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Review Article

Psychogenic Neuralgia

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Abstract

Psychogenic neuralgia is a form of psychosomatic pain disorder in which emotional and affective disturbances manifest as severe pain resembling neuritis or neuralgia. This pain can be localized in various areas of the body – from the chest and face to the spine and extremities – and often becomes the focus of hypochondriacal fixation. A characteristic feature is the "wandering" nature of the pain, its inconsistency, and its dependence on the patient's emotional state. Such pain is often mistaken for organic diseases, leading to unnecessary interventions and ineffective treatment. Recognizing the psychogenic nature of neuralgia is essential for the timely prescription of antidepressants and psychotherapy, which can achieve a lasting therapeutic effect.

Keywords: psychogenic neuralgia; depression; hypochondria; psychosomatics

Introduction

Cutaneous hyperesthesia is often associated with sharp, painful sensations reminiscent of myalgia or neuralgia. Severe pain along the intercostal spaces typically does not cause particular concern in patients if it is localized in the right side of the chest; such symptoms are usually perceived as intercostal neuralgia. However, if pain is felt in the left side of the chest, it is inevitably associated with the heart and becomes the subject of hypochondriacal fixation. Even severe intercostal pain and increased pain upon abduction of the arm rarely convince patients of the absence of cardiac pathology; for them, their "heart is giving out" [1, 2, 3]. In women, hyperalgesia in the mammary glands can become the center of hypochondriacal fixation. Fear of cancer or the belief in its presence often forms the basis of hypochondriacal depression. Complaints may also concern shoulder pain, which often intensifies at night, is accompanied by limited mobility, and the development of so-called "frozen shoulder" [1-5]. There are known cases of so-called "phasic" pain, which occurs in the morning and disappears after arm movement, as well as "permanent" pain, which persists even after neurosurgical intervention but correlates with depressive phases and is successfully relieved by antidepressants. In extreme cases of mental hyperesthesia associated with affective disorders, a condition occurs in which even the slightest movement causes unbearable pain [3]. In some patients, the discomfort radiates along the trigeminal nerve, from the temples to the gums and jaw. Its intensity varies from mild paresthesia with a sensation of numbness and tingling (especially in the occipital region, upper lip, and less commonly the chin and lower jaw) to sharp "shooting" pain, which patients mistake for neuralgia and unsuccessfully treat with pyrazolone derivatives or even narcotic analgesics [3,6]. Particular attention should be paid to patients who consistently seek the extraction of healthy teeth due to complaints of "hellish" toothache. This phenomenon, known as "dental rage," has long been described as a form of mental disorder in "chronic neuropaths." Dentists, who often fail to consider the emotional state of their patients, encounter this problem quite frequently [7, 8, 9]. A key feature of pseudoneurological disturbances associated with affective disorders is the unusual mobility of painful sensations. So-called "wandering neuritis" is often encountered, in which the patient undergoes prolonged and unsuccessful treatment for trigeminal neuralgia, intercostal neuralgia, or cervical or lumbosacral radiculitis. In this case, the pain zone often extends beyond the innervation of a specific nerve trunk: for example, during the initial examination, the painful area may be on the right, while on a follow-up examination, it may be on the left [8-11]. The term "vagina neuritis" should alert physicians, as it is a common masquerade symptom of depression. It is important to remember that in some cases of persistent neuralgia that is resistant to standard therapy, treatment with antidepressants is indicated [10]. Furthermore, patients who have experienced at least one attack of precordial melancholy and psychogenic neuralgia sometimes begin to abuse narcotics. Pain addiction to such medications is considered, along with alcoholism, a possible masquerade symptom of depression.

Pseudoradicular Syndrome

For hundreds of years, the back has been considered "the main site after the head for various abnormal sensations." Painful sensations in the back and spine associated with latent depression, which does not occupy a leading place in the clinical picture but is accompanied by a predominance of fear and anxiety, were previously described as an independent clinical entity [1]. Psychogenic pain in the lumbosacral region, which causes temporary disability and is effectively relieved only by antidepressants, often perplexes

