

# Psychiatric Problems in Urology\*

JAMES L. MATHIS, M.D.

*Professor and Chairman, Division of Urology, Medical College of Virginia,  
Health Sciences Division of Virginia Commonwealth University, Richmond, Virginia*

The emotional charge invested in the genitalia far exceeds that of any other part of the human anatomy. Both the conscious and the unconscious feelings about the genitalia are subject to gross distortions which do not respond readily to logic or to intellect. This means that the complete urologist must view the emotional aspect of his area of work from two angles:

- 1) Illnesses, injuries, and manipulations of the genitalia, regardless of etiology or need, may produce major emotional upsets in susceptible people.
- 2) Symptoms involving the genitalia may be the first and most prominent expression of an emotional disturbance.

An example of an emotional disturbance which was precipitated by (you will note that I do not say "caused" by) genital manipulation occurred with a 45-year-old aide at a Veterans Administration teaching hospital. Hematuria had been discovered in the aide's urine upon a routine physical examination. The cause could not be determined readily, and he was admitted to the hospital for a cystoscopy which was done by the chief resident in urology. The procedure did not yield a diagnosis, and the aide was discharged with instructions to be readmitted in three days for a more complete work-up. He returned to his ward work but adamantly refused to have any further procedures even though the cause of his urinary bleeding was still undetermined. His nursing supervisor asked me to see him in consultation when he was heard making threats toward the cystoscopist.

The aide spoke freely and convincingly of what the urological resident had done to him. He was perfectly accurate in his details, except that he

quite irrationally misinterpreted the entire procedure. He had not been able to get an erection since the cystoscopy, and it represented to him a gross homosexual assault which had deprived him of his "manhood." He was so enraged that he was determined to kill the urological resident. The aide was not psychotic nor out of contact with reality in any other sphere.

Two one-hour sessions with the aide resulted in detaching some of his rage from the urological resident and in getting him to see that there might be other causes for his impotence. He remained quite suspicious, however, and would not agree to more urological examinations. Before his next appointment a few days later, a perfect stranger jostled him on the street as he was entering a neighborhood bar. Unfortunately, he had been hunting rabbits that morning and he had a shotgun in his nearby car. He quickly took the shotgun from the car and literally blew the head off the man who had accidentally bumped him. He had displaced his rage from its original object, the cystoscopist, but it obviously was still there.

This anecdote represents a type of paranoid reaction which is not uncommon after genital manipulation or injury, but fortunately most are not so severe and do not end so tragically. The operating urologist had not communicated fully to the patient; he did not make certain that the patient had a complete understanding of the procedure, and he did not work with the patient after the procedure to make certain that there were no overt or covert misunderstandings.

Janis (2) stressed that surgical procedures about genitalia produce an inordinately high level of anxiety in most patients and that it may be catastrophic in some susceptible individuals.

An example of the genitalia becoming symptomatic as an expression of an emotional reaction occurred in a young housewife who presented herself

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to her family doctor for dysuria. The physician found nothing of note and referred her to a urologist. He found no reason for the painful urination, and the patient did not return. However, over the next one and one-half years, the patient visited many urological clinics throughout the country and spent several thousands of dollars. The symptoms persisted despite innumerable urethral dilations, the installations of many medications, and several ineffective prescriptions for urinary tract sedatives and antibiotics.

She came to the attention of a urologist in a teaching center who was interested in the emotional aspects of his patient. He took a very careful history which included a detailed account of her sexual life and of her feelings about it, and he discovered that the dysuria had originated under the following circumstances: The lady and her husband had been to the country club one evening and had had more than their usual number of martinis. In some sexual play at home her husband titillated her clitoris with his tongue, and she had the first orgasm of her life. A few days later they repeated the act after several martinis, and again she had a gratifying orgasm. The next day, however, she began to have pain and burning upon urination.

The final urologist allowed her to vent her feelings of guilt and allowed her to express the fact that she felt that this act had made her some sort of a "pervert." (Like many superficially sophisticated people, she also was very fundamental and conservative in her basic beliefs.) During these brief sessions he was able to communicate to her that she was in no way abnormal but that she might need a bit of work concerning the fact that she had been unable to have orgasm by other methods. The dysuria stopped on approximately the fifth visit and had not recurred at a two year follow-up.

Sexual problems in the female frequently are expressed as urinary dysfunction. The intimate anatomical and neurophysiological connection between the lower urinary tract and the sexual apparatus is obvious, but many times it is not so obvious that the female uses this part of her anatomy, especially the urethra, to express conflicts in the area of sexuality and hostility (4). The symptoms may vary from urinary retention to dysuria, frequency and incontinency. There does not appear to be a one-to-one relationship between the symptomatology and a specific sexual conflict, but some degree of anger, frustration and/or general hostility frequently

is seen. Some of our vernacular statements, such as "Piss on you," indicate an unconscious awareness that the urinary functions can be related to strong emotions, frequently hostile. There can be no substitute for a full sexual and marital history as a part of the diagnostic work-up in every patient with complaints involving the genitourinary tract, even when they are of obvious organic etiology.

Another group of patients, those with a diagnosable mental illness, frequently present with complaints involving the genitalia. For example, the conviction that there is a urinary tract infection, frequently a venereal disease, is quite common in severely depressed and in schizophrenic patients. One young man, a 25-year-old farmer with borderline schizophrenia, went to his family physician with the conviction that he had gonorrhea. No infection was discovered, and the patient was dismissed. This did not change his conviction, of course, so he visited a urologist in a nearby larger town and was given the same information. The urologist had done a good diagnostic work-up, but he had ignored the possibility of a deeply fixed delusion which, in fact, existed. The young man went home and put a .38 caliber bullet in his head. The physician's responsibility is not finished simply because there are no positive physical findings to explain the complaint.

