PSYCHOGENIC INFERTILITY AND ADOPTION

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SUMMARY

It is suggested that a lack of normal maternal nurture is the most important factor on which the relatively high incidence of psychiatric disturbance in adoptees is to be explained. Psychogenic infertility is discussed and the psychodynamics thereof related to those responsible for the rejection of adoptees by their psychologically infertile mothers. A psychogenic infertility-adoption syndrome thus emerges. An illustrative case is reported.

In the discussion, recommendations are made whereby an improved situation can be achieved in respect of both the treatment of infertility and the management of adopting mothers.

It is probably a truism that in no other field of medicine does the psyche contribute so frequently and dramatically to physiological dysfunction than in gynaecological disorders. It is not surprising that the ancient Greeks looked to the womb for the source of hysteria. It is generally accepted that psychological factors control many cases of menstrual disorder, ranging from amenorrhoea and dysmenorrhoea to menorrhagia. Frigidity is essentially an emotional disturbance. Emotional factors may be important in vomiting during pregnancy and in uterine inertia, and a good deal has been written about psychogenic factors in certain cases of recurrent spontaneous abortion. Major forms of psychiatric illness are not infrequently associated with the menopause and puerperium.

There is a hesitancy to accept the role of psychological factors in the genesis of infertility in the female. A survey of the literature has shown that neither gynaecologists nor psychiatrists have given the concept of psychogenic infertility the attention which it deserves. It is with this topic that this article primarily will be concerned. The term infertility has been preferred to sterility. It is suggested that infertility implies a reversible state, whereas sterility relates to a condition based on organic pathology.

In the course of over 20 years in psychiatric work I have come to recognize my patients as the greatest teachers of psychiatry. It is essentially from these patients that the ideas which will now be presented have evolved. It was surely in his wisdom that Albert Schweitzer pointed out that it is not through knowledge but through experience of the world that we are brought into relation with it.

ADOPTEES AND THEIR ADOPTING MOTHERS

There seems to be little doubt that there is a high incidence of psychiatric disturbance in adoptees. Most writers are in agreement on this point, although some doubt was introduced by an investigation carried out by Goodman *et al.*[1] I have been impressed by the frequency of psychiatric disturbance in adolescent adoptees and through personal communication, child psychiatrists confirm a high incidence of disturbance in adopted children.

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Writers on the subject[2-4] offer various pointers to the possible psychodynamic factors in these cases. The psychological abnormalities usually takes the form of either a behaviour disturbance or a personality disorder.

The fantasies of the parents about their inability to have children are important. An adoptive mother needs a child to reinforce her biologic-sexual-social role, demonstrating femininity to both herself and society. But the adopted child is not a verification of this biological role and sexual identity from which she can receive gratification and pride. The child is a constant reminder of what is not possible, arousing in the adopting mother guilt about her inability to conceive, and feelings of hostility. The mother's ego is protected by blaming hereditary for the child's disturbed behaviour.

Problems of identity in adoptees are obviously encountered. The fact that they were saved and loved by their adopting parents reveals to them that they were abandoned by their biological parents. The immature ego cannot cope with knowledge of rejection by the original parents. Fantasies about these real 'bad' parents become active and all-important. With the fear of having been abandoned once for fantasied reasons, may come a fear of being abandoned again. Adoptees may tend to identify with their 'bad' original parents and, as Simon[2] and Schechter[3] point out, the disturbed behaviour of many adopted children is an attempted identification with the distant real parents. Schechter[3] suggests that an adoptee may intrapsychically continue a split between good and bad in his infantile object relations, since in reality he has two sets of parents. In their adolescence, in their search for their original parents and attempt to identify with them, adoptees often become involved in sexual acting-out and aggressive, antisocial behaviour.

While these observations all contribute towards an understanding of the psychological problems of adoptees, Toussieng,[5] a child psychiatrist from the Menninger Clinic, offers the most important contribution in this field. He quotes Deutsch[6] who believed that an adoptive mother's failure to develop motherliness is the major cause of later disturbances in the child. Toussieng points out that these parents have greater difficulty in emotional involvement than other parents. He suggests that the difficulty that these parents have in being close to their adopted child and in feeling genuine parental love for the child becomes an important aetiological factor in the child's disturbance. This is more significant than the child's later awareness of his adopted status.

