Infertility Presenting As Psychiatric Illness
The Psycho-dynamics of infertility

By M Shallan and F. Kamel

I. Infertility presenting as psychiatric illness:

B.H. is a 43-years old married woman who works as a teacher of handicrafts in a primary school. She came from Benha referred by her physician seeking treatment for her present illness. Her complaints included : feelings of boredom and sadness with a constant wish to cry and scream. She was also feeling irritated and lacking in appetite. She was unable to sleep easily except with the assistance of a tranquilizer, and when she did, she often woke up disturbed in the early morning hours, and generally would not resume her sleep. There were somatic symptoms such as blurred vision, paraesthesias and heaviness in the arms, nausea and abdominal and back pains.

This condition had developed about three months previously but four months prior to that she had a haemorrhoidectomy. The operation was followed by some minor complications which necessitated her staying in bed for some time. She then developed a low back pain which was confirmed by X-ray diagnosis to be due to spondylotic changes in the lumbar vertebrae (osteophyte formation, narrowing of intervertebral spaces and sacralization). A belt was applied and physiotherapy was recommended but had not commenced yet.

Her busband who, along with her sister, was accompaying her, supplied additional information that she had a long history of morbid preoccupation with her health. This concern took on such forms as seeking the consultation of ten physicians at once because she developed a belief that she suffered from a malignancy in her uterus. Her actual condition was of cervicitis and mennhorrhagia. This had been going on for ten years beginning shortly after her father's death, five years after

her marriage. She had been nursing him in his terminal illness and indicated that she had a strong attachment to him, much more than to her mother. She was the older of two daughters in the family.

However, there was another factor which was associated with the accentuation of her overconcern with her physical health. She had been admitted to Ma'adi Military Hospital three years ago for a laparoscopic procedure aimed at repairing her Fallopian tubes by a visiting gynecologist from Europe. While waiting her turn a fellow-patient had told her of the remote chances for cure that were associated with that procedure; consequently she got frightened and got up and left the hospital. This was the last in a series of investigations for infertility which had been going on for over 10 years. One year after marriage to her present husband it was realized that she was not fertile. She was eager to have children by him because she was afraid he might leave her. Prior to marrying her, he had just been divorced from his previous wife who remaried and left him with three childen. Our patient was then twenty-seven and after a brief meeting got married to him. Though he was earnest in pursuing medical care for her condition, he was not himself very eager to have children, already having three of his own. She went through various medical and traditional procedures. These latter included magic and supersititious rituals. The belief that her condition was due to a "'Amal" (a form of black magic) led her to consult Sheikhs and others for counter-black-magical procedures such as the "Hejab" (written material appended to her body or attire). Again she went through three sessions of Zar, but without physical benefit albeit with (very limited) psychological benefit. Another prescription was to kill poultry and bathe herself with their blood, then remain unbathed for three days. Though this was an unpleasant experience, the hope for cure alleviated its impact. However, no benefit came out of the procedures any more than from numerous medical procedures she went through, including laboratory, radiographic and clinical procedures and hordes of medical prescriptions.

She added that her menstrual cycles were always irregular with regards to timing and quantity of bleeding. Her premorbid personality

was of an outgoing, active and energetic nature. In addition, to her function as a teacher she was an efficient housewife and took very good care of her step-children who referred to her as "Mama" and were very appreciative of her. Yet in her present illness she tended to misinterpret any remark they made as being directed against her.

She was prescribed with antidepressive medication (motival 5, which is a combination of fluphenazine I mg. and nortryptilline 5 mg, twice a day, and amitryptilline 25 mg. in the evening). She was instructed to cease complaining and seeking medical help (for her present symptoms) until she would be seen two weeks later. In addition she was to be engaged in activities (handicrafts).

Comment : This is one example of those cases in which help is sought for psychiatric symptomatology where infertility is an important underlying complaint. In this case the infertility was the primary concern and the apparent cause for medical referral. This was maintained as long as it was perceived to be a medically removable condition. As medical and non-medical procedures failed to show any visible improvement she gradually went on to a substitute focus for her concern; her physical health. Such over-concern actually reached its aims when she finally gave up pursuing a cure for her infertility about three years ago. However, her hypochrondrial defenses could not maintain the homoestasis indefinitely. Her husband, though tolerant and generous with her medical needs, could not tolerate the situation much longer. In a private interview, she denied that privacy was necessary, and did not add any information that she could not mention in the presence of her husband and sister until, after having summoned them, she mentioned as they were entering, that she was angry with her husband. When this comment was pursued, (and not spontaneously) she indicated that his tolerance to her illness had diminished markedly of late. He explained that, while she was almost totally inactive, he could envisage her making a ten-kilometer walk on foot if a doctor's office was her destination.

