EMOTIONAL PROBLEMS OF GONORRHOEA

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GONORRHOEA is defined as "an inflammation of the genital and lower urinary passages causing a purulent discharge due to inflammation by *Neisseria gonorrhoeae*, commonly known as gonococcus. The infection may spread or be carried to other parts of the body such as the mucous membranes of the rectum and conjunctiva, the synovial membranes and fibrous tissues of the joints, tendon sheaths and bursae, and much more rarely, the endocardium, pericardium, pleura and meninges" (Harrison 1955).

This definition covers the aetiology and all the possible complications of the infection, except one—the psychological complications. Though much has been written about the venereal diseases, there is no reference to the emotional aspects of gonorrhoea, as there is with syphilis. And yet this disease is greatly dreaded. Here in Nigeria, as in many parts of the tropics, gonorrhoea is the commonest venereal disease. It is seen with such frequency in medical practice that there is a tendency to 'take it for granted'; and more so since the advent of the antibiotic drugs. It is so common that in a busy clinic the patient's diagnosis may be accepted and treatment initiated without examination of the patient. It is therefore not surprising that treatment is often ineffective. Under the prevailing conditions it appears easy to understand why the emotional involvement in gonorrhoea has been neglected. Or is it due to the subconscious condemnation of the patient—'serves him right for living an immoral life or for being weak'?

Any doctor who has practised in Nigeria, especially in and around Ibadan for some years, cannot but be impressed by the fear, of almost phobic intensity, in which this disease is held. All sorts of conditions are attributed to it. It is not uncommon for patients to cite gonorrhoea as the cause of their hernia or hydrocoele, or even a pyloric stenosis. The phobia of gonorrhoea can be compared with that of cancer in the more advanced countries. This fear is accompanied by all sorts of psychosomatic symptomatology. It is this

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aspect of the illness—the psychological complications—that I wish to deal with here.

This letter from a patient is pertinent and is therefore reproduced in full:

"Hello Sir,

This is to refer you to the conclusions of my last visit to you, and I wish to be there some days after you must have received this letter.

Of course the problem is still the same, though you doubtlessly convinced me that I was suffering from a sort of psychological impulse, but I think that is judging too much from my appearance, hence I will be much relieved if the doctor can help with the following facts as an aid for him:—

1. The fact was I had contracted the disease about five years ago. It was treated both with native and English medicine, and I had no doubt about its exhaustion from my body until recently.

2. I came to see the doctor last time with the complaint of right shoulder pain, usually severe at night. That my urethra was very hot when it was erect, but the doctor brought me to the point that it was all a psychological trouble, and I was such a credulous fellow, hence I could go no further.

3. However the trouble continued, hence I went to a chemist. He tried a lot and the treatment he gave was very effective for a while (for the shoulder pain and all the rest of it went down) but he could not ascertain whether the treatment was enough and what other precautions to follow, hence the halfly cured disease started again, and from that it is sure the statement I gave was real, hence I strongly need the doctor's help.

To my opinion, I think it is now a complicated sort of disease and what I observe are these:—

1. Firstly, it was only the right shoulder, but recently I feel the pain at both.

2. I think there are some dislocations of some of my joint bones, hence there is usually some cracking at the heel and pains at the wrists.

3. Occasionally I have constant dizziness of the eyes.

4. The vas efference pains, and I always feel a sort of weight has been pushed down through it.

5. Actually I cannot differentiate between hottness and pains, but my urine is always yellow, sticky at times and pains too.

6. Inflammation at some muscles e.g. the pelvic muscles.

7. I feel always, at all times, bubbles moving down at all parts of the body i.e. something like the lather of soap being forced down through the muscles.

8. Lacking of instinct of having sexual intercourse, and weakness of the penis—which I think is getting me near being sterile, for in the morning the penis does not move and the honeymoon dream had never happened since the last three years—instead nothing comes and I feel stiffness at the penis.

9. Constant headache and cold.

10. The failure of the penis—completely weak.

Actually I want the whole care to be under a special care, because a health adviser of the Welfare advised that it could not be cured completely and success-

fully too, except with the strict supervision of an experienced doctor, and I hope you will do your best to help me.