Toussieng also maintains that if the parental figures clearly show that they view the presence of the adopted child as a narcissistic injury, as evidence that they themselves are 'damaged', the child in trying to identify with such parents may well acquire shaky and defective primary introjects.

A mother who has not yet worked through her conflict about being a mother is likely to show this in her all-

important early mothering of the child. Later, Toussieng continues, the child may be driven into fantasies regarding the real parents or into more disastrous forms of unreality. This is caused not only by the child's awareness of being adopted, but also by the fact that he never has been able to be 'real' in his relationship with parents who continue to consider their parenthood artificial and uncomfortable.

Toussieng leads one to the conclusion that it is the adoptive parents' unresolved resistance to parenthood that constitutes the major factor in causing emotional disturbance in the adoptive child.

In the course of treating emotionally disturbed young adoptees, I have had the opportunity of interviewing numerous adoptive mothers. With a quite remarkable consistency, these women provide a history of gynaecological disorders which might include menstrual abnormalities, sexual maladjustment of one sort or another, frequently frigidity, recurrent spontaneous abortion and, of course, infertility.

They will profess dismay concerning their inability to bear a child and there is no doubt that on a conscious level, this represents a true expression of their feelings. They have all most willingly undergone extensive gynaecological investigation and treatment in sincere endeavour to overcome their infertility. In some instances, they have been subjected to a surgical approach. After these efforts have failed, they have pursued the various avenues of adoption with relentless determination.

In discussing with these adopting mothers the problem of their disturbed children, certain characteristic features have emerged. The adopting mother tends to be lacking in warmth and leans more towards being coldly hostile. She sees the problem with an emphasis on how it effects her. Her attitude towards the child's distress is unsympathetic, affectionless and perhaps even blatantly rejecting. It is as if she feels that because the child is after all not her own offspring, but the product of goodness-knows-what heredity, she is justified in her rejecting attitude.

It is clear that these adoptive mothers experience an inability to provide their adoptees with normal maternal nurture. It is suggested that this lack is due to the same psychological forces which account for their infertility. It is probable, too, that these forces explain the history of menstrual disorders, sexual maladjustment and recurrent spontaneous abortion in these women. In her book, Deutsch[6] pointed out that the psychology of the adoptive mother is largely determined by the psychologic motives for sterility.

It should be noted that in those cases where adoptive mothers have been the victims of sterility caused by organic pathology, these psychological factors do not apply. The incidence and nature of emotional disturbances in the adoptees of these women could be expected not to differ fundamentally from children of the general population.

THE SOURCE OF PSYCHOGENIC INFERTILITY

In the case of psychological infertility, it is suggested that the woman is rendered infertile either by her emotionally sensitized state causing chronic spasm of her anatomically patent oviducts, or by psychic influences interfering with cortico-hypothalamo-pituitary relationships and resulting in anovulation. The source of this functional infertility must now be considered.

On a conscious level, these infertile women have a normal desire and striving for pregnancy after marriage, with motherhood as the goal. An assumption of femininity is, after all, incomplete without the climax of motherhood. But in these cases, anxiety and fear, arising from unconscious psychological forces, act as antagonists against the conscious strivings. Sometimes the conscious forces may triumph over those which are unconscious, and then a state of pregnancy will be achieved. In those cases where the conscious demands are unable to maintain their position of superiority in the conflict, spontaneous abortion will result. Where the unconscious forces are altogether too overwhelming in their strength, pregnancy will never occur.

To express this situation in different terms, what these women are trying to avoid on an unconscious level, is the very femininity and motherhood that they consciously seek and desire. It is the unconscious psychological forces that prevent them from fulfilling their feminine role. This implies that there is in these cases an unconscious psychological defence mechanism which defends the ego against the physiological process of procreation which is basically feared.

