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Review Article

Thymopathic Dizziness

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Abstract

Thymopathic vertigo is a common psychosomatic disorder associated with emotional stress, anxiety, and autonomic dysfunction. It manifests as a feeling of instability, fear, nausea, and weakness in the absence of organic disorders. It is important to promptly recognize its psychogenic nature, as misinterpreting symptoms as neurological leads to ineffective treatment. Understanding the role of emotional factors allows for the selection of appropriate therapy, preventing chronicity and social maladjustment in patients.

Keywords : thymopathic vertigo ; anxiety ; psychosomatics ; autonomic disorders

Introduction

Dizziness, fainting, and "paroxysms of weakness" are among the most common psychosomatic disorders, long described as fairly common occurrences in neurotic and pseudo-neurotic conditions with pronounced autonomic instability. So-called simple, non-systemic dizziness is known to occur with arterial hypo- and hypertension (especially during crises), chronic anemia, and heart disease, and ultimately, with any pathological processes associated with a specific functional state of the central nervous system and increased excitability of autonomic innervation in affective disorders. Heart palpitations and cold sweat, a pale face, a "terrible noise, either in the ears or in the head," and "nausea" suggest paroxysmal vascular disorders, sometimes mimicking Ménière's syndrome at the height of affect (in the complete absence of inflammatory processes in the inner ear or indications of possible vestibular damage in the anamnesis) [1, 2, 3].

Many emotionally unstable people with psychovegetative disorders experience severe dizziness associated with a fear of even moderate heights. "When I looked down from a hanging balcony, my head spun, my heart went cold, and my toes ached cloyingly." The genuine torment experienced by patients standing on a bridge, a balcony, or simply looking out of upper-story windows (especially at the thought of falling or throwing themselves) has long been regarded as one of the characteristic manifestations of neurasthenia. For example, a patient has been described who, on the very first day of moving from the mezzanine to a beautiful apartment on the floor above, suddenly felt an overwhelming fear when looking out the window overlooking the street or an open square; this fear, accompanied by a feeling of unbearable dizziness, did not subside even at night, with the shutters closed, but disappeared in one of the rooms overlooking a narrow courtyard [1,4,5].

The same fear underlies the dizziness that often arises when looking into the depths; too clearly imagining each meter of ever-increasing depth under the keel, many passengers who cannot swim turn pale and are ready to faint when the steamer turns into the open sea. It is precisely fear that most likely plays a significant role in the development of seasickness in young sailors and those finding themselves on a ship for the first time, although attacks of dizziness and nausea do not subsequently develop in them, even during a storm [5].

The underlying agoraphobia, often associated with hypochondriacal fears in patients suffering from psychosomatic respiratory and cardiovascular disorders, is not always revealed. “I either don’t cross the street at all or only use the underpass,” says one patient. “When I look at the opposite side of the avenue or square, my heartbeat quickly starts pounding and my vision blurs; I feel like I’m going to lose consciousness in the middle of the road and be run over by a car; then the sidewalk starts spinning, the ground gives way under my feet, and I have to urgently lean against a wall or post to avoid falling” [5,6].

The extremely unpleasant feeling of dizziness is often associated with mental strain and occurs during lectures or classes. "From the painful attempts to concentrate," says the patient, "the head feels unwell: it seems as if my temples are moving towards my forehead, and this makes me feel nauseous, and my thoughts are slipping away, getting confused, I read and don't understand anything, the lines before my eyes are blurry, as if I'm in a semi-fainting state, as if I'm about to lose consciousness." We are

therefore not talking about true dizziness, but rather about a special state of consciousness with a disturbance in the perception and comprehension of what is happening. Such conditions develop especially easily when intense mental workload is combined with affective tension against a background of pronounced (including somatogenic) asthenia – in connection with work on an annual report or an important and urgent assignment, during an examination session for part-time students, during prolonged depression with an influx of uncontrollable distressing thoughts [5,6,7].

