Acta Scientific MEDICAL SCIENCES (ISSN: 2582-0931)

Volume 8 Issue 7 July 2024

Short Communication

Russian School of Psychosomatic Neurology: Key Aspects

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Received: April 25, 2024

Published: June 05, 2024

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Every year, such a direction of clinical psychology and urology as «psychosomatic»/«psychodynamic» urology is gaining momentum, which examines the interactions between the body and the nervous system, the mental organization of the patient in the functioning of the pelvic organs and pelvic floor. In the cycle of our work since 2019, it has been shown [1-10] that the bladder, rectum, pelvic floor, and genitals are very vulnerable to psychosomatic phenomena, acting as a kind of thermometer of distress and conflict. In addition to physical causes, malfunctions in these organs are often associated with events in consciousness, certain types of reactions to everyday events and social conditions of life. However, these connections are often overlooked or not given sufficient attention by general practitioners. Recall that bladder function control is learned in the first years of life. Physiologically, it is a very complex system that is very susceptible to disorders. Neurophysiologically, urination behavior is a hierarchically structured control circuit with cognitive-conscious motor components and affective-unconscious components. Thus, in the broadest sense, urination is associated with the excretion, emission, stopping of urine with delay and restraining functions. In principle, there is a deliberate relationship between the human psyche and bladder dysfunctions (urinary incontinence, pollakizuria, dysuria, urge symptoms, urination disorders): somatic disease affects the mental state. This explains the fact that different people experience similar situations in different ways and cope with them (coping strategies), someone is somatized, and someone is not. Thus, with the development of bladder dysfunctions or other urogynecological symptoms, it is necessary to take into account the individual psychological situation and the mental status of the patient, to understand the peculiarity of the symptom, why it arose right now, the cycle of occurrence, the characteristics of resilience/stability, conflict, vulnerability.

The bladder is a «storage and retention organ» that needs to be emptied from the very first day of life. Unlike other mammals, humans in the early years of life learn to control urination until a suitable place and time appear, that is, until it becomes socially acceptable. During this period, the child, on the one hand, feels his power over his parents, voluntarily restraining the discharge, and on the other hand, he turns out to be powerless before external coercion of "urination on command", possibly with punishment. Rewarding urination in the right place is a form of drawing attention to bladder and bowel control training, which will again play a role later in life when an incontinent patient needs to restrain urination until he/she gets to the toilet. Thus, human secretions are relevant from infancy to old age. Especially at the stage of formation of cleanliness skills, there is a danger of psychopathological changes and psychosomatic disorders of bladder function. From a

psychophysical point of view, the genitourinary tract is the "organ of desire", the safety (hold-release) of production and reproduction. This leads to a psychology of impact on the pelvic floor, consisting of three main effects: aggressive affect of urination ("wet his pants", also straining in irritation, anger), with restraining affects (delay, waiting until there is a suitable place for urination at hand, also convulsions, for example, as a result of a previous injury) and with depressive affects (decreased muscle tone).

Psychosomatic urology considers certain bodily symptoms from the point of view of the patient's mental and psychological health. On the one hand, physical problems and symptoms from the pelvic and pelvic floor organs can cause mental problems (for example, risks of depression, anxiety spectrum disorders), while, on the other hand, certain mental disorders (for example, social anxiety, situational, personal anxiety) can provoke physically tangible problems or malfunctions in the pelvic organs and pelvic floor. In psychosomatic urology, pelvic symptoms are investigated both objectively and psychodynamically at the same time.

Syndromes related to psychosomatic urology:

- Chronic pelvic pain in men
- Chronic pelvic pain in women
- Painful urethral spasms (urethral syndrome)
- Psychosomatic urination disorders
- Special forms of urinary incontinence in children
- Psychogenic urinary incontinence
- Psychogenic urinary retention
- Symptoms of bladder irritation
- Special forms of recurrent bladder infection
- Interstitial cystitis

These disorders are often referred to as somatized or somatoform disorders, they can act as a mask of PTSD, depression within the framework of somatized or recurrent depression. We also remember that urological symptoms can be the somatic equivalent of an anxiety spectrum disorder, as well as a manifestation of borderline or general personality disorder.

