Psychosomatic-Psychotherapeutic Approach to Chronic Pelvic Pain in Women

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Introduction

Treating women with nonmalignant chronic pelvic pain often demands both a medical and a psychological approach. For more than 30 years a model has been applied at the gynecological department of the Karolinska Hospital, in which training in psychiatry and psychotherapy is used as a therapeutic tool in near collaboration with the gynecological-surgical staff.

Sample and Methods

Thirty women suffering from chronic pelvic pain for more than 6 months were referred for psychosomatic treatment during 1983–1984. Sixteen women (group A) had some minor pathological somatic findings but the gynecologist who referred the patient considered further surgical treatment meaningless or even harmful, or had felt that the patient needed psychological support. The other 14 (group B) had no evident pelvic pathology.

Treatment consisted of consultations in the outpatient clinic, lasting 20–60 min and characterized by a psychotherapeutic approach in combination with medical care, a very nonorthodox psychotherapy. When surgery was required, one of the other gynecologists performed it. The basic rule in the treatment was to accept the bodily pain as a reality [1], but with this attitude as a starting point, invite the woman to discuss many other important aspects of her life (Fig. 1): “How can you manage your work, holidays, and pleasure when you have this pain? How is your family life while you are suffering in this way? Do you remember anything from your childhood about painful experiences, your own or another significant person? What will you do when you recover?” Furthermore, when necessary, vaginal examinations were performed with utmost respect, in order to change her view of her genital organs, if this was negative. By teaching and discussing during these consultations, the women were offered the opportunity to obtain a firm cogni-
tive framework regarding her bodily functions and anatomy. Furthermore, the medical care was often used as a symbolic caretaking of the whole individual. Finally, strong efforts were made to resist the patient's and the physician's depressive feelings of hopelessness and giving-up [2], applying the old art of the physician – just to be near the sick person. All consultations were performed by the author.

The 30 women treated in this way were retrospectively followed up by means of analysis of the medical and psychosomatic records and by a questionnaire, sent by the professor at the clinic and a social worker.

Dropout from the questionnaire was high; nine women did not answer.

**Statistics.** A nonparametric method, Fisher's exact probability test, was used. The study was approved by the Ethical Committee of Karolinska Hospital.

**Results**

The mean age of the women and the number of children born by the women were almost similar in groups A and B. None of the women had a university or other higher education (Table 1). Eight women had suffered from their pain for 8 years or more, only eight women for a shorter period than 2 years. More than half of the women reported fluctuations of pain during the menstrual cycle (Table 2). The number of visits ranged between a few to 20. Almost half of the women were still under treatment at the time of follow-up.

Information about some psychological characteristics were collected by analyzing the psychosomatic records. The majority, 24/30 (80%), had reported feelings of depression and/or sleep disturbances. Furthermore, self-esteem was low or ambivalent in most of the women. Almost all of the women reported sexual difficulties although two-thirds of them considered their relationship to the partner as good or rather good (Table 3). Two-thirds of