In many patients, the sensation of dizziness turns out to be, in essence, a clinical expression of confusion with a feeling of "either surprise or fear" when asked an unexpected question by an examiner or when given a "dressing down" by a superior, "when you don't even know what to answer." "You get confused, you ask again," says one patient, "and I hear everything perfectly well, but the meaning of the words doesn't get through; my head tightens; my head spins; I feel nauseous in my chest; my fingertips go numb, as if I were wearing muffs... and then you understand everything, but there's a lump in my throat and I can't say a word, and for some reason involuntary tears flow." Such confusion (an inconsistency of thinking, which is acutely evident only at the height of affect) in itself already testifies to the special affective significance of the initial situation for the patient – a situation when emotion takes over reason and, so to speak, crushes it [7,8].

Loss of self-control, body control, and balance disorders are most characteristic, however, of the fear of death. Psychogenic dizziness, observed in only 20-30% of patients with psychoneuroses, is not surprisingly found in 78% of individuals with functional disorders in internal medicine clinics and 63% of all those examined in psychosomatic clinics. The neurophysiological basis for complaints of dizziness is the same state of anxiety and inner restlessness, depression, and a feeling of "intolerance to effort" characteristic of the overwhelming majority of patients with psychosomatic disorders. Fear of severe heart disease is noted in such cases in 63% of patients (including fear of myocardial infarction in 57%), and a desire to "spare oneself" as much as possible is found in 62%. Such patients typically complain not of fear and melancholy, the somatic expression of which is a feeling of dizziness, not of a fear of heights and open spaces, or sometimes of an unconscious fear of death, but of dizziness when going outside or simply frequent dizziness [7,9].

The relationship between affective disorders and dizziness has long been a focus of clinical attention. It has long been known that states of melancholy and agoraphobia are often mistaken for dizziness due to the extreme uncertainty, ambiguity, and even "incorrectness" of patients' complaints. They report not fear and melancholy, but rather "sickness" and dizziness. Instead of a fear of heights, depths, or open spaces, they report dizziness specifically at heights, depths, or open spaces. The patients themselves often define these attacks as "special states of either fear or surprise in the head", developing, as a rule, in connection with some unusual, unprecedented sensations in one or another organ or in the whole body ("this is something new, incomprehensible, unpleasant; something is happening to me – this has never happened to me before"). The feeling of instability of one's own body that arises, especially when walking ("legs, like cotton wool, shake at the knees, do not obey; as if the ground is leaving from under my feet, as if there is no ground under my feet") is not objectively confirmed during a repeat neurological examination, but is very difficult for patients to experience. Prone to hypochondriacal fixation on this sensation, they actively complain of unsteadiness when walking and claim that they are "pulled" or even "thrown" from side to side; They move around "along the wall" and are afraid to go out of the house onto the street, where they might be mistaken for "drunk" [5,10].

Such "balance disorders" are often concealed behind the so-called hysterical paralysis of "emotional girls," whose legs buckle or even give way when attempting to stand or walk unaccompanied. This buckling of the legs, a purely affective reaction, most often rooted in fear, is encountered in clinical studies of neurotic depression with hysterical hypochondriacal disorders even today. Patients, fixated on every step and fearful of "losing their legs," seem to forget what they need to do to stay on their feet: anxiety and fear for their well-being disrupt the automaticity of walking and the complex coordination of movements required. Ultimately, we are also dealing with confusion and fear at the height of affective tension [10].

Dizziness and fainting spells sometimes act as the most striking clinical manifestation of generalized mental hyperesthesia, even in the absence of any painful or unpleasant sensations. Any more or less unexpected stimulus is extreme for the body. Visible evidence of increased vestibular excitability includes, for example, sudden dizziness, and sometimes brief fainting spells, caused by a brightly lit surface moving across the visual field (car headlights, the glare of an opening glass door, etc.), or by looking out the window of a fast-moving train at flickering telegraph poles, by sudden fright, or, occasionally, by the sight of blood. The most common cause of brief fainting spells is acute vascular insufficiency – a rapidly developing cerebral anemia caused by a drop in vascular tone at the height of emotional stress. Dizziness and syncopal episodes can also be caused by psychogenic hyperventilation (neurotic asthma), with a drop in blood pressure, reduced venous return, and decreased cardiac output. Orthostatic reactions associated with a rapid change in body position upon standing (especially after prolonged lying in bed) must also be considered; such disturbances are most characteristic of patients with a clear tendency toward persistent arterial hypotension against a background of general (often somatogenic) asthenia. Among the possible mechanisms for the development of psychogenic dizziness and fainting spells, a sharp rise in blood pressure during some unexpected event or fright should be highlighted [5,6,10].