Investigators[7-10] reporting on the personality structure of psychologically infertile women stress the prevalence of emotional immaturity. Bearing a child becomes intolerable because they themselves are emotionally childish and essentially dependent. An ambivalent attitude towards their own mothers has frequently been noted. Hateful and revengeful feelings towards their mothers lead to a rejection of the mother image. Everything that the mother stands for is then rejected and this includes the rejection of a feminine and, particularly, a reproductive role.

In a significant number of cases of infertility the typical aggressive, masculine-protest type of personality is evident. These individuals, who are often career women, have a psychological need to be strong, independent and dominating, with an obvious preference for masculine activity. Their feminine functioning is psychologically blocked.

It is suggested that the common denominator in all cases of psychogenic infertility is an underlying unconscious fear of assuming unreservedly the role of femininity and motherhood. In Rheingold's book,[11] *'The Fear of Being a Woman'*, there is a most informative and comprehensive exposition on this aspect of female psychology. His theory of maternal destructiveness is quite alarming but, at the same time, entirely convincing.

The origin of the fear in the psychologically infertile woman can be traced to her relationships with her emotionally disturbed mother. In dealing with young married women who present with chronic anxiety, depression, problems of marital maladjustment and difficulties in the assumption of the maternal role, psychotherapists are confronted with the frequency of the primary importance of the patient's relationship with her mother. A lack of affection from the mother is a common finding and often the mother has been not only affectionless but actively destructive in her relationship with her daughter. This may have taken the form of frank physical abuse but more

often the destructiveness has expressed itself in a much more subtle form. This psychological destruction has been relentless and persistent, allowing the victim no opportunity of normal ego development or fulfilment of the feminine role.

In the psychotherapeutic situation, the young woman may express her hostility towards her mother *ab initio*. A patient who was recently questioned about her feelings for her mother said, 'I think it would explain it best if I simply tell you that I hate her guts.' A more controlled patient might say: 'I suppose she is a good person but she really showed me no affection,' or 'I shouldn't talk about my mother like this but . . . '. In other cases, the malevolence of the mother and the hostile feelings towards her, may only emerge well on in the course of psychotherapy. This is understandable when one appreciates that the mother-daughter relationship is always an ambivalent one, with a constant conflict prevailing between hostile and dependent feelings, the 'bad' mother image always seen alongside the 'good' mother image.

These ego-damaging, fear-inducing mothers feature prominently in the clinical records of psychotherapists. They are detailed in type by Rheingold[11] as follows: 'The withdrawn, self-absorbed mothers; the efficient but affectionless mothers; the cruel persecuting mothers; the oversolicitous and over-protective mothers; the rigidly controlling, domineering, intrusive mothers; the seductive and castrating mothers; the mothers who tyrannize by illness, more often feigned than real; the martyred and dolorous mothers; the 'schizophrenogenic' and suicide-fostering mothers; the mothers who do not release a child from symbiosis; the mothers who exploit a child to satisfy their own conscious and unconscious needs, who scapegoat it, or drive it into delinquency; the jealous mothers who suppress their daughter's femininity; the mothers who vacillate between hostility and remorse.' This is a frightening list but certainly one which is not divorced from reality of clinical experience.

THE PSYCHOGENIC INFERTILITY - ADOPTION SYNDROME

Out of the material which has thus far been presented, most particularly the work of Rheingold,[11] Toussieng[5] and Deutsch,[6] coupled with my clinical experience, there emerges what might be called the psychogenic infertility-adoption syndrome.

In the first instance, an emotionally disturbed mother defeminizes her daughter and opposes her becoming a fulfilled female. It is the mother's uncertainty of her own femaleness which results in her daughter's femininity representing a threat to it. A situation of rivalry is fostered, where the daughter becomes a constant threat to the mother, and the mother in turn a threat to the daughter. The insecure mother fears that her ill-established femininity will be supplanted by that of her daughter. She endeavours to suppress her daughter's femininity, and in the struggle to become feminine, the daughter is faced with a constant fear of mother's retribution.

