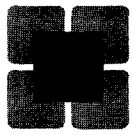

Psychological factors in men with genital pain

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■ Among 48 men with genital pain and no organic findings, psychological disorders were diagnosed frequently, including somatization disorder in 56%, nongenital chronic pain syndromes in 50%, major depression in 27%, and chemical dependency in 27%. About one third of the group were socially isolated and 18% had had an important emotional loss at the time of pain onset. Despite their mean age of 41, only half of the men were married. These data suggest that genital pain without organic findings is often related to psychological disorders, life stress, and poor social support. Treatment planning should take these factors into account.

□ INDEX TERM: GENITAL PAIN, MALE □ CLEVE CLIN J MED 1990; 57:697–700

MEN FREQUENTLY present with genital pain for which no physical cause can be found.[1,2] The dilemma is whether to treat as if the diagnosis is nonbacterial prostatitis or epididymitis, or to diagnose the problem as one related to psychological stress. Most patients are indignant and incredulous if told their pain is psychosomatic, and reluctant to accept a referral to a mental health professional.[3] Consequently, it is not uncommon to prescribe antibiotics, even when cultures of urine and prostatic fluid are negative.[2] Another approach is to fall back on sitz baths and reassurance.

Several authors have suggested that men with genital pain and no organic findings have a high incidence of life stress and psychological disturbance.[4–6] Their observations primarily concern men who complain of pain in the perineum, suprapubic area, testes, groin, and flank, often accompanied by urinary urgency and frequency, and pain on ejaculation. These men are often diagnosed as having chronic prostatitis. In our experience, men with nonorganic genital pain are similar psychologically, regardless of the site of the discomfort.

We report the results of a psychological evaluation of 48 men seen in our urology clinic who had no organic basis for their genital pain.

MATERIALS AND METHODS

The subjects of this study were 48 men consecutively referred by urologists unable to find an organic cause for complaints of genital pain. The men agreed to consult a clinical psychologist based in the urology outpatient clinic as part of the Center for Sexual Function.

Each man had a structured, 60- to 90-minute interview. The psychologist reviewed the patient's medical chart for demographic information and medical history, particularly a background of other chronic pain syndromes, psychological disorders, chemical dependency, or complaints suggesting a somatization disorder.

The interview included a detailed assessment of the pain in terms of onset, location, triggers, and duration; questions about the patient's social support and satisfac-

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TABLE 1
PATIENT CHARACTERISTICS

Variables	N (%)
Race	
Caucasian	43 (90)
African-American	5 (10)
Marital status	
Married	24 (50)
Divorced	9 (19)
Widowed	3 (6)
Single	12 (25)
Work status	
Working	44 (92)
Retired	3 (6)
Disabled	1 (2)
Economic status	
Professional	7 (15)
White collar	24 (50)
Blue collar	17 (35)

TABLE 2
PSYCHOLOGICAL DIAGNOSES

Diagnosis	N (%)
Somatization disorder	27 (56)
Chronic nongenital pain	24 (50)
Major depression	13 (27)
Chemical dependency	13 (27)
Obsessive thoughts	12 (25)
Somatic delusions	8 (17)
Panic disorder	4 (8)
Psychotic thought disorder	4 (8)

tion with marital or dating relationships; detailed assessment of sexual function using the multiaxial problem-oriented diagnostic system[7]; diagnostic evaluation for mood or anxiety disorders according to Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R) criteria[8]; and current stresses as well as stresses present during the onset of pain. Psychological testing was not routinely performed.

In 37 cases (77%), the man was interviewed alone. Seven (15%) were seen jointly with their wives or sexual partners and four (8%) had both individual and couple interviews.

RESULTS

The men had a mean age of 41 years (range, 20 to 72; SD=12). The mean duration of the pain was 4.7 years (range, <1 to 36; SD=6.7) Other demographic characteristics are summarized in *Table 1*.