One of the most important causes of recurrent dizziness is subsequently (after at least one experience of a "semi-fainting state" with a feeling of "the end" at the height of affect) a painful hypochondriacal self-observation associated with the anticipation of another attack – a fear of dizziness with persistent or periodically arising images of it, dominating the patient's consciousness against a background of depression and anxiety about their condition. Almost everyone is capable of inducing a feeling of dizziness in themselves using the principle of trace revival, "if they begin to think intensely about the mechanism of balance disorder and renew in their memory the idea of dizziness" [5].

Many patients complaining of dizziness experience extreme self-doubt with the need to sit down or lean against something from time to time, "a premonition that something bad will happen", from which "a terrible weakness comes from somewhere, and the legs strangely bend at the knees, and a fog appears in the head" ("as if you are falling somewhere; as if everything inside you freezes – life is leaving you"). In contrast to systemic dizziness caused by organic damage to the central nervous system with the involvement of the vestibular apparatus in the

pathological process, such patients experience, as a rule, "internal" dizziness without a sensation of rotation or displacement of the surrounding environment (it is not so much a dizziness as a darkening of the vision); spontaneous nystagmus during head movements is not observed, vomiting occurs rarely [5,6].

A significant feature of these difficult-to-classify bodily sensations and balance disorders is, first of all, the extremely vague, unclear nature of the patients' complaints ("some kind of disorder in the head, inexplicable in words, something abnormal in the back of the head; incomprehensible weakness and swirling"). The head is stale, foggy, cloudy ("as if with a high temperature; as if under anesthesia; as if the nose is blocked and there is not enough air"). The most indicative complaints are about a veil or darkening before the eyes ("I look as if through a gray haze; as if I am about to lose consciousness or death is already near"). At the height of "internal" dizziness, nausea and belching, a feeling of heaviness, emptiness or tightness in the epigastric region and an anxious squeezing in the chest ("like on a swing") usually occur; and even in those cases when unpleasant sensations initially appear in the head, they most often "immediately radiate to the heart." Such conditions usually develop in patients primarily or only on the street (on the way to work, in a crowd, when crossing a square), when descending or already on the subway platform, in connection with certain emotionally significant situations, at the height of affect, during excitement or fright (from unpleasant conversations, “from resentment and frustration”, etc.) or according to the type of “expectation neuroses” – for example, when the weather changes (more precisely, in connection with the fear of a repetition of certain unpleasant sensations with a possible change in the weather according to weather reports) or “from stuffiness” (“I immediately understood that since all the doors and windows are closed, I will feel bad”) [8,9,10].

Extremely distressing, affectively charged sensations – "either pain or anxiety" – in the heart and epigastric region (the most striking and persistent somatic symptoms of anxious melancholy or melancholy anxiety), changes in respiratory rate, pulse, blood pressure, and pupil size, increased sweating, and pallor or, conversely, flushing of the face, described in the structure of dizziness syndrome, essentially represent common vegetative signs of fear. It is no coincidence that the pathological fear of the "neurotic" is defined as a feeling of dizziness developing in a special state of the cerebral cortex, intermediate between sleep and wakefulness [8].

Ménière's syndrome, so frequently diagnosed in patients with numerous psychosomatic disorders, is currently considered a possible equivalent of masked depression, most often as thymopathic vertigo.

Only by considering the pathogenetic role of affect can one understand the "intrinsic constancy" and, at the same time, the unusual lability of psychogenic vertigo in the clinical setting of psychosomatic disorders. Most often, a transient or fleeting sensation of dizziness can persist for hours, weeks, and even months in some patients, leading to the concept of "neurosis occurring in an atmosphere of dizziness." The peculiar lability of these sometimes almost imperceptible, sometimes intensifying, phenomena (for example, their presence in the morning and absence in the second drink during a conversation with a doctor) is determined not by patterns inherent to the organic process, but primarily by a specific affective state of the individual, which is particularly noticeable in cyclothymic states [4,5,8].

Only the primary role of affective disorders in the development of non-systemic dizziness can finally explain the latter's continuation with the normalization of overall vitality and mood during adequate treatment with antidepressants and sedatives.

