Psychological and Cross Cultural Aspects in Infertility and Human Sexuality

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Abstract

The influences of culture are present in different areas of human health, as is the case of reproductive behaviors.

To have a child means a decision made with responsibility. If conception takes longer to happen, these patients require results from the doctors in order to revive the refractory body.

In light of data suggesting that psychosexual symptoms may interfere with fertility, success of infertility treatment and the ability to tolerate ongoing treatment should pay attention to them.

Infertility is not only a fault of nature, but it is also something that does not respect the established order, a fact that puts in doubt the truth of the femininity
and the masculinity representations prevailing in the culture.

The infertility is always the disease of the couple and is the couple that must be treated. The same is true when it comes to addressing a sexual dysfunction.

The dominant values and cultural practices indelibly affect the sexuality of infertile couples. The humanization of the treatment protocols of infertile couples, to be credible, must take into account the problems of intimacy and the sexual health of those people.

Introduction

Ancient people believed that the fertility of the soil and of all species is a single phenomenon, determined by divine will. The eternal fertility represented hope. Infertility was symbolized by the image of death. Still today that happens in people with a strong communitarian existence, as it is the case of the Gypsy people. They reflect the communitarian knots in the genetic cohesion [30].

Parenthood is one of the major transitions period in adult life for both men and women and even most homosexual couples. The conception of a child is known to depend on the anatomical, functional interaction and immunologic of the partners. However, anatomical, hormonal, functional defects, immunologic and iatrogenic can make impossible that there is fecundation and that the couple gets pregnant. Is Infertility a Disease? Since reproduction is one of the systems required for the normal functioning of the human body, any abnormality in the functioning of the reproductive system would constitute a disease.
For couples of reproductive age who are having sexual intercourse without contraceptive methods, infertility is defined as the inability to establish a pregnancy within a specified period of time, usually one year. Given this definition, it is estimated that between 8 and 12 percent of couples experience some form of infertility during their reproductive lives [28]. Approximately one out of six married couples experiencing infertility. Data gathered by the World Health Organization (WHO) through Demographic and Health Surveys in developing countries estimates that 186 million married women (excluding China) were infertile in the year 2002 [27].

It might be something that you’re currently experiencing. If not, simply look at couples around you and certainly you will know or suspect someone who is silently suffering from fertility issues. Many don’t admit or seek help to in order to resolve their fertility problems, even though we have great medical and technological advances to help couples conceive. Many still consider infertility a stigma. The culture, like organized system of beliefs and values, influences in the determinative form all the human behavior namely the sexual behaviors. Great part of the stigma associated to the Infertility depends on the cultural aspects. Social norms play an important role in determining behavior and have a special relevance to issues of parenthood, fertility and sexuality. The fragile balance between what the individual needs and what the society finds as normal, can have a profound impact on personality, coping, well-being and sexual behavior. Furthermore, the cultural differences can impact sex drive in infertility context [3].

The married population who chooses to remain without children is reduced
(our Hospital experience points to only 5%). Even now in a world with a tremendous change in family values, it is important for men and women to feel the parenthood. That is an important goal for most men and women, being a necessary criterion to achieve personal satisfaction, social acceptance, religious affiliation and sexual identity. The fertility can be like a human basic function and to assume the condition of father or of mother is a landmark in the human development up to because, from much early, the persons build a project of life that passes, nearly always, by finding a loving couple and, with him, constituting family [3]. A few decades ago being infertile it was a social embarrassment. Today it is, more and more, an individual option, influenced largely by the contingencies of assisted reproductive techniques and the dominant social and cultural values and some individuals' fears. This relieves the importance of the beliefs that govern the life of the individuals.

South Europe for many centuries always integrated people of different cultures. The multiculturalism is it is historical fact in countries like Portugal, Spain, Italy or France. In spite of the favorable conditions to the integration of different cultures, it is noted that in South Europe only a small number of African, Asian and Gypsy couples spoke about the suffering they experience as infertile couple. They are ashamed of publicly assuming their problem. Even though they raise children, they are still considered childless because of not producing biological offspring of their own.