The onset of the pain was sudden for 35 men (75%), gradual for 8 (17%), and intermittent in 4 (8%). Reported sites of pain included the testes in 25 (52%); bladder, urethra, or both in 14 (29%); penis in 14 (29%); perineum in 13 (27%); and groin in 12 (25%). Seventeen men (35%) reported only one site of pain, while 21 (44%) had two sites, 9 (19%) had three sites, and 1 (2%) had four sites. The pain was bilateral in 37 men (77%). In 16 men (33%) pain occurred during urination. Pain was associated with sexual arousal, activity, or orgasm in 17 men (35%).

Table 2 lists the psychological diagnoses made in the sample. Somatization and other chronic pain syndromes were particularly common (56% and 50% respectively).

Table 3 lists the common life stresses present at the onset of the genital pain. Significant loss was the most frequent and included multiple bereavements within a brief time period, recent death of a parent, childhood loss of both parents, recent death of a child or spouse, an intimate relationship that was chronically threatened, and complete estrangement from the family.

Social support and relationship satisfaction were low in this sample. All men were heterosexual. Twenty-one (44%) had marital or sexual relationships with a high degree of conflict and dissatisfaction. Spouse abuse had occurred in nine couples (19%). To express anger, 35 men (80%) typically used withdrawal and yelling was the strategy for 8 men (18%). Only 1 (2%) expressed anger by calm discussion. Expression of affection was rare for 22 men (52%), average for 18 (43%), and high for 2 (5%).

Several men had unusual anxieties about sexual issues, or had had sexual experiences that could have been factors in psychogenic genital pain (*Table 4*). The 6% incidence of childhood incest is probably an underestimate because the psychologist did not routinely assess sexual abuse in the earlier interviews.

Sexual dysfunction was quite common in this group, with 8 (17%) reporting low sexual desire, 23 (48%) having erectile dysfunction, 4 (8%) complaining of decreased orgasmic intensity, 13 (27%) having premature ejaculation, and 5 (10%) having difficulty achieving orgasm.

Dissatisfaction with the quality of the sexual relationship was also prominent. Sexual communication was rated as inadequate in the men's relationships by the interviewer in 40 cases (83%). Performance anxiety was severe in 31 men (65%). Twelve men (25%) wanted the frequency and variety of their sex lives to increase.

The 15 factors most likely related to the genital pain were tested to see if their presence correlated sig-

TABLE 3
STRESSES AT PAIN ONSET

Stresses	N (%)
History of significant loss	23 (48)
Recent breakup of relationship	17 (35)
Job stress	16 (33)
Social isolation	15 (31)
Financial problems	13 (27)
Pressure to commit to a new partner	13 (27)
Illness of spouse or partner	4 (8)
Infertility	3 (6)

TABLE 4
POSSIBLE SEXUAL FACTORS

Factor	N (%)
Severe guilt over masturbation	24 (50)
Phobia about contracting STDs	18 (38)
Partner had recent affair	10 (21)
Patient had recent affair	9 (19)
Fear of unwanted pregnancy	7 (15)
Homophobia	6 (12)
Belief that penis is abnormally small	5 (10)
Deviant sexual fantasies	5 (10)
History of incest as child	3 (6)

nificantly with a particular site of genital pain. The factors included other chronic pain, somatization disorder, depression, social isolation, history of loss, chemical dependency, obsessive thinking, marital status, job stress, stress due to recent break-up, marital conflict, guilt over masturbation, phobia about sexually transmitted diseases (STDs), sexual performance anxiety, and erectile dysfunction.

The only significant correlations were as follows: Testicular pain was more common in depressed men ($P < 0.04$). Perineal pain was more common in men who were married ($P < 0.02$) or who had had a recent breakup of an intimate relationship ($P < 0.01$). Dysuria was associated with marital conflict ($P < 0.01$). Pain during sexual activity was more frequent in socially isolated men ($P < 0.01$).

DISCUSSION

The psychological evaluation of a group of men with genital pain and no organic findings reveals that psychological problems, life stress, and poor social support are frequently present and may play a causative role in the pain syndrome. Half of these men had histories of multiple somatic complaints or other types of chronic pain without physical findings. Social isolation, bereavements in close relationships, and marital conflict were common among these patients. It is striking, in this age group, that only 50% were currently married.

A few men had delusions, such as a belief that the penis had shrunk, or overt psychotic thought disorder. Only one man was clearly schizophrenic, however; most coped well enough to work and function in society.