Thanks, Sgd. T.N."*

A look at his record showed that the patient was seen five months previously with a history of right shoulder pain of seven months duration. He had heat in the urethra when he had penile erection. He also complained of some dysuria and spermatorrhoea. All examinations were negative. The patient came armed with a bacteriology book and asked a lot of questions about gonorrhoea and its possible complications but denied ever having had the infection: a fruitful discussion.

At his next visit the following additional information was obtained. He had had gonorrhoea five years previously—one week after coitus he noticed urethral discharge, slight dysuria and some pain in the penis, but there was no frequency of micturition. After having no treatment for two weeks he had native treatment which was ineffective; he then took 12 tablets of penicillin and there was no urethral discharge for about three weeks. He then noticed some more urethral discharge and so took 20 tablets of penicillin, after which he had no complaint for about two years, then he noticed his urine was dirty and sticky. There was also very slight 'pus' per urethram on penile massage early in the morning—he said he thought there were some sores in the urethra and that pressure would express the 'pus'.

At this stage he bought 100 tablets of 'urofix' but these had no effect. He said that he then became careless about noticing urethral discharge. About a year ago he noticed some pain in the right shoulder which was very severe at night. He thought he had rheumatism, attended a general hospital and was given some tablets but had no relief. It was then he noticed some heat in the urethra with penile erection.

The patient was a Roman Catholic. He denied guilt feelings at extramarital sexual intercourse, but admitted fear when he noticed the urethral discharge. However, he admitted guilt feelings following frequent masturbations and fear of shortage of semen, blindness, sterility or impotence, and so tended to brood. He said he had no interest in social contact and that his work dragged. He had insomnia—slept early but woke in the middle of the night. His bowels were regular and appetite good.

*The importance of this letter may be summarized as:

(*a*) Motivation for treatment. (*b*) Insight into his illness. (*c*) The degree of somatization very common in all types of depressive illness in this country. (*d* The phobia of impotence.

The case summaries of a few other cases are given below:

Case 1. Mr G.E. Two years previously Mr G.E. had sexual intercourse and had fever the same day. Three days later he noticed a bead of urethral discharge after penile massage. There was never free urethral discharge, dysuria, or frequency of micturition. He consulted a native healer and was given some treatment, but there was no improvement. He then consulted a doctor in town who prescribed pills, but still no improvement.

By the time he was seen he complained of heat in the abdomen and waist. He also had crawling sensations all over the body and biting sensations in the skin. He had dimness of vision and discharge from the eyes which cleared up with rubbing the eyes. He was married and had a seven-months-old baby. His complaints, however, had started before he got married. His wife occasionally complained of heat in abdomen but had not related it to anything. There was no history of heat and crawling sensations previously.

Case 2. Mr G.C.A. Mr G.C.A. said that in March 1965 he noticed urethral discharge and consulted the doctor in the general hospital near his station. He was given 12 injections without improvement. He was then referred to a specialist in a nearby town where he was thoroughly investigated, including x-ray examination. He was given a course of albamycin T orally but said that he still noticed urethral discharge on penile massage every morning. The specialist reassured him there was no cause for alarm, but he bought some more albamycin T tablets from a chemist. Still there was no change. He then returned to the doctor in the general hospital who gave him seven more injections without improvement. He claimed that he was then subjected to bouginage. By this time he became worried and took a course of 15 injections from a quack. He had become very apprehensive of sexual intercourse with his wife, and when he did try he failed woefully.

When he was seen, he said that he had no sexual urge most of the time. There was never pain in the urethra or dysuria, but after micturition he felt as if his bladder was still not empty and he had to pass urine again about ten minutes later. He said that he developed some heat in the back since onset of illness, but had improved after treatment by the specialist.

There was no headache and his appetite was good. He said he was worried by his impotence which had not been cured after all the treatment he had had. He was married and had two children, but had kept away from his wife sexually. He did not know what his wife thought of his abstention, but felt sure she was worried at his lack of interest; besides she had weaned her baby. She also received eight injections from the doctor at the general hospital.

Case 3. Mr B.U. Mr B.U. complained that three months previously he had gonorrhoea—four days after coitus he had noticed some urethral discharge following urethral massage. There was never dysuria. He consulted a doctor and was given a course of injections without improvement. He had waist pain, slight biting in the penis, but no urethral discharge without penile massage.

