

Case report**Psychogenic Urinary Retention: A case report**

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Abstract

Psychogenic urinary retention is a rare condition, though better described in adults it is rarely seen in children. Very little literature is available about its diagnosis and management. It often poses treatment challenges because of involvement of several psychological and social factors. We report a case of a 15-year old girl presented with five months duration of urinary retention, without improvement on medical management. On inpatient admission, psychosocial stressors were identified and child recovered from the symptoms when a pathway to resolve these stressors was facilitated.

Key words: Psychogenic, Urinary retention, Adolescent.

Introduction

Urine retention is defined as the lack of volitional bladder emptying for more than 12 hours, with a urine volume greater than that expected for age $[(\text{age in years} + 2) \times 30 \text{ ml}]$ or a palpably distended bladder [1]. The causes of urinary retention can be divided into four etiologic groups: obstructive, neurologic, pharmacologic, and psychogenic [2]. Psychogenic urinary retention is a rare condition almost often considered only as a diagnosis of exclusion with scarce literature available on its diagnosis and management guidelines. It can be suspected when organic

etiology is ruled out with diagnostic procedures. Though better described in adults, it has rarely been described in youngsters so far [3]. We hereby report a case of a 15-year old girl who presented with chronic retention of urine as a symptom with strong psychosocial antecedents; and she recovered completely once the personal challenges were identified and a pathway to resolution formulated. Treatment challenges that were faced due to a complex interplay of psychological and social factors in this case are highlighted.

Case history

Ms. J, a 15-year old girl, residing with her parents and sister with no significant past medical history presented to the psychiatry outpatient department after referral from a neurologist for evaluation of the possibility of psychogenic urinary retention. The preliminary inquiry found a 5-month history of urinary retention with no cause emerging after several clinical, imaging and neurological evaluations.

The onset of complaints was sudden with retention of urine five months prior to consultation, lasting for three consecutive days following which she was taken to a local physician and was found to have a distended bladder on physical examination. Subsequently, an ultrasound abdomen revealed only an insignificant non- obstructing left renal calculus. The patient reported an urge to pass urine. There was no history of fever, abdominal colic, nocturnal or diurnal enuresis or constipation and history of any medication intake at the time. After symptomatic medical treatment failed, she was catheterized to provide relief. Subsequently, on follow- up any attempt of removal of catheter resulted in urinary retention, lower abdominal pain and even lead to the child taking recourse to intermittent self-catheterization daily. Repeat ultrasound abdomen revealed no obstruction.

Over the span of the five months under various clinical specialties, the child had been empirically exposed to medical management but with no improvement. Three-weeks-, prior to the psychiatry consultation, she had reported sudden onset of difficulty in recollecting names of family members, school and details of life events that had transpired especially following the onset of her urinary complaints. She also developed complaints of difficulty in walking, reduced power of limbs, multiple joint pains and headache.

There was inconsistent reporting of difficulty in walking and other physical complaints. On examination, no focal neurological deficits were found. On mental state examination (MSE), the child was alert and had depressed affect. During the initial days of admission, the child continued to do intermittent self-catheterization. Other than maintaining a strict input-output chart, no other active intervention was provided. On serial MSEs, the child reported low mood, decreased interest in activities, decreased appetite and decreased sleep. Over time, the child revealed long standing difficulties at home. Her father was a daily wage worker, consumed alcohol daily, and provided minimal financial support and no emotional support to the family. Parents had repeated arguments over many issues. The father would remain absent for extended durations without informing about his whereabouts. Therefore, her mother was the primary caregiver, with the maternal uncle playing key instrumental roles for the family.

Over the next five sessions, the child expressed disappointment at her father's constant lack of participation in the family and the financial stressors that her mother has had to face by herself. She reported being worried from an early age about her mother's stressors and had made multiple futile attempts to improve her father's behavior as well as having tried to convince her sister to start working in order to support her mother, but had been unsuccessful. The child received emotional support and was encouraged to develop an activity schedule. Gradually, her

reactivity to surroundings, participation in the ward activities and engagement with the treatment team improved substantially, over the course of admission. The frequency of self-catheterization reduced and eventually stopped in about ten days of ward stay.