In urogynecological practice, bladder pain syndrome is most often found in women who simultaneously report sexual, interpersonal difficulties and suffer from chronic emotional stress. The mental correlate of this may be a latent sexual disorder, a somatic correlate of an anxiety disorder or a flowing narcissistic wound (fragility). In the study of the psychogenic causes of bladder hyperactivity, it was found that there are causal relationships between urinary incontinence and pointed personality traits, maladaptive coping strategies for coping with stress and unsafe attachment style. It is shown that the individual perception of urinary incontinence in the form of catastrophization has an effect on the sharpening of personal traits. We remember that chronic recurrent cystitis can be an expression of an unconscious "proximity-distance conflict" and dedication. It is assumed that this is due to suspicion, urethral-aggressive impulses and the inability/unwillingness to let them go, which we often observe in the patient's posture, emotional reactions to various life situations, the predominance of such protective mechanisms as denial, suppression, compensation, reactive formations and a tendency to intellectualization. In contrast to the frequently expressed opinion, it was not possible to demonstrate either the relationship between chronic recurrent urinary tract infections and sexual disorders, nor between sexual intercourse and cystitis, nor the dependence of the ability to have sexual experience on a partner. Instead, altered sexual activity (fears, barriers, inability to relax, obsessive purity rituals) and a limited ability to experience emotions (alexithymia) are rather secondary consequences of chronic recurrent cystitis. Partly based on our own long-term urogynecological experience of receiving a patient, it is possible to observe a psychosomatic component or draw a conclusion from medical histories in a relatively large number of women with urgent urinary incontinence.

Since the 1980s, various authors have tried to identify the mental causes of urinary incontinence based on special diagnostic scales. Some of our foreign colleagues could not find any clear psychosomatic differences between women with urge urinary incontinence and women with other forms of incontinence [12,13]. Others found higher values of physical and mental anxiety and distrust among women with urgent urinary incontinence, while other studies revealed higher values of anxiety and depression in patients with urgent urinary incontinence. It was found that women with call sign and mixed call sign stress incontinence were more likely to experience anxiety than women with "pure" stress incontinence, and that this was reflected in insecurity, obsessive rituals and a general fear of disease (the formation of health

anxiety). These patients also tended to develop psychosomatic reactions depending on the severity of their symptoms.

Forms of urinary incontinence are more likely to be of psychogenic origin: “painful bladder”, overactive bladder and “recurrent urinary tract infections”. Symptoms are a great burden for patients, and therapy often creates serious problems for the attending physician.

A psychosomatically oriented approach to urination disorders consists of the following stages [14]:

- Anamnesis of symptoms, including drinking and eating habits (eating disorders, emotional hunger)
- Psychosocial history, including partnerships and sexual disorders, as well as signs of anxiety, depression, somatization and adaptation difficulties, coping strategies, relevant protective mechanisms
- Questions about neurological symptoms of other organ systems
- General gynecological history
- Urogynecological diagnostics. Clinical data on the condition of the pelvic floor (neurological examination, ultrasound examination, assessment of the condition of the vagina, position of descent under pressure, stress test for coughing), ultrasound of the vagina and perineum, hormonal status, cystoscopy and, if necessary, urodynamics are absolutely necessary for accurate diagnosis of bladder dysfunction.

The differential diagnosis should include various mental illnesses, since symptoms such as pollakizuria and bladder emptying disorders may be part of a complex of psychosocial complaints. In everyday life, there are hints of a psychogenic causal component of urinary dysfunction and bladder incontinence, especially when there is an obvious discrepancy between objective and subjective data.

In addition, the simultaneous appearance of functional complaints such as vague pain, intestinal problems, fibromyalgia, etc., and mental symptoms such as anxiety and depression as concomitant symptoms suggests a relationship. In addition, the rejection of intimacy with a partner (interpersonal stress, difficulties in building relationships) is a sign of a psychosomatic component, as well as the mention of specific provoking, supportive situations. Moreover, somato- and psychogenesis often overlap. It is always necessary to take into account the multifactorial pathogenesis of urinary disorders. Before proceeding with a specific treatment procedure, it is necessary to take into account various differential diagnostic considerations:

- Disguised sexual disorder
- Communication disorder (social phobia), insecure attachment style
- Unconscious affect transformed to the body level
- A symptom of a severe mental illness such as post-traumatic stress disorder, anxiety disorder, or psychotic disorder.

It should be remembered that psychosomatic associations arise from the fact that difficult or traumatic events in the past should have remained untreated and, therefore, they are not so easy to cope with now. The symptom does arise from their suppression and is thus a suboptimal, neurotic solution. Whenever these burdensome experiences come out of a depressed state, there is resistance to their conscious awareness [11].

The goal of treatment is to effectively improve symptoms without constant medication, if at all possible with the cure of the underlying disease. It should be noted that the patient will be open to confrontation with her bladder dysfunction when she feels that her personality is viewed as a psychophysical entity.

Referral of a patient with bladder dysfunction to a specialist for psychotherapy should be considered in the presence of constellations that require in-depth clarification, and, of course, always when the patient herself realizes that there may be a psychogenic cause and is motivated to effectively solve her problem. To this end, a urologist, gynecologist can provide important motivational assistance through the aforementioned application of their basic psychosomatic competencies. A psychosomatically oriented approach to the treatment of female urinary incontinence, especially mixed and purely callsign forms, is more effective in most cases, treatment costs are lower from an economic point of view, and patient satisfaction and, most likely, the attending physician is higher.

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