Having a basic knowledge of infertility is an important challenge and a demand to health professionals because the diagnosis of infertility usually is a
threatening surprise. During the last few years, the study of the emotional aspects of infertility has gone through changes. For instance, within the general concept of psychogenic infertility, with a few exceptions, anxiety started to be considered a result and not the cause of infertility. The technological progress in the treatment of infertility collide the individuals when the social pressure is very strong and the cultural influence is relevant. [10].

While many couples presenting for infertility treatment have high levels of psychological distress associated with the diagnostic of infertility, the process of assisted reproduction itself is also associated with increased levels of anxiety, depression and stress [18].

The perception of the stigma related to infertility can have an impact in the level of physical, emotional, sexual and social well-being, but these factors have not received enough attention [2]. It is likely that couple’s presenting with fertility problems to health professionals will also have concerns related to their sexuality. Issues that are related to sexual dysfunction, sexual behavior, inter-spouse relationship and communication are important aspects into the reality of an infertile couple’s life. As a matter of fact, everything what concerns the sexual health of the infertile couple, general rule, it is not carefully evaluated in the consultations of Medicine of the Reproduction. In some countries infertility and sexual dysfunction are stigmatized by local realities [3],[6].

Sexual dysfunction can be both a contributing factor to fertility problems and a by-product of the diagnosis of couple infertility itself.
This paper deals with some relevant themes that infertile couples often struggle with and stresses the importance of having a biological, psychological, social and cultural understanding of infertility. In addition, the paper suggests possible interventions that couple therapists can use in helping infertile couples, integrating, in a harmonious form, the Biology with the cultural influences and the individual expectations. Awareness of racial and ethnic disparities is critical to a complete understanding of the health and particularly the sexual health issues facing couples of reproductive age.

**Diagnosis and epidemiological aspects**

The World Health Organization (WHO) acknowledges infertility is a disorder affecting men and women all over the world. Probably, every year there are 2 million new cases of infertility, and approximately 8% of the couples have some problem related to infertility during their reproductive life [26], [27]. This is responsible for significant pressure in the financial resources of health systems. The estimate of the international prevalence of infertility and the search for treatment showed that the frequency and the demand for medical services to treat infertility were lower than those previously mentioned and quite similar among developing and developed countries [1], [26].

The problem can be of both feminine and masculine origin. On the whole, the origin of the infertility is:

- Exclusively feminine in around 30 - 40 % of the cases.
- Exclusively masculine in around 10 - 30 % of the cases.
• In case of a combination of both partners around 15 - 30 % of the cases presents alterations you were detecting [26].

After the medical examinations, the causes of infertility are confirmed in only 5-10 % of the couples [26]. At present, and nevertheless not to constitute true consolation getting pregnant is not so easy, same for the persons who have not problems of fertility!

It is a not much known fact that the human ones are between the least fertile creatures of the land. There is only a very short period inside the menstrual cycle during which the conception is possible, what it does so that this probability is of only 25 % to each month [26].

It is appreciated what 10 % of the normally fertile couples does not manage to conceive inside his first year of attempts and around 5 % after two years [26].

Between 2 and 10 % of the couples in whole world are incompetent of a child conceives and more 10 - 25 % present secondary infertility, which means what after a first quite succeeded pregnancy, are incompetent of a second child conceives [1],[26].

A number of factors influence self-reported rates of infertility, including access to care; percentage of unmarried women in ethnic cohorts; and acceleration of infertility treatment, specifically, Assisted Reproductive Technology (ART) [1].

**Reasons to have a baby**

Advances in reproductive technologies - in particular in genetic screening and selection - have occasioned renewed interest in the moral and the
psychological justifiability of the reasons that motivate the decision to have a child. Couples who decide to have a child have a significant moral reason to select the child who, given his or her genetic endowment, can be expected to enjoy the most well-being and defend it against various objection [26]. The wish of having children, building the family itself and the common project, constitutes a very important existential moment for the couple. Inherent in this project are strong social and cultural conditionings. They are several mechanisms that influence what is behind the aspiration of having a son and to assume the father's condition.

In some cases, the wish of having a descendant can constitute the principal factor of continuity of the couple. The attachment to the familiar values and to a certain idea of tradition turns the fertility into the principal pillar of the life of the couple. All the other reasons that feed the life in common are relegated for a secondary plan. In that idealized son, the adult tries to sublimate much his past, the suffering that he or she had passed and the dreams that did not happen. Great deals of these couples believe equally that their biological clock is ticking. They are carrying out a mission imposed by the nature [2]. While assuming their biological destiny they are equally respecting the cultural impositions – family tradition, social norms and religion. The importance of fertility among Muslim women and other ethnic and religious groups is exemplified by the social pressure on newly married women to become pregnant as soon as possible [3].