Mr B.U. was married and his wife was nursing a baby at the time of consultation. He admitted to being worried, especially when the back pain was on. When a soldier in the last world war he had a previous attack of gonorrhoea and was an inpatient for three weeks. After his discharge from the army he had a spell of weak penile erection, attended a mission hospital near his home town and got better. He complained of heat in both feet of about one month duration; also heaviness in occiput when lying down. At the time he contracted the infection, the patient was unemployed—he said he took to drink and so got into bad company. At the time of consultation he was in a settled job.

Case 4. Mr A. The story was that four days after sexual intercourse some months previously, he felt some pain in the penis. There was no urethral dis-

charge but he had dysuria. A month later he noticed a bead of 'pus' per urethram following penile massage one morning. Two weeks prior to this consultation he had noticed irritation in the penis and backache. He said he felt nervous and trembled all over—this happened whenever he was busy working and he had to abandon whatever he might be doing. He complained of severe backache and waist pain since the day before consultation.

Mr A. was a Roman Catholic. He expressed guilt feelings because his religion taught that extramarital sexual relationship was sin. But he felt better after confession and doing his penance. However, when two weeks ago he felt some irritation in his penis—he had abstained from sexual relationships since the previous experience—he became afraid. There was dysuria, frequency of micturition, but no discharge per urethram.

Case 5. Mr A.A. Mr A.A. was seen with a history of intermittent swelling and pain in his right scrotum, spermatorrhoea on defaecating, and frequency of micturition. He also complained of dysuria for one month, urethral discharge after micturition, and abdominal colic. He said that six days after coitus with a casual acquaintance he noticed some sticky substance on his penis after micturition. There was no pussy urethral discharge, but there was slight dysuria with the urinary stream splitting into several streams. He complained of frequency of micturition, abdominal discomfort which was worse after hot food or drinks, and pain in the anus. He consulted friends who advised him to buy some antibiotic capsules—he bought 16 capsules terramycin—but there was no improvement. He then went to the general hospital where he was given four injections with improvement in the anal pain, but no change in the other symptoms. One week before consultation he noticed that the right testis was larger than the left and became worried about his future, for he had been told that gonorrhoea made one very weak sexually, impotent, and infertile. He had been so tired he could not cope with his duties as a domestic servant.

Discussion

The complaint of gonorrhoea usually means a purulent urethral discharge and therefore covers non-gonorrhoeal urethritis, and trichomonal infection as well as true gonorrhoea. Failure to recognize this fact when a patient presents with a complaint of 'gonorrhoea' leads to ineffective treatment, with consequent emotional complications. When a patient has been to several clinics and his urethral discharge persists, he invariably develops a phobic state of serious emotional consequences. Nnochiri (1964) reported of cases of trichomonal urethritis who admitted to having received as many as 50–100 injections with no benefit.

The incidence of gonorrhoea has been on the increase in Britain since the last war (Wilcox 1963, 1965), and in Lagos, Nigeria (Nnochiri 1964). The impression exists also of high incidence of gonorrhoea here in Ibadan, even though there is no statistical evidence in support.

Wilcox (1963) stated that venereal diseases have always rightly been regarded as social diseases, reflecting situations and habits in the communities concerned, and not solely as medical problems; they were an index of promiscuity which is their basic cause; and later (1965) he suggested that the recrudescence of gonorrhoea since

the fifties, despite the use of antibiotics, involved many factors such as detribalization, large-scale population movement and integration, a more rapid exchange of ideas than ever before with modern mass media, and rising standard of living with increasing potential for travel at all levels. There are thus mounting opportunities to acquire, not only venereal diseases but new standards of behaviour and values, all of which are operating today at a pace which was never before possible.

These findings in Britain could have been written for the big towns in Nigeria, with the addition—that in Nigeria antibiotics by injections or orally are freely administered by non-medical personnel, as shown in some of the cases above. Nnochiri (1964) found the same situation in Lagos.