During adolescence the conflict becomes intensified, and menstrual disorders and problems of sexual maladjustment arise. Later, after marriage, when pregnancy and motherhood are contemplated, the conflict reaches its peak. At this point, the mother sees her last chance of maintaining a position of female superiority in relation to her daughter, about to disappear. Until now, her motherhood had placed her ahead of her daughter in the tussle for superior femininity. If her daughter now becomes a mother, her position as the superior female will be usurped.

The psychologically oppressed daughter consciously strives for the goal of motherhood but is repelled by the unconscious fear of her mother's retribution. Her fear of being a woman assumes its most threatening role. If this unconscious fear finally overwhelms her, she remains psychologically infertile.

The battle lost, this young married woman now adopts a child. This step is readily acceptable when it is appreciated on a conscious level her normal desire for a child has remained unaffected.

Once having adopted a child, although she has not transgressed against her mother by bearing a child, she is still guilty of having assumed the role of motherhood. Her conflict is unresolved and she is prevented, psychologically, from providing her adopted child with normal affection and nurture. The same psychological factors which were responsible for her infertility now result in her emotionally rejecting her child. It is this rejection, above all other factors, that accounts for the high incidence of psychological disturbance in adoptees.

It is well known that once arrangements for adoption are under way or, more commonly, after adoption is completed, a previously infertile woman may fall pregnant. This phenomenon warrants brief comment.

Andrews[12] offers an interesting theory in this regard. It is suggested that the adoption agency comes to symbolize to the adopting woman a new authoritarian parent. This new maternal figure is sympathetic, supporting and altogether approving of the infertile woman's pending motherhood. It seems feasible that under such circumstances, at least a sufficient degree of her fear might be relieved to enable her to fall pregnant.

CASE REPORT

The following case serves to illustrate the features of the psychogenic infertility-adoption syndrome:

The woman was referred for the treatment of a rather severe depressive state. She was afraid of committing suicide. After matriculating, she had obtained a university degree and then ,at the age of 22, she married. She is an attractive woman in her early 30s, very happily married to an emotionally well-adjusted professional man.

Her gynaecological history is interesting. She menstruated for the first time at the age of 16, and although her menses never lasted more than 2 or 3 days, she continued to menstruate regularly for the next 3 years. Then she stopped menstruating and her amenorrhoea persisted up to the time of her coming under psychiatric treatment. The amenorrhoea in itself never disturbed her, but at its start, her mother had insisted on an extensive gynaecological examination. A diagnosis of Stein-Levinthal syndrome was eventually suspected and the appropriate surgery was undertaken. The operative procedure proved ineffective and menstruation was not restored. Later, hormonal therapy produced some bleeding but this was very temporary and treatment was eventually abandoned.

Once married, this woman seemed most enthusiastic about having a child, but at the same time was not really surprised to find herself unable to fall pregnant. She very soon adopted a child and, at the time of embarking on psychiatric treatment for her depression, her adopted girl was 3-years-old.

There had been no premarital intercourse and when questioned on her sexual adjustment during marriage, she described herself as 'being not a great one for sex'. Orgasm had been achieved on only a few isolated occasions.

Her husband reported on his wife's behaviour towards their adopted child with alarm and considerable resentment. 'Our little girl is not at all naughty or difficult, but my wife screams and shouts at her all the time. It upsets me to see how she treats her. She is really very severe and it seems to me that she is not at all fond of the child.'

The patient displayed full insight into her attitude towards the child. At the same time, she explained that she simply could not control her hostility towards the child and expressed genuine concern both about the harm that she was probably causing the child, and the fact that her unreasonable behaviour was beginning to interfere with her relationship with her husband. She was at a loss to understand why her daughter riled her to such an extent.

There seemed little doubt that this woman's amenorrhoea, infertility, relative frigidity and rejection of her adopted child were all psychogenically induced and probably related to a common psychological origin. The course of events during psychotherapy proved confirmatory.

In view of the fact that the patient claimed that Parstelin, which had already been prescribed for several weeks by her general practitioner, had been effective in relieving her depression at least to some extent, this medication was not discontinued. There was clearly a very great need for psychotherapy and for this purpose, the patient was seen at first for weekly sessions and subsequently once a fortnight.