treating physicians, sometimes prompting them to suspect malingering on the part of patients. This psychophysiological reaction, usually diagnosed as sciatica or lumbago, has recently become one of the common manifestations of anxious depression, occurring regardless of patient age. According to research, this syndrome is the primary manifestation of depression in 14% of patients. Moreover, even in the absence of overt symptoms of anxiety and melancholy, when lumbar pain is the only complaint, the degree of depression is comparable to that in patients with pronounced clinical signs of depression [1.3,11]. The possibility of purely psychogenic lumbago in the absence of organic changes and the statistically significant frequency of "lumbar pain" in the structure of hypochondriacal neurosis have led psychoanalysts to pay special attention to this syndrome. In psychoanalytic theory, the spine, especially the lumbar region, is given a key role in the symbolism of "resisting – holding on" or "bending – yielding." The more confident an individual feels in interpersonal relationships, the easier it is for them to maintain an upright posture. The development of lumbar pain in depressive-hypochondriac disorders is interpreted as clear evidence that the patient is losing the ability to "hold on" and is abandoning active resistance and "aggression" [3,6]. If migraine or trigeminal neuralgia are associated with an unconscious or unexpressed emotion of anger, then sciatica ultimately acts as an expression of the desire to shirk some duty or avoid danger [3,9,10]. Of particular interest are the results of a study of 150 patients with sciatica at work. Many of them, despite continuing to work, continued to experience symptoms typical of the acute period – pain points, tension symptoms, and so on. These patients could be temporarily or even permanently disabled, but nearly 90% of them continued to perform heavy, formally contraindicated physical work. The social and biological compensation of these patients (often high-performing workers or individuals with extensive work experience) calls into question the "one-sidedness" of standard approaches to assessing work capacity [10]. In clinical practice, it is not uncommon for patients to experience annual depressive phases, beginning with sciatica in the same months, followed by mild hypomanic states. A number of patients admitted with a diagnosis of "exacerbation of lumbosacral radiculitis" demonstrate such a close psychosomatic link between depression and radicular syndrome that any anxiety or stress immediately triggers painful sensations, even in the absence of objective symptoms. Family conflicts or problems at work are often the reason for hospitalization. For example, in one of our patients, annual exacerbations of radicular syndrome always began in January – a period of intense work on the annual report – and ceased after its submission. Such patients typically have at least one history of objectively confirmed radicular syndrome or low back pain, most often associated with a previous injury (sports or work-related in men, pelvic diseases in women) [1, 9, 11]. Spinal pain in this case arises or intensifies at the onset of depression, periodically worsening or weakening in intensity in accordance with daily affective fluctuations. Nocturnal attacks of vital fear with cardialgia and palpitations may be accompanied or alternate with sharp pains, mimicking the clinical picture of lumbosacral or cervicothoracic radiculitis. Painful sensations along the spine – spontaneous or with pressure, predominantly in the area of the spinous processes or paravertebrally – may be localized in specific vertebrae, occur simultaneously in several areas, or "move" from place to place. They are often mistaken for signs of spinal cord damage or bone changes, leading to diagnostic errors. Patients frequently perceive these symptoms as manifestations of a severe, unrecognized organic disease [1, 3, 9, 10]. A marked increase and heightened perception of somatic symptoms against a background of depression and anxiety, accompanied by a grotesque processing of even the most minor functional disorders, forces such patients to seek the cause of their severe, and sometimes life-threatening, condition in the spine. Diffuse pathological sensations – rustling or crunching in the intervertebral joints and large joints, a feeling of "fatigue" or "ache" in the spine, a sensation of warmth or cold along the spine, a feeling as if broken glass or sand were inside, and sometimes even a feeling of "flattening" of the vertebrae – make these patients regular visitors to neurologists, rheumatologists, orthopedists, and physiotherapists [6]. The so-called cervical syndrome, in which painful sensations are localized in the neck, has acquired particular notoriety. Psychogenic cervical syndrome is often mistaken for a consequence of spondylosis, arthrosis, chondrosis, and osteochondrosis, especially in the presence of even minor radiographic changes in the spine. However, there is a clear clinical correlation between the onset of complaints of "occipital pain" and the development of depression: the pain disappears upon recovery from depression spontaneously or under the influence of antidepressants – despite the unchanged radiographic findings of cervical osteochondrosis. This fact, recognized worldwide, is often ignored in practice [10]. Complaints of painful sensations in the occipital region radiating to the head and upper extremities, as well as tension in the cervical and occipital muscles and sometimes "tightening" of the facial muscles, occur in the structure of depressive disorders even in the complete absence of organic changes. However, this aspect is sometimes overlooked [10, 1]. As a result, many patients endlessly "run" from one doctor to another and end up in research institutes specializing in spa treatment and physiotherapy, where they are unsuccessfully treated for "cervical osteochondrosis" or "lumbosacral radiculitis." For example, only 36% of patients referred to spas for musculoskeletal disorders do not have varying degrees of "neurotic complications" [1, 9]. Identifying the affective nature of such disorders opens the way to successful treatment with antidepressants after numerous unsuccessful courses of painkillers and anti-inflammatory medications, not to mention physiotherapy.