The clinical association of dizziness complaints with experimental psychopathological and psychosomatic phenomena has not accidentally led to a significant expansion of these concepts in our time. Dizziness began to include such seemingly heterogeneous and distinct conditions as depersonalization-derealization disorders and body schema disorders, a feeling of lightness and heaviness of the body, symptoms of metamorphopsia, macro- or micropsia (distortion, enlargement, or visual perception of objects). Phobic states and even acute precordial melancholy, one of the manifestations of which can be a sensation of dizziness, were erroneously assessed each time as various equivalents or sometimes as major circular vertigo [9].

Dizziness is often understood as a vague and distressing sensation that defies precise definition – a feeling of cold or heat, heaviness, or, conversely, a lightness and emptiness in the head, a feeling of fluid shimmering in it, or shooting and stabbing pain. The almost elusive line for many patients between vague, unpleasant sensations in the head and mild dizziness allows some to complain of dizziness, while others (with the same initial data) complain of a headache. A more or less pronounced labyrinthine component of "senesthopathic" headache has long been noted by clinicians [4].

Banking complaints of dizziness often conceal psychosensory disturbances and depersonalization phenomena: a sensation of a heavy or, conversely, unusually light, "weightless," "empty, as if the brain is no longer in it," "not one's own" head; a very unusual, peculiar sensation in the legs or throughout the body; The body becomes either heavy, or wobbly, or even alienated; the entire organism seems "completely out of whack, something terrible is happening within it." Along with this, signs of derealization arise – "everything around is perceived differently, blurrily; as if something is preventing one from seeing clearly and thinking clearly" [4, 8, 9].

However, even behind these psychopathological phenomena, which are ultimately unambiguous for the patient, there is always, in one way or another, anxiety ("as if you were expecting something") and fear, from which "consciousness fades, the whole body goes numb, the limbs grow cold, and a white fog floats before the eyes."

It should be borne in mind that the cause-and-effect relationships between fear and similar sensations on the one hand, and the sensation of dizziness on the other, are by no means straightforward. It is necessary to differentiate between secondary fear (arising from genuine organic processes as a physiologically conditioned reaction of the individual to the threat of loss of consciousness) and primary fear – anxiety that reaches the point of uncontrollable, oppressive anxiety.

In the clinical setting of affective disorders, it is not so much dizziness that causes fear, but rather fear itself that generates (due to certain autonomic-vascular shifts at the height of affect) a sensation of dizziness, which then recurs as an equivalent of fear.

In neurological hospitals, such patients are sometimes diagnosed with arachnoiditis – especially if there is evidence of influenza or a history of head trauma. Corresponding complaints (headache, dizziness, tinnitus, pain in the trunk and extremities) and a prolonged course of the disease

with remissions, without worsening neurological disorders, truly require the exclusion of an organic origin of the suffering [9].

The well-known difficulties in differential diagnosis of all forms of arachnoiditis have made it a common diagnostic guise in medical practice, hiding many patients with pseudo-neurological disorders due to affective pathology. Often, the speculative diagnosis of "arachnoiditis," based on a routine neurological examination, represents a serious and, as a rule, lifelong iatrogenic injury to the patient.

"Chronic arachnoiditis" (which, as is known, can develop even in the absence of severe neurological symptoms and pathological changes in the cerebrospinal fluid and fundus) is essentially diagnosed based on highly subjective patient complaints, sometimes supported by nonspecific diffuse changes on the electroencephalogram (EEG). It is these patients who constitute the majority of the significant contingent of patients with arachnoiditis of "unclear etiology." The complete ineffectiveness of conservative therapy (use of urotropin, antibiotics, physiotherapy, as well as invasive methods such as blowing air into the subarachnoid space to rupture suspected adhesions and improve cerebrospinal fluid circulation) and frequent decrease in vitality, leading to loss of ability to work, often become the reason for referring these patients to a labor examination, where their social disability is actually legitimized [4,8,9,10].

Patients with particularly persistent complaints stemming from senestopathic and hypochondriacal disorders actively seek repeated inpatient examinations, including pneumoencephalography, craniography, myelography, and spondylography, and even undergo neurosurgical interventions, most often due to a misdiagnosis of a space-occupying lesion in the brain. For example, one patient (18 years old) with senestopathic-hypochondriac disorders classified as psychopathic-like schizophrenia was admitted to a psychiatric hospital after a repeat craniotomy. When the patient was transferred to a disability group, the diagnosis was already one of schizophrenia due to an organic deficiency [10].