It proved a simple matter to establish a promising psychotherapeutic *rapport* in this case. A marked lifting of the depression was noted after only a few sessions.

At the 6th psychotherapy session, the patient announced that she had had a normal menstrual period which, she pointed out, had occurred for the first time since leaving school. Clinically, it was clearly discernible that this dramatic development had provoked in her a considerable amount of anxiety. She hastened to relate how, with the advent of menstruation, had come the realization that she might now fall pregnant. Her immediate reaction to this line of thought was to contact her general practitioner for a prescription for contraceptive pills. 'It's too late now for me to go in for a baby,' she immediately interjected, presumably rationalizing in anticipation of my possibly querying her behaviour.

While the result of this very brief therapeutic encounter was indeed quite remarkable, it would not be reasonable to suggest that the onset of menstruation was perhaps coincidental and not related to the effect of treatment. The psychotherapeutic situation proved sufficiently supportive to provide this woman with at least some reassurance in respect of her femininity. During those early sessions, her mother had emerged as a Victorian, affectionless, controlling woman. In therapy, the patient was able to 'work through' her ambivalent feelings towards her mother. Concurrently, she was already beginning to establish a much more comfortable emotional relationship with her child.

Psychotherapy was continued for about 6 months and then treatment was terminated. The patient had become free of depression and continued to menstruate normally and regularly. Her sexual adjustment was also perhaps somewhat improved. Her handling of the child still left room for criticism, but had certainly assumed more reasonable proportions.

One thing that was never relinquished in this case was a grim determination to avoid pregnancy. This woman's present state of fertility remains her secret. It may be asked why treatment was not continued in the hope of this woman reaching a point where she would be able to accept a state of pregnancy. But sometimes it is wiser to limit one's goals in psychotherapy. Mandy and Mandy[7] actually raise the question of whether we are justified in forcing a woman such as this patient, by prolonged and intensive psychotherapy, into assuming a role for which she is basically emotionally ill-equipped. Such over-enthusiastic psychotherapeutic endeavours are probably ill-advised.

DISCUSSION

Psychiatrists have a good deal to offer towards a better understanding of the aetiological basis of a number of gynaecological disorders. The psychiatrist may also have a very real contribution to make in respect of the general management and specific treatment of many of these cases. More consideration should be given to the importance of psychological factors in gynaecological disorders and the value of well-directed psychotherapy must be viewed with greater enthusiasm and recognition.

In the case of infertility, psychological factors are not infrequently extremely important, but as yet inadequate cognizance has been taken of this fact. It is suggested that all cases where investigation has failed to reveal a convincing organic cause for infertility, should be referred for psychiatric assessment and possible treatment.

In modern medicine, a most unfortunate lack of co-ordination between specialists working in different fields has developed. The lack of co-ordination between gynaecologists and psychiatrists is a case in point. It is not suggested that the blame for this unfortunate state of affairs lies necessarily with the gynaecologist. It may be that the psychiatrists have displayed insufficient interest in the treatment of psychosomatic disorders, or that they have failed to convince the gynaecologists of their ability to be of any real assistance in these gynaecological problems.

There is a high incidence of emotional maladjustment in adoptees. Various reasons for this fact have been postulated but the importance of the role of the adopting mother's own personality problems has been thus far neglected. It is now being maintained that it is the mother's emotional rejection of the child that is all-important and that this rejection stems from psychological factors which accounted for her infertility in the first place.

If this premise is correct, it suggests that any woman applying for the adoption of a child should first undergo psychological investigation and psychotherapy. If she is psychologically infertile, she may, by virtue of psychotherapy, be rendered fertile. If she is markedly disturbed from a psychiatric point of view, she should be discouraged from adopting.

There will be those cases where psychotherapy fails to induce fertility, but where the woman's emotional disturbance is not of such a severe degree as to render her unfit to adopt a child. Psychotherapy, made available to these women, before and after adoption, will enable them to establish a reasonably satisfactory maternal relationship with the adopted children.

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