The serious and crippling emotional problems of gonorrhoea are found in connection with the following factors:

1. Sterility—This is of phobic proportions in prostitutes, partly because of secret longings to escape the grips of prostitution, settle down with a man and raise a family, and partly because the infection is detrimental to business. Men feel that gonorrhoea will make them sterile.

2. Impotence—This offers a great threat to his maleness, and in a culture where polygamy is practised, it is a great tragedy if a man is incapable of sexually satisfying his wives, or is unable to have children. Emphasis is placed on sexual potency in this culture.

This situation is made worse by poor erection or premature ejaculation, both conditions arising from fears or guilt feelings of the victim, thus setting up a vicious circle. In this culture the highest premium is placed on sexual potency.

3. Guilt feelings—Mainly in cases arising from extramarital adventures usually with strong religious background. In the latter type, as with Roman Catholics, confession and penance relieve the tension because they believe that their sins are forgiven. However, most of them suffer from fears of possible transmission of the infection to their wives and thus being found out.

4. Paranoid tendency—Bongoro blamed his copious purulent urethral discharge on his wife's seducers. He alleged that his enemies took his wife from him, and then by witchcraft they had tortured him by inserting broomsticks into his urethra and twisting them round and round!

Lambo has reported that schizophrenic-like reactions are often found among undergraduates who have had such experiences. These students are introverted, ruminative, and exhibit signs of inferiority complex. They are usually pre-occupied with religious ideas. Very

often they operate on the periphery of the group and are unable to fraternize with the undergraduate population, and seek solace in the anonymity of association with prostitutes. The emotional reaction of these students to gonorrhoeal infection or any form of urethral discharge tends to be very violent.

5. Depression—usually due to the failure of scientific medicine to cure their infection. Depression may be somatized as heat in waist or abdomen, thighs or urethra (Mbanefo); impotence or lack of sexual desire.

6. The shock to first offenders—as in the case of T.N. above, who contracted his infection at the tender age of 14 years. This emotional upset could be so severe that the patient's future sexual life will be adversely affected. The author had as a patient a young man who on two successive sexual episodes, soon after his arrival in Ibadan, had gonorrhoea. His faith in women was so shaken he cried during consultation.

7. Finally, hypochondriasis which gives rise to the regular inspection of the urethral orifice after penile massage first thing every morning. The bead of 'pus' at these early morning exercises or the glistening reflections of light by the mucous membrane may perpetuate the practice and cause deep fear. Hence the patient often states that the 'pus' only appears first thing in the morning but disappears after micturition. He tends to get morbidly occupied with his penis.

This early morning massage may progress to masturbation with consequent guilt feelings and fears of exhaustion of the store of semen and thus becoming impotent.

It is therefore vitally important that for every complaint of gonorrhoea certain steps must be taken:

1. A good history—urethritis arising three to seven days after sexual intercourse, with dysuria, is likely to be gonorrhoea. The author had a patient who had consulted several doctors, took so many injections, bought antibiotics from chemists, and consulted native healers, over a two-year period all because he woke up one morning, felt some irritation per urethram and consulted his elder brother. The brother diagnosed 'gonorrhoea' and despite the young man's denials of any sexual adventure, sent him to hospital. There was neither urethral discharge nor dysuria. At the hospital the patient's diagnosis was accepted and treatment initiated without any investigation. No wonder he never found a cure for his 'gonorrhoea'. He was seen in a state of depression.

2. It must be borne in mind that purulent urethral discharge may

be due to non-gonococcal infections. It is therefore essential, whenever possible, to clinch the diagnosis by bacterial examination.

3. Post-treatment examination and follow-up, especially in patients who exhibit more than normal anxiety about the infection. Such patients must be given the opportunity to express and discuss their fears.

4. As most cases first present to general practitioners, who have to rely only on their clinical experience for diagnosis, if the infection fails to respond to antibiotics or metronidazole (Flagyl M & B), more thorough investigation is indicated and the patient must be referred to a centre where this can be done without delay.

By these means, the general practitioner, who is consulted in the first instance, will be effecting primary prevention of mental illness (Mbanefo 1965), in addition to seeing that his patient is adequately treated.

Summary

1. The emotional complications of gonorrhoea are discussed.

2. Possible steps to be taken in dealing with cases presenting with a history of 'gonorrhoea' are suggested.

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