The challenge of the parenthood can have a very personal mark. Some young couples are excited about the pregnancy and the prospect having a baby
of their own; so much more they do not want to be the only one of their friends without children. The personal needs appoint other one of the dimensions of the aspiration of having a son. For many individuals it can prevail to the inclination of being complete. The birth of a son transforms deeply the parents, influencing their growth like persons. They try to exceed the personality’s defects, introduce new competences in their options of behaviors. In the bottom, they make an effort to be better adults. It is how if the son was marking the transition of a state for other. If do not without surviving this experience they do not believe to have reached the adult's true state. The pregnancy will help the personal confirmation of the existence of an adult self. “I want a baby who is all mine and will love me unconditionally”, many patients say in consultation.

Other one of the dimensions, not less relevant, is the necessity of bringing into effect the parental expression, presented traditionally like a time of joy and satisfaction, like an affectionate and socially compensatory function and like an individual and familiar enrichment. There is no joy like the joy of welcoming a child into our life.

In clinical practice we find couples that want to get pregnant to reinforce the marital relation independently of the quality of their sexual achievement [4]. While procreating they look materialize energy of approximation, of fusion and of union with the loved person, the new child is going to increase the cohesion of the couple. There are equally couples that want it to resolve difficulties and conjugal conflicts. A couple is in the death-throes of their relationship, so they
make the decision to get pregnant in the expectation that a life-changing, potentially traumatic experience will bring them back together. They dream that the marital and even the sexual problems come to be resolved by the appearance of a new element in the family. The pregnancy is faced like a last opportunity for a system that is already worn away there is much time; it is a sort of miraculous solution that is going to resolve everything. In the past it was, especially, the women who were resorting to this strategy of salvation of the marriage. The recent clinical practice shows that, in European countries, the emancipation of the women, it has leading to a progressive desertion of the marriage like space of individual sacrifice [5], [7], [26].

The market economy presupposes a particular model of human functioning. The dominant culture celebrates the success, prosperity, wealth, and abundance. The success must be present in all social events. But not all individuals have the necessary skills to succeed, especially in professional terms. Therefore, it is foreseeable that this type of people dream; wishes and want their children go a step further: to achieve what they were unable to achieve. In other words, the realization of ideals, lost opportunities and failed expectations: what the adult was not able to obtain for it own, he or she waits could come true in the life of his or her children, especially, in academic terms and from the professional point of view.

Independently of the reasons that take them wanting to have children, these couples have the perception that they are being prevented from carrying
out a biological, social and cultural function that keeps on being highly valued and considered as necessary in a heterosexual stable relationship. In the social context of the western countries where a decrease of birth rate has been noticed, the children appear like a precious social value. So, it is understood that the social control should accent and amplifies the sensation of emotional discomfort that stipulates or influences these couples [5].

The socio-cultural context interferes with the regulation of emotions and strategies adopted to deal with expectations in human fertility. In Ghana, according to legend, a woman named Akua was "sterile" until a healer instructed her to do a monitor and care for her doll as if it were a child. The neighbors enjoyed the poor woman, but her faith was rewarded with the birth of a daughter - the "ba", or child, was the name of the doll. In Africa, after the doll perform its task, it is delivered to the healer, that joins all the other dolls that were offered, as happens in our society, to send a photo of our son to the doctor who accompanied us, to prove its competence. For men, the dolls are used to help find a wife. It is customary among the Mossi of Burkina Faso to give a mother the first drops of its milk to the doll that followed over time until you have your son. The Baule of Ivory Coast "cure" for infertility also carving a doll to appease the jealous spirit of the wife of a lifetime [32].

