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Short Communication

Psychological Factors of Chronic Recurrent Cystitis In Women

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Introduction

Interstitial cystitis (IC) is a chronic bladder disease with a possible psychosomatic etiology [1-3]. It is usually assumed that this inflammation is caused by a urinary tract infection, in which the immunological, neurological prerequisites remain completely unclear. Typical symptoms include discomfort, pulling sensations (foreign body in the lower abdomen), pain when urinating, frequent urination. Symptoms may appear after intimacy with a partner. There is coital and postcoital pain, tonic manifestations during sexual contact with a predominance of anxious expectations (for example, "what if a child comes in and takes us away") and not the ability to relax. Patients may also experience chronic pelvic pain, blood in the urine, and fever, which significantly affects the quality of life and relationships. Patients note atypical symptoms that when they go to bed after an intense working day in a horizontal position, the bladder pulls and aches and they want to go to the toilet, during the day, when they sit, walk, nothing uncomfortable About half of all women have at least one bout of cystitis in their lifetime. Many women suffer from only one or two seizures in their lifetime, and some from more frequent episodes. Treatment is primarily aimed at relieving, managing symptoms.

In most patients, there is no apparent reason why cystitis recurs. In IC, antibacterial therapy, intimate gel lubricants, gels with bacteriophages for intimate hygiene and behavioral recommendations (sexual contact, physical activity, clothing, personal hygiene) can be indicated. Although interstitial cystitis is often associated with emotional disorders (anxiety spectrum disorders) and functional disorders of the gastrointestinal tract, it is often difficult to determine the cause and effect in each individual clinical case [2]. In clinical psychology, the psychosomatic aspects of CI have only rarely been the subject of research. Studies of the communication pathways from the immune system to the nervous system have provided exciting new data on the pathophysiology of inflammatory symptoms of somatoform disorders [3]. The research results confirm the significance of changes in the regulation of the stress axis (hypothalamic-pituitary-adrenal axis), catastrophic thinking style, narcissistic personality disorder, reduced psychological flexibility, a history of physical/sexual violence, feelings of shame, a tendency to somatization, and high neuroticism in CI [2-3].

The measurement of inflammation using biomarkers not only clinically documents the relevant infection, but also serves as an important tool for determining the potentially harmful effects of chronic psychosocial stressors, such as financial, social, family stress and childhood traumatic experiences (the phenomenon of the "phallic mother"), as well as other life events, such as loneliness, excessive hyper-vigilance, problem-oriented personality type. It is assumed that the basis of CI in women is changes in the psychoneuroendocrine-immunological pathway, which are activated when building a relationship with a partner [2]. The mental state of the patient, being in hypermobility mode, affects the immune system and neural activity, bacterial load. In this regard, when examining patients with IC, attention should be paid to the mental state in order to build an effective treatment strategy.

25 women aged 25 to 48 suffering from recurrent CI for 7-12 years. Symptoms by urologists and gynecologists were identified as bacterial pollakiuria and dysuria, accompanied by the presence of bacteria in the urine and vaginal smears, which mainly consisted of Escherichia coli and enterococci. Urological examination and

urodynamics revealed no abnormalities except for a hypertonic bladder. Patients have the following diagnoses: somatoform autonomic dysfunction of the genitourinary system (F45. 34); psychological factors in chronic recurrent cystitis (F54); recurrent depressive disorder, moderate episode (F33.1). Research

Methods

questionnaire on the severity of psychopathological symptoms (SCL-90-R); diagnosis of early maladaptive schemes (Young Shema Questionnaire-Short Form Revised, YSQ S3R).

Result

According to SCL-90-R, patients have high rates of 1) depression (much is given by excessive effort; loss of sexual interest or pleasure; a lot of anxiety about various things; a feeling of reduced energy, slow; a feeling of loneliness; melancholy 2) obsessive-compulsive manifestations (you need to do everything very slowly to ensure accuracy; the presence of repeated unpleasant thoughts that do not leave the voice; problems with concentration; the need to check and recheck what it does) 3) Anxiety (feelings of fear, tension, or hyperexcitation) and 4) Interpersonal sensitivity (resentment; feeling critical of others; feeling that others do not understand you or do not sympathize). GSI (general index of severity of psychopathological symptoms) - 1.70.31. According to YSQ S3R, high scores are observed on 1) The search for approval "Am I good? » Self-esteem depends on people's opinions, concern about how other people look at me; 2) Abandonment / Instability. "Don't leave me! "The belief that at any moment a close relationship can end; 3) Lack of self-control"I can't help myself". Avoiding boredom, problems with abuse, and irresponsibility.

Psychodynamically recurring bladder problems were closely related to the problem of partnership, relationship with another. The perception of the other is not through the prism of a paranoid-schizoid position. Patients tend to suppress personal desires and needs, in particular aggressive impulses and efforts of individuation, with the help of "rigid" defense mechanisms. These suppressed affects and impulses seemed to change and manifest themselves as the equivalent of the affect of bladder problems. The organ of choice and this was confirmed during our treatment also pointed to issues of sexualization, sexual problems. In the context of the "secondary benefit of their illness", the patients accepted their sexual denial to their partner only under the guise of a somatic symptom. Simultaneous depressive symptoms are easily explained by the mechanism of turning aggression against itself. In addition, the patients largely unconsciously identified with their depressive maternal figure (mother, grandmother), which was reinforced by an unconscious sense of guilt. Hostility could not be contained only by the symptoms of the bladder, and the patients ' need for punishment as a means of calming their anxiety and atoning for the hateful impulses they felt towards others could be partially satisfied by their numerous illnesses, polysurgical-pharmacological interventions and multiple cystoscopies, not to mention serious characterological shifts with constant reinsurance of antibacterial therapy and attacks on the partner. Repressed hostility towards significant parental figures, who were masochistically treated by patients through bladder symptoms from infancy and into adulthood, was most evident. The only somatic symptom for the patients to which others reacted ambiguously, and one of the few acceptable ways in which they could strike back or establish some kind of perverted contact. When examining patients, we noticed that they had masochistic manifestations in the form of visits to surgeons, polysurgical procedures, multiple cystoscopies, severe restrictions on sexual contacts, and the phenomenon of eliminating genitality from life. An early awareness of the psychosomatic factors of the disease could have prevented the tragic consequences of this vicious circle.

Conclusion

The findings should be taken into account in the course of complex treatment of patients and for multimodal psychodynamic psychotherapy, or cognitive-analytical therapy, which have the ability to reduce somatization, and positively influence the psychoneuroendocrine-immunological pathway to reduce relapses and improve the quality of life [4].

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Conflict of Interest

No conflict of interest.

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