The case was formulated using the family systems model [11, 12]. The treating team got the father involved in the therapy process after intense efforts. Initial sessions were conducted with each family member including the parents, sister and maternal uncle individually to get information about their understanding of the problems in the child. This was done along with joint sessions later to understand the dynamics within the family that was maintaining the symptom. The symptoms were understood using the following formulation. Ms. J presented with problems of difficulty in passing urine for duration of five-months. She may have been predisposed to this problem due to her past experiences with urinary symptoms. Her tendency to worry may have further increased her predisposition to a psychological problem. There was strained marital relationship between her parents. Her father would consume alcohol and not provide support to the family. Ongoing financial stressors further lead to discord between the parents. Her mother was the primary care giver and her maternal uncle began to play instrumental roles in the family. The child's symptom manifested in the background of these factors. Her symptoms may be understood as serving a function to stabilize these complex patterns in the family. These symptoms persisted when her father was not involved in her care. Only after the father began to get involved in the treatment process, symptoms began to improve gradually.

Therapy was begun based on the above formulation. Before starting the sessions, the number of sessions, members attending the session, the setting, common treatment goals and follow-up were discussed. Structured family therapy sessions were held with the parents, sister and the

maternal uncle. The child was unwilling to return to her parents' home. A temporary foster care arrangement with a relative was arrived at. The child was discharged after 3 weeks of hospitalization. She has been on regular out-patient follow-ups for the last two months and there has been no recurrence of symptoms till date. The father was also noted to be abstinent from alcohol use with a greater involvement in care of the child.

Discussion

Urinary retention is relatively rare in children [3]. Psychogenic causes of urinary retention in adults, though uncommon has been described in literature but rarely described to play a role in children [4]. It often poses challenges to decide whether the patient requires further investigations or a multidisciplinary approach to address various dimensions of the issues.

Larson et al., (1963) reviewed cases of 37- female patients with urinary retention who reported emotional difficulties in addition to the urological complaints. More than 50% of the individuals underwent surgical procedures with improvement reported only in one case. Authors suggested in these cases that a conservative approach and individual consideration of each case is necessary to decide the required therapeutic approach including avoiding needless and at times counterproductive surgery [5].

A review by Hoeritzauer et al., (2016) found that among the cases of psychogenic urinary retention, there were various psychological factors like emotional deprivation during childhood, an unhappy marriage, and fear of punishment of a culturally unacceptable promiscuous sexual relationship [6]. In several patients, urinary retention was precipitated by physical triggers such as UTI or surgery. Modeling from parents with genitourinary problems, sudden death of a friend or colleague from renal disease, and rape was found in other cases. Among these cases possible benefits that could be postulated was freedom from an unhappy

home or household duties or sexual situations and the ability to exert control in situations in which the patient was being exploited [6]. A late recognition of this type of urinary retention can worsen its prognosis as the high pressure and infection in the urinary tract can lead to serious complications [7, 8].

Agarwal et al., (2017) reviewed medical records of 38 children of 1-18 years of age in a tertiary care center in India. After common causes were excluded by detailed physical examination and relevant laboratory and radiological investigations, only three cases were considered due to psychological causes and referred to a psychiatrist [9].

Literature on treatment options of psychogenic urinary retention is limited. As described in the earlier study [5], patient may have an unnecessary surgery and risk the possibility of having an indwelling catheter for a protracted duration of time. Studies have described systematic desensitization with relaxation training and biofeedback-monitored relaxation training in these cases [10]. The management in this case was, mainly supportive psychotherapeutic techniques including holding and containment, reassurance, advice and encouragement. Also, psychosocial issues were addressed openly and communication between the family members facilitated. This may have helped the child to resolve her emotional difficulties.

Conclusion

We report a case of psychogenic urinary retention which can pose diagnostic and management challenges as various factors can influence it. Comprehensive review and focus on physical, psychological and social factors can be helpful in the management of these cases with supportive psychotherapy being the primary treatment.

Conflict of interest: None declared

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