Restless Legs Syndrome

A fairly common and highly demonstrative manifestation of affective disorders, particularly in the clinical setting of melancholia and so-called "depression without depression," is restless legs syndrome. This is nocturnal paresthesia – an unpleasant sensation in the legs that disappears with movement. These symptoms were first described by French psychiatrists in the 19th century and have recently gained renewed interest among physicians as a variant of masked depression [1,8]. Patients complain of transient or persistent "restlessness in the legs," accompanied by dysesthesia – abnormal but non-painful sensations of warmth, cold, crawling, tingling, and the like. This is sometimes described as "sadness in the legs," reminiscent of the sensation after a long walk or horseback ride. Importantly, there are no organic changes, and these sensations arise specifically against the background of neurotic depression [8]. Patients experience this anxiety, which is accompanied by persistent insomnia and an influx of anxious and depressive thoughts: "all sorts of thoughts creep into my head at night, and my legs seem to beg to go somewhere when I go to bed" [1,8,9]. Similar sensations can also arise upon early awakening, often accompanied by nightmares. One patient describes it this way: "At dawn, I wake up with an indescribable agitation in my legs – a sensation close to a very painful cramp, although the muscles remain relaxed. It seems as if all the tension of the day is transferred to my legs at night, and this feeling is so excruciating that I want to kick my legs like a baby in a cradle" [9,10]. Formal complaints of leg pain and cramps conceal very unique and excruciating sensations, bordering on physical pain and mental anguish. Patients describe them as "sickness from the legs at night," "boredom, nervousness," "aching, tugging, burning, itching, like needles," "as if they're being twisted with a rope," or "like a child moving in the legs." These sensations drive people to despair and exhaustion, forcing them to pace the room for hours, rubbing and

scratching their legs until they bleed, cooling them with cold water – and only with the onset of morning does temporary relief come. During the day, these sensations typically disappear or become less noticeable. Sometimes, a purely motor form without paresthesia is also observed [1,6,9]. Treatment of such disorders is difficult, as they are poorly controlled by standard medications, including analgesics. However, it has been proven that most of these symptoms are of an affective nature and are significantly reduced or disappear with properly selected psychotropic therapy, in particular when taking antidepressants [10].