Many mildly disturbed adolescents are convinced that they have an undersized penis or distorted testicles and present to the physician with this complaint. Undue examinations or manipulations do nothing to ameliorate the deep anxiety and may serve to fix the idea more firmly. The complaint usually represents grave doubts of sexual identity and/or of general adequacy and should be viewed as a warning sign. Simple reassurance by an authority figure may be sufficient, but the adolescent should be encouraged to voice his deeper feelings.

No discussion of the psychological aspects of urology can ignore impotence. The ability to achieve and maintain an erection suitable for sexual activity is one of the prime measures of manhood in Western society. Earlier, and perhaps more thoughtful societies, included religious ceremonies and frequently had specific deities to insure man's continued potency. The Egyptians, in keeping with their extremely compulsive attention to all details, took pains to insure that this part of man's existence would continue in the after-life by mummifying the penis in the erect position. Judeo-Christian religions solved the problem by completely doing away with

any form of sexuality in the life hereafter. In order to accomplish this, it was necessary to classify sex as a sinful thing to be avoided except for procreation. Thankfully for those of us who came after them, they were not able to succeed entirely, but they did leave us a legacy of problems which still plague us.

Differentiation of psychogenic impotency from that of organic etiology usually presents no great problem. Impotency of organic etiology is rarely selective in nature, but the reverse is true for that of psychogenic origin. The physician determines whether or not the man achieves erections during dreams, upon arising in the morning, during masturbatory attempts, with daytime fantasies, or with one woman and not another. A positive response to any of these areas goes a long way toward ruling out organically produced impotency. A major exception to this is the impotency which accompanies severe depression. The impotency of depression may cover all areas of sexuality, but the crucial point here is that the desire will be just as absent as the ability. The lack of potency will be of little or no concern to the patient who is truly depressed; whereas, it usually creates great anxiety in non-depressed males.

Whether or not the urologist chooses to treat male impotence, he cannot avoid his diagnostic responsibilities and the need to counsel the patient about possible treatment. Many patients respond to a type of superficial educational counseling quite within the ability of any physician, but all will appreciate the opportunity to talk to an interested and knowledgeable authority and to receive guidance toward the proper treatment.

Time does not permit discussion of all the many urological entities that have a major psychiatric component. In general, we have said that all genital manipulation should be considered from this viewpoint, but obviously some have a greater significance than others. The manipulations involving children are always of extreme importance, and the urologist who treats children must have an understanding of the developmental phases of childhood and what they mean to future emotional adjustment. In general, such procedures should not be done unless absolutely essential, and if the child's history indicates that emotional problems already exist, then a consultation with a child psychiatrist is mandatory.

It is equally important for the urologist involved with procedures such as kidney transplants to know that both the patient and the donor frequently have

rather severe emotional reactions. Most of these reactions appear to be preventable if adequate concern is given to them before surgery. Donors, for example, frequently develop feelings of anger and rejection (1). They seldom are given the sort of credit and adulation which they think their major sacrifice warrants, and reactions of passive-aggression and depression are not uncommon.

There have been equally important reactions in those receiving kidney transplants (3). One center, for example, has noted that a recipient who is still living in excellent physical health after more than ten years has failed to function at even the most rudimentary level since receiving his new lease on life. While this may be considered a surgical success, it is by no means all that could be desired. Marked attention to this aspect must be considered just as significant as the more technical problems.

The crux of this aspect of urology is that in no other medical speciality is a complete emotional history so important. Patients will not volunteer much of the significant material unless asked. For example, a 44-year-old professor of engineering had a routine, elective hemorrhoidectomy. He was seen in consultation by a urologist when he was unable to void spontaneously by the sixth postoperative day. Nothing was effective and eventually some operative procedure was done transurethrally. The patient still could not urinate when the catheter was out. Another procedure, a bladder neck resection, was performed with no results, and after several weeks, a psychiatrically oriented urology resident sat down with the patient and took a complete history as follows:

The man was unmarried, lived alone with his mother, had never had a sexual life beyond masturbation, and had not even had a girlfriend. He had never been able to urinate in any public place without being totally alone and while sitting on a toilet seat. Even at home he had trouble starting a stream while standing and had never in his life urinated while another person was in the room with him.

This history should have alerted the original surgeon and certainly would have warned the urologist to avoid surgery if at all possible. If not possible, he would have done as little as possible while working with the patient's emotional problems or asking for psychiatric consultation.

Major diagnostic problems with, or genital surgery upon one member of a marriage should always include the partner. Valuable information may be obtained by interviewing the partner, and many

false beliefs may be corrected with a beneficial effect upon the patient. For example, the wife of a man scheduled to have a prostatectomy of any type has many fantasies of what will happen to his sexual abilities. She should be encouraged to express her thoughts; then she should be given the facts as the urologist sees them. This is equally true of any form of genital manipulation.

The urologist may wish to consider himself primarily a surgeon and wish to avoid the role of sexual consultant or marriage counselor. That is hardly possible for one whose field of work is the genitourinary system. Patients expect the urologist and the gynecologist to be experts in all areas of sexuality, and perhaps they have a right to do so. The well-read patients of today expect the urologist to explore the sexual and marital aspects of their conditions and to counsel them accordingly. This means that the complete urologist needs expertise in the techniques of interviewing as well as in the techniques of surgery.

In summary, the urologist cannot escape from a major responsibility for his patients' emotional com-

ponents. The very area of his work is highly charged with emotional potential, primarily of a sexual nature. A careful sexual history is essential to the full understanding of the symptoms of many urological complaints and is equally necessary for the prevention of emotional complications to genital surgery.

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