attacks, general somatic psychiatric repercussions, strong impacts on life, and rotating vertigo crisis (without signs) that do not occur in POI, unless there is vestibular co-morbidity. In no way can we identify SV with POI even though, conceptually, POI may be considered as a somatoform disorder, but not "somatoform vertigo" which, on the other hand, we have not been able to identify as such in CIE-10 and at times is used as a generic denomination for the psychogenic disorders of "dizziness" and disequilibrium.

Phobic Postural Vertigo and Phobischer Schwankschwindel

For Brandt,²⁰ the age of presentation is between 30 and 50 years (mean 41); on the other hand, Ciriaco et al²¹ find an epicenter at 53.7 years (30-84), almost equal to that in our POI (a mean of 52 years).

In addition, the triggers for PPV (frequently a vestibular condition like neuronitis or BPPV and situations of psycho-social overload) are very similar to those of POI, as are its aetiopathogenic basis and the possible spontaneous onset of symptoms without the need for triggering situations, which may, on the other hand, constitute a similar constellation in both disorders.

In terms of the oscillating attacks described in PSS, we have not selected these as symptoms of diagnostic value for POI and they were not included in the protocol, even though they have been spontaneously described by some patients.

Despite this last point, we believe that POI and PPV are not only the same condition, but in fact the same clinical form. We attribute these small differences to an easier finding of vertiginous co-morbidity at our otorhinolaryngological/neurotological unit, greater than that registered in neurological clinicals, and also to a lower incidence or a less insistent search for bouts of swaying. We admit the greater pertinence of the description Brandt et al⁸ have made of the entity in question, which should prevail over ours, and we would like to join them in disseminating this clinical entity, which has regrettably not achieved the significance it deserves. But we cannot accept, we stress, that PSS be called in Spanish phobic postural vertigo when it is a condition, often monosymptomatic, essentially characterized not by vertigo, but by unsteadiness or insecurity in bipedestation and/or deambulation. Thus another name should be found and it does not necessarily have to be the one we use.

Spatial Phobia

In our opinion, if POI can be identified with PPV, it can also, in everyday practice, be considered the same as the SP of Marks,³ which appears at exactly the same average age as our POI; this is one of the aspects considered by the original author to distinguish it from agoraphobia, together with the absence of a fear of crowds. But this characteristic also appears in some patients in our POI group, and differences have not been noted with the others in terms of the aetiopathogeny and final results, which is why they have not been excluded.

Importance of the Prevalence of POI or its Homologues, PPV, and SP

This is based on 2 motivations: its high frequency of presentation and that it is nevertheless insufficiently diagnosed.^{8,22,23}

In our neurotology unit, out of the total number of visits for vertigo and disequilibrium disorders dealt with in 2001, POI was the second cause (22.11%): the first was Meniere's disease and the third, BPPV. For Brandt, PSS/PPV represented the second cause: the first was BPPV, and PPV was second (14.3%), and Meniere's disease and others

represented less than 10%. For Ciriaco et al,²² PPV was the second reason for consultation at a vestibular disturbance unit with the first being BPPV. For Strupp et al,²³ also at a vertigo unit, PPV was the first cause for the group aged 20-50 years (22%-26%) and the second, after BPPV, for all age groups.

With respect to the difficulties that can justify the insufficient diagnosis of POI and its counterparts PPV and SP, with or without organic vestibular co-morbidity, the following should be considered: first, its absence in the diagnostic repertoire of many specialists, which leads to unwarranted complex instrumental and diagnostic studies of peripheral vertigo, cervical vertigo or vertebrobasilar insufficiency,⁷ and consequently, to submitting the patients to ineffective treatments with vestibular sedatives, vasoregulators, calcium antagonists, cell protectors, etc. Secondly, the confusion entailed by questioning this kind of patient, given their hypochondriac nature and their conviction they suffer from an organic condition. In this respect, we call attention to the great frequency with which the psychiatric substrate of the disorder is mild or subclinical, involving unipolar depression and without patent symptoms, known in psychiatry as latent or masked depression. In addition, some patients did not manifest the fundamental depressive axis of deep and vital sadness, like the so-called *depressio sine depressione*.²³ If we add the fact that they also have, or may have, organic vertigo, it is easy to explain the above and that these patients are not referred to a psychiatrist, but to an otorhinolaryngologist or neurologist.^{8,21,22} If they are referred to a psychiatrist, some are rejected or underestimated because they do not correspond by age or seriousness to true agoraphobia or SV.

On the Results of the Treatment

Similar to the findings published in other studies (for Strupp et al,²² there was a satisfactory cure in more than 70%; for Ciriaco et al,²¹ 62% were asymptomatic and 29% oligosymptomatic; for Phollak et al,²⁴ the problem was resolved by psychotherapeutic means in 72% of the patients, while in 24% improvement was only achieved with anti-depressants), our final results (Table and Figure) include complete disappearance of symptoms in 69.3% and satisfactory results (80 to 100 points) in 94%.

CONCLUSIONS

The proportion of “dizzy spells” and undefined equilibrium disorders is very high and its diagnosis continues to be very difficult, as it involves in a large proportion of cases the psychogenic disorders discussed: agoraphobia, SV, PPV/PSS, SP, or POI.

All of them have common clinical traits, among which instability or insecurity in bipedestation or deambulation stand out, greater while away from home and (except for SP and some cases in other groups) in aggravating situations in a variable constellation of contexts.

All of them have an equal or similar aetiopathogenic substrate (anxiety, depression, or anxiety-depressive condition), and their common treatment consists of cognitive-behavioural techniques and exposure to triggering situations, when sufficiently trained psychotherapy is available or, when psychotherapy fails or is not available, antidepressive-anxiolytic pharmacological treatment, (rarely pure anxiolytic treatment), with high proportions of satisfactory results.

We believe that the complex problem of “dizziness” or “vertigo” of phobic origin can be simplified by assimilating the various conditions described into a single set of representative symptoms that allows a simple diagnosis, no less demanding or critical, and an effective treatment. This is what we believed was feasible with the approach we tried to give to POI, when we were less knowledgeable than now of the richness of descriptions that existed in this interesting field and which we have tried to analyze here.

We do not believe the type of treatment described for POI (pharmacological) is the best or the only treatment in all cases, but it is more accessible for clinical setting not specializing in psychosomatics.

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