Psychogenic Dyskinesia

Functional cramps, such as writer's cramp, are of particular interest in the context of affective disorders. In this condition, handwriting becomes clumsy and choppy, and the patient is unable to write a single word without distortion. Similar cramps are also observed in other occupational groups, including telegraph operators, tailors, musicians, and ballet dancers [1,2]. These disorders are most often associated with professional activity; however, they often develop against a background of underlying depression and are associated with emotionally significant circumstances for the patient. Writer's cramp typically begins with a feeling of fatigue in the hand, uncertainty in handwriting, and tremors, and then progresses to convulsive contraction or relaxation of the hand muscles, occurring only during fine, professional movements. These symptoms are closely linked to the patient's mood and emotions, confirming their affective nature [1,6,7]. In one case, a patient suffering from depression following emotional stress developed writer's cramp while writing a report, accompanied by a fear of recurrence. His condition and handwriting returned to normal after treatment with small doses of amitriptyline [1,9,11]. The affective basis of such cramps is particularly evident when they develop in people who write little – for example, civil servants whose work involves rarely signing their name, or those who fear their superiors. In such cases, the cramp is caused not by physical exertion, but by intense emotional tension, fear, and anxiety. A striking example is the "jumping" handwriting of students during exams [9,11]. False professional cramps and vague but extremely distressing sensations accompanied by complaints of extreme and even painful fatigue in the right shoulder alone or all the muscles of the shoulder girdle are common among female pianists and are increasingly common in the context of depression and asthenia among typists. The latter sometimes tightly bandage both forearms when faced with urgent, tedious, or simply boring typing tasks, but are capable of literally sitting at the typewriter for days on end, completing a challenging task. Occurring muscle spasms and "small contractures" cause such patients to complain of "major pain" and are usually regarded as symptoms of neuritis or myositis [1,6,7,11]. Characteristically, complaints of limb weakness, tremors, spasms, pain, and other pathological sensations often precede movement and sometimes appear at the mere thought of performing a burdensome, emotionally significant task. A significant proportion of cases of so-called professional autonomic polyneuralgia should be considered within the general category of psychogenic dyskinesias. These include complaints of dull, vague, "yearning" pain (primarily in the forearms), paresthesias of the distal upper extremities, and a feeling of "stiffness" in the extremities. These symptoms include morning disobedience, such as when patients break dishes or are afraid to pick up a child for fear of dropping them [2,7,9]. These unpleasant and distressing sensations disappear during the day and recur in the evening, sharply intensifying at night and associated with insomnia. Acropareesthesia, bordering on excruciating pain in the terminal phalanges of the fingers, sharply worsening at night and preventing work in the morning, is common in clinical cases of neurotic depressive disorders. Painful sensations arising in the hands can spread to the forearms and even the entire shoulder girdle, and are usually accompanied by severe hyperhidrosis of the palms and other autonomic disorders [9,11]. Finally, we should address the role of affective disorders in the development of acquired spasmodic torticollis. Its pathogenesis is often unknown, and treatment is unsuccessful. Clinicians have already noted a clear link between torticollis and a psychopathic predisposition and its frequent association with mental disorders (primarily with a frequently preceding long-term melancholy). For example, spasms of the neck muscles, interspersed with hallucinatory confusion, have been described [1,2]. Functional spasmodic torticollis, not associated with severe neuroinfections or organic damage to the musculoskeletal system, is sharply aggravated not so much by physical work (during which it may even disappear), but by anxiety, under the influence of feelings of embarrassment, shyness, fear, and fear of ridicule. It is the patient's affective state that determines the direct dependence of spastic contraction of the neck muscles on mental representation and attentional focus [2,6,11]. Depression and anxiety may underlie the origins of hyperkinesis, which at a certain stage of the disease appears to be the sole and seemingly autonomous phenomenon. In three of the patients we observed, spasmodic torticollis with a forced head position (and elements of tonic spasms of the neck muscles in one case) developed against a background of latent endogenous depression with a feeling of as yet unspecified, diffuse anxiety. The causes of the patients' hypochondriacal fixation were: accidental superficial neck trauma in one case, mild pain associated with a certain head position during prolonged reading in another, and severe iatrogenic influence in a third [1,6,7]. Behind the bright facade of “monosymptomatic” torticollis, in all three observations, there was hidden a rather massive psychopathological symptomatology with overvalued ideas about one’s condition, reaching the level of delirium (“stroke”, “brain tumor”) when the condition worsened and at the height of hypochondriacal raptures [9]. The dependence of muscle spasms on the patients' attentional focus manifested itself in accordance with daily mood fluctuations. In the mornings, during a period of improvement under the influence of combination therapy with antidepressants and neuroleptics, the patient could sit upright for long periods without any signs of spastic contraction of the neck muscles while talking about foreign objects, but would begin "turning his head as if it were on a spring" when asked how he was feeling (which usually produces the impression of aggravation). In the evenings, the same patient enthusiastically played table tennis and noted with amazement that no fixation of attention, no "self-hypnosis," had any effect on him – his neck remained straight [9,11]. Iatrogenic influences associated with inadequate therapy are particularly significant in the formation of pathological stereotypes. One of our patients, for example, received over 500 injections and over 2,000 tablets of various medications (including 9 cyclodol tablets daily) during six months of inpatient treatment in a neurological clinic. In all three cases, the question of surgical intervention was raised, with the patients themselves insisting on it. The possibility of malingering was completely excluded; the depth of the depressive state was confirmed by the presence of distinct suicidal tendencies in two of the three patients [1,7].

Conclusion

Thus, the diverse pain, sensory, and motor disorders described in the text demonstrate that many clinically striking and sometimes severe symptoms resembling neurological diseases are, in fact, manifestations of anxiety-depressive and somatoform disorders. They are characterized by mobility, variability, inconsistency with objective data, and a pronounced dependence on the patient's emotional state. Misinterpretation of these disorders leads to excessive testing, ineffective therapy, and the development of hypochondriacal fixation. However, timely recognition of the affective nature of the symptoms and the administration of appropriate

psychopharmacological treatment, primarily antidepressants, allows for significant improvement and avoids the chronicization of the disease.

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