One of the few comparable case series is the 56 urology patients with prostatodynia seen by Keltikangas-Järvinen and colleagues in Finland. That group was slightly younger on average than our sample, but a larger proportion (82%) were currently married.[4,9] The incidence of "hypochondriasis" was similar to the rate of somatization disorder in our sample, and probably represents the same phenomenon. The prevalence of erectile dysfunction in the Finnish sample was almost identical to ours.

Although pain sites in our sample were more diverse than those often labeled as "chronic prostatitis," it is our impression that complaints of diffuse, atypical genital pain are often given that diagnosis. Orland and colleagues[2] described prostatitis symptoms as including pain in the perineum, suprapubic area, testes, groin, flank, and lower back, with pain on ejaculation or urinary urgency and frequency as common.

Finnish researchers also documented unusual sexual concerns and anxieties in their sample.[4,9] The unusual intensity of guilt over masturbation was especially striking in our men, as was the phobic fear of contracting an STD. Many of these patients were lonely and isolated and viewed sex as sinful and contaminating. Our findings are similar to those in women with chronic pelvic pain, who have a high prevalence of sexual molestation or incest, lifetime depression, somatization disorder, and chemical dependency.[10]

The prevalence of sexual abuse as a child or rape as an adult should be carefully assessed in future studies of this population. Sexually traumatized men show a pattern of psychological distress and symptoms similar to that observed in abused women, including depression, chemical dependency, and sexual dysfunction.[11,12] In our sample, a variety of sexual problems were reported, with erectile dysfunction the most common.

Urologists have speculated that prostatodynia is a consequence of sexual inactivity. A number of our patients had been advised by physicians to ejaculate on a more regular basis, whether through partner sex or in masturbation. Only three patients in our sample were chronically sexually inactive, however. Rather than a side effect of prostatic "congestion," the genital pain in

our sample seems to be a direct, bodily communication of psychological distress about perceived sexual inadequacy, loneliness, and fear of being hurt by loss of an intimate relationship. Because it interferes with sexual function, the pain becomes a strategy to avoid intimacy, at the same time eliciting attention and nurturing from significant others and health care professionals.

Relationships between the site of the pain and factors such as depression or social isolation remain speculative. Because we performed a number of analyses, a few correlations may have been significant because of chance. A study is needed that compares men who have atypical genital pain with urological patients who have documented disease, such as testicular torsion, epididymitis, balanitis, bacterial cystitis, or bacterial prostatitis. The two groups should be matched in age and socioeconomic status. Standardized psychological testing could be included. Such a design could verify whether the high incidence of psychological problems and sexual dysfunction in men with atypical pain is unique and bears a relationship to their complaint.

Despite the lack of a control group, the evidence from this pilot study suggests that psychological factors may play a role in genital pain that has no identifiable organic cause. The use of antibiotics and other symptomatic treatment has been discouraged by other researchers; they have reported successful outcomes with relaxation training and other forms of stress management.[5,6]

Our policy is to tell patients that we believe they have a psychogenic disorder. We present the problem as one of stress-related chronic muscle tension, and advocate short-term, behaviorally-focused treatment, avoiding the language of psychology as much as possible.[3] Although many men refuse referral to a psychologist and some drop out of treatment, it helps most patients to have an accurate assessment of their syndrome and a recommendation for appropriate therapy.

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Commentary

MANY men who present with genital pain have no apparent organic explanation for their symptoms. The practice of many urologists is to treat these men as if they have chronic prostatitis, despite lack of evidence to support the diagnosis. Needless to say, this results in much inappropriate antibiotic therapy.

The current study suggests that a large number of men with atypical genital pain have an underlying psychological disorder as a causative factor. The patients reported by the author were selected, in that a psychological referral was made by the urologist and accepted by the patient. This introduces the possibility of bias in favor of men willing to articulate psychological problems. As noted, however, this was a pilot study whose results suggest the need for a prospective controlled study. In the meantime, it is advisable to consider psychosomatic factors as part of the differential diagnosis and to recommend referral to mental health professionals when appropriate.

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