At the height of a psychovegetative paroxysm with an acute fear of death from cardiac or respiratory arrest, many patients experience a brief clouding of consciousness – just for a moment. A particular predisposition of such patients to paroxysmal fainting spells, accompanied by intense fear and threatening perceptions, has been repeatedly noted by clinicians. Thus, in 35% of patients with functional complaints in internal medicine clinics, fainting spells occupy a significant place among psychosomatic symptoms [9,10].

In a significant proportion of cases, these are pseudosyncopal episodes, which are sometimes mistaken for absences. This is explained, in particular, by the patients' well-known clumsiness – for example, they drop objects, not because of loss of consciousness, but because they are clutching them too tightly. When the spasmodic contraction ceases, the object falls. Patients dominated by anxious thoughts or diffuse anxiety complain that the objects around them seem to "dislike" them: they constantly bump into things, everything breaks, "their arms and legs don't obey their heads." When asked about dropping objects, patients with fine motor coordination disorders associated with affective disorders may respond affirmatively: "Oh, yes!" – without any connection with the epilepsy clinic [1-5].

A sudden sensation of muscle weakness in the arms, legs, or even one side of the body is often the cause of the described phenomena. It is usually short-lived, lasting a few minutes, but sometimes persists for hours or even days.

Patients with severe but latent depression make up a significant portion of these unfortunate individuals. Such people often spill red wine on the holiday tablecloth, burn it with a cigarette, drop tableware, and leave marks from collisions with furniture. While attempting to cope with household chores, they suffer abrasions and bruises, drop a hot iron on their bare feet, and spill boiling milk on themselves. One of our patients with a clinical picture of latent depression was hospitalized with a closed fracture of both femurs after falling from a balcony – he leaned over to shake bread crumbs for pigeons [4,5]. According to research, 60–90% of industrial accidents are caused not so much by poor work organization or technology, but by the emotional state of the worker themselves. The incidence of accidents depends primarily on the level of asthenia and depression – increased fatigue, decreased attention, impaired motor coordination – as well as disregard for real danger or, conversely, excessive caution due to imaginary risks. Emotional instability and loss of self-preservation instinct lead to serious mistakes that even a novice would avoid. This can be considered a form of self-destructive behavior. For example, one of our patients, a high-rise worker who miraculously survived a 15-meter fall, drinks a glass of vodka "for courage" every time before climbing, despite knowing that alcohol impairs coordination [9].

Even unsuccessful suicide attempts are not always a display of demonstrative behavior. The impulsive nature of such actions in a state of strong emotion or the patient's excessive fixation on their own experiences often lead to strange occurrences: a laxative is taken instead of poison, or a carefully prepared rope of twine unexpectedly breaks under the patient's weight.

Complaints of dizziness and pseudosyncopal episodes – especially when combined or alternating with sensorimotor coordination disorders and functional cardiovascular disorders – sometimes lead to a misdiagnosis of vertebrobasilar insufficiency or temporal lobe epilepsy. Inadequate treatment in such cases usually worsens the patient's condition and reduces their ability to work. Furthermore, an erroneous diagnosis of epilepsy entails serious restrictions: a change of job or even profession, the loss of a driver's license, and a dramatic change in social status. All this leads to a negative attitude of patients towards psychoneurological consultations and psychotropic therapy, which almost excludes the possibility of adequate treatment of their affective disorders, in which vegetative-vascular manifestations occupy a central place [5-10].

Conclusion

Thus, the phenomenon of non-systemic dizziness associated with psychosomatic and affective disorders is a multi-layered and highly variable condition, rooted not in organic lesions of the nervous system, but in complex interactions between anxiety, fear, emotional tension, and autonomic-vascular reactivity. The wide range of subjective sensations – from mild "fainting" and brain fog to severe imbalance, senestopathic experiences, and pseudosyncopal episodes – reflects primarily the patient's affective status, rather than the presence of structural pathology. Failure to understand the true nature of these conditions leads to overdiagnosis of organic diseases, iatrogenesis, and social maladjustment, whereas adequate recognition of the leading role of affect and timely psychotherapeutic and pharmacological interventions can relieve dizziness, reduce fear, and significantly improve patients' quality of life.

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