Thus, the unfolding psychodynamic of her core feelings proceeded

through the years. She was essentially concerned with her marital stability. She also wanted to secure her love-oject's concern for her. At the outset she had married a man who himself was insecure concerning his marital stability : Despite three children his first marriage ended in divorce. He was uncertain that any woman would remain with him "for better or for worse". She, on her part, also felt insecure, having reached the age of twenty-seven without marriage while her younger sister was already married (a generally unwelcome situation in most middle-class Egyptian families). She was uncertain that a man could want her "for better or for worse". With this feeling of insecurity in common between them they had at least a ground for meeting in a pact that was presumably geared to compensate for that deficiency. Both feeling unneeded, they shared the need to feel needed.

Having atained a preliminary satisfaction of that need, its further expression could be entertained. Thus she could demand that she have more basis for securing her husband's relation to her than their mutual emotional needs (to be needed). She wanted to procure an offspring that was a product of their physical union. His other children were after all not hers physically, though emotionally she was relatively successful in sharing them with him. She would, in this manner, be assured that his cathectic investment in her would be ensured by an egotistic motive due to that "extension of both of their bodies".

When this was not physically feasible on account of her infertility her own underlying egotistical need became more visible : that her husband cathect **her** body (rather than through their joint offspring). There were two avenues for such cathexis : one, which could be described as positive and life-enhancing, and the other, negative and life-inhibiting. These could be either an entirely erotic interest in her healthy body or a morbid interest in her unhealthy body. In this case the latter became predominant. Illness, especially physical illness, was her surest way of securing her male partner's attention. Doctors being a respectable sector of society, were her witnesses of defense as well as competitors offering such attention when her husband failed. By authoritative acknowledge-

ment of her over concern with her body's physical integrity, they gave her the legitimacy to demand her husband's concern.

However, ten years of treatment without satisfactory outcome, was tiring to both patient and doctor, and a point came when both had to confront the need for attention in its pristine form.

Thus, as her depression unfolded, so did the underlying dynamics of her whole illness as part of a relation with her male love — object. She was insecure and needed attention in progressively increasing doses; when such attention was not provided in a positive, life-enhancing context, she went on to demand it in any other possible form. Starting with an interest in a potential object that was relatively non-egotistical, a joint offspring, it proceeded to another object, which was more obviously egotistical, her body. As this, in turn, was not enough and the underlying psychodynamics unfolded, she came closer to direct expression of her need for attention.

While she could heretofore say "not I but my body craves," now she was in more direct confrontation with her need : "I crave attention". At this point her husband, could, if from nothing but an expression of equal rights, say that while he could give that kind of attention, he too needed the same kind. Thus, they could become directly antagonistic. There were no more doctors, either as intermediatries or as competitors (This was the underlying rationale for the psychotherapeutic injunction to abstain from complaint, specifically medical complaint for the current symptoms).

CONCLUSION :

At this point we might pose the question : Was infertility the underlying illness and the depression its symptoms ? Or was the depression (due to the unexpressed and unfulfilled need for love) the underlying illness and infertility only one in a series of manifestations of that illness ?

No doubt, there was a physical basis for her infertility — the obstructed tubes — but illness consists of a combination of a physical defect plus a dissatisfaction with it that leads its owner to seek help (from a designated helper) a licensed physician or an informal traditional healer). It is this latter factor that forms the basis of one of our questions whether or not the underlying illness was the unfulfilled emotional need which provided the motivation for complaining.

If this were indeed the case, then would it not be possible from the outset, to detect such unfulfilled emotional needs, even though the overt complaint concerned the infertility ? Though its mere detection may not at first glance seem to be more than an additional problem for the physician, with which he is reluctant to deal with anyway, the first step towards finding a solution is recognition of the problem. Naturally such recognition would involve the active participation of two parties — the physician (as well as the social functions he represents) and the patient (along with her social milieu). This in turn would involve both in the treatment process. Rather than the omnipotent role of change agent, vis-a-vis the helpless role of patient, a different form for the physician-patient interaction might be envisaged. This would be a mutual, participatory-collaborative, problem-solving alliance between both.

In this light, infertility, even its manifest physical forms, would not be regarded as a merely physical-medical (gynecological) problem, but rather a problem of a more holistic nature.

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