For my doctor: shy bladder syndrome (paruresis)

I am handing you this sheet because I find it hard to say out loud.

WHAT IT IS

> *Paruresis refers to the inability to initiate or sustain urination where individuals are present due to the fear of perceived scrutiny from others.*
>
> [Kuoch 2017]

In plain words: I cannot start, or cannot keep going, if someone else is there or might walk in. It happens in public toilets, at work, in hospitals. Sometimes at home, if a visitor is in the house.

IT IS NOT SHYNESS, AND IT IS NOT A CHOICE

The word that matters is *inability*. Nothing comes. Trying harder does not help. I am not being difficult, and I am not refusing.

It often goes unsaid:

> *As a result of stigma and a perception that symptoms are embarrassing, patients hesitate to raise paruresis and parcopresis issues with their clinicians and may choose not to disclose.*
>
> [Kuoch 2019]

That is why I am giving you this sheet. (Parcopresis is the same thing for the bowel.) [Kuoch 2019]

HOW COMMON

A systematic review reports:

> *The prevalence of paruresis ranged between 2.8 and 16.4%, and around 5.1-22.2% of individuals with paruresis also had Social Anxiety Disorder.*
>
> [Kuoch 2017]

The same review is careful:

> *Little is known about the prevalence of paruresis and more rigorous studies of paruresis are required.*
>
> [Kuoch 2017]

Women and men both have it. A 2024 survey of 356 university staff and students – "221 (62.1%) females, 119 (33.4%) males and 16 (4.5%) other genders" [Hutchings 2024] – found the adjusted odds of 'mild' paruresis "higher for men than women (OR 3.39; 95% CI 1.90 to 6.06)". [Hutchings 2024] More common in men is not male-only. Its authors note: "The sample may be motivated and may not be generalisable to the wider population." [Hutchings 2024]

THREE THINGS I WOULD LIKE TO DISCUSS

1. Referral for graduated exposure therapy or CBT. The RACGP's journal for GPs says:

> *...psychological interventions are likely to be the first line of treatment. Although clinical trials have yet to be undertaken, cognitive behavioural therapy (CBT) is likely to be helpful...*
>
> [Kuoch 2019]

One study followed 101 people through graduated exposure therapy in weekend workshops. Its authors report: "Findings suggest that graduated exposure therapy improves self-reported global severity of shy bladder symptoms and that these gains were maintained at 1-year follow up." [Soifer 2010]

2. Whether training in clean intermittent self-catheterisation (CISC) would suit me, for situations I cannot avoid – a drug test, a long flight. I am asking about it. I am not asking for it. I know it is not what catheters are normally prescribed for. The nurses' guideline's list starts at "acute or chronic urinary retention" and does not include this. [EAUN 2025] As I understand it, it would manage those situations rather than treat the anxiety. Please correct me if that is wrong. And it is taught, not self-taught: "IC should be taught by an appropriately experienced nurse." [EAUN 2025] If it is wrong for me, please say so.

3. Whether medication has any place here. The only statement I have is "Pharmacotherapy may also be appropriate as an adjunct." [Kuoch 2019] I am not asking for anything specific. I would like your view.

First, though: "Patients presenting with suspected paruresis or parcopresis should be examined for anatomic or physiologic abnormalities prior to a diagnosis." [Kuoch 2019] Please rule out physical causes. The same journal's test for telling them apart: paruresis "is isolated to unfamiliar or busy public restrooms". [Kuoch 2019] In private I pass urine normally. Trouble I have everywhere points somewhere else. Please also look at my medicines. Urinary retention "has been described with the use of drugs with anticholinergic activity", among them "antidepressant agents", and with opioids. [Verhamme 2008]

IF I FACE A US DRUG TEST

US rule 49 CFR § 40.193 sends the worker to a doctor. That doctor does not decide the outcome. The rule says the referral physician "must recommend that the MRO make one of the following determinations" – the first being that "a medical condition has, or with a high degree of probability could have, precluded the employee from providing a sufficient amount of specimen." The medical review officer is the one who chooses whether to "accept this recommendation". [49 CFR 40.193]

The rule then says what counts as a medical condition. It includes "a medically documented pre-existing psychological disorder". It excludes "unsupported assertions of 'situational anxiety'". [49 CFR 40.193]

So a note in my record matters a great deal to me. *(US rule only.)*

A note matters outside the US too. If I am admitted or have an operation, the ward needs to know. Urinary retention "is common after anesthesia and surgery" [Baldini 2009], and a ward bathroom is a public toilet to me.

TWO THINGS THAT ARE NOT SHY BLADDER WAITING

A high temperature with pain in my side or back is not paruresis: it suggests an infection of the upper urinary tract. [EAU 2026] Guidelines say that has to be told apart from its obstructive form as soon as possible, because that form can lead rapidly to sepsis. [EAU 2026]

Not being able to go in a public toilet and then going at home is not an emergency. Being suddenly unable to pass any urine anywhere – at home too – with a bladder that is full and painful, is. [NIDDK 2019] That is acute urinary retention, and it needs emergency care whatever caused it [NHS inform 2026], including this.

Source: shybladder.help/en/doctor-brief/ Last checked September 7, 2026.
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