Infertility, Culture and Healthcare

There is a cultural impregnation of the human fertility phenomenon. Since ancient times the traditions and popular culture have joined hands on issues
related to fertility. The Jerk store signs traditions. Many ancient peoples as the Celts, Egyptians and Persians celebrated Juno, the god of fertility, during the summer solstice - the longest day and shortest night of the year, which occurs in the northern hemisphere in June. Around the open fire, offerings were made to ensure good harvest, ward off evil spirits and bring prosperity. Over time, the Catholic Church allied these traditions to official calendar. In Brazil to please St. Anthony, who received the title of matchmaker in his day, June 13, is erected a mast with his image at the tip. Who wants to find your match has to put his hand on it. This and other sympathies are part of the party [30].

Even today in Japan there is a public worship of fertility: the Kawasaki's fertility festival. Spring is in the air, and perhaps the joys of the season in the Kanto region are nowhere more lusciously expressed than in Kawasaki Daishi, Kanagawa Prefecture, which is bracing itself for its annual phallic festival. Shinto offers more titillating tumescent thrills than most world religions, at the Kanamara Matsuri (Festival of the Steel Phallus) [31].

Myths and legends litter the popular imagination, and to make sense of a collective life, they influence behavior and individual choices. In northern Portugal there is a curious legend about infertility, mixing the religious with the pagan tradition.

Relied on for many favors, S. Pedro de Rates associated with sterility. From an old fountain with his name says that if you could get cured of the disease, fulfilling the following ritual: a woman should sit on a rock stuck that existed there.
Perhaps because it is so divine mercy, has the fame of St. vindictive toward those who do not fulfill their promise. It is probably for fear of "mood", many pregnant women who guard the Holy Day - April 26 - and even to the female in the same state is not advisable to use the work [29].

In the popular imagination we found many aphorisms or predictions related to fertility. In some communities believe that if a cow were to swallow the cloth that will curse the girl with infertility. It is abundant literature demonstrating the social imposition of motherhood for the "normal woman" and the personal and social consequences of reproductive problems [3], [5], [6], [14].

Over the centuries, involving infertility, culture legitimated normative practices. Social rules have emerged, often with a strong moral component, regulating the sexual behavior of infertile persons and their respective partners. In some African tribes, the emphasis on fertility was demonstrated by the strategies used by the couple: the husband was impotent, the woman was encouraged to have sexual relations with relatives and friends until they get pregnant if the woman not getting pregnant, was one that to have children in their name. In ancient Hebrew culture, the man who was allowed to divorce if the woman was sterile and that swapped for another when the first older. In Mozambique, still today, women infertile Macua ethnic group suffer various consequences for the infertility, one of the most important exclusion of some traditional ceremonies and social activities. Most of them commit adultery with the hope of getting pregnant [15].
Healthcare is not a “one-size-fits-all” profession! It is important to be sensitive to ways in which culture and different ways of living impact patients’ healthcare experiences. One of the most sensitive dimensions of clinical practice has to do with the reading frame we use to interpret reality and misperceptions arising from the incorrect use of the reading frame. Misperceptions are sometimes hurtful, occasionally dangerous, and often get in the way of getting what we really want in our lives. The misperceptions about African or other ethnic or cultural groups and infertility are a perfect case in point. For example, it’s a common perception that black women are incredibly fertile. They couldn’t possibly have problems with infertility? No! Factors causing high rates of infertility in parts of the developing world are varied, but tubal infertility due to sexually transmitted, postpartum, post abortive and iatrogenic infections is widely regarded as the primary form of preventable infertility in the world today. Fertility rates of ethnic minority groups in Western countries are similar or superior to that of the dominant groups [28]. But Infertility is unaddressed and complex problem. As a result, minorities couples suffer in silence when they can’t conceive, believing – even more so than other ethnic groups – that they’re all alone in their infertility [2].

The culture influence infertile couples through the moral and the dominant values but also conditioning the individual behaviors. Consequently, in Africa, in most Asian countries and almost always on ethnic minorities in western countries, the desire for children and fertility is very high [14], [28].

Physicians, politicians and other stakeholders to put forward proposals to
help minimize the negative effects of infertility - provided greater incentives for
couples to have children earlier, such as tax benefits, easier to buy the house for
a significant share of the state in the techniques and drugs for treatment infertility
[1], [12], [26], [27].

Regardless of the willingness of health professionals there are social
constraints that hinder the approach the problem of human infertility. It is known
that access to health care also represents an indicator of human development.
Research indicates that the problems of infertility are particularly severe in sub-
Saharan Africa [28]. The levels of primary infertility is measured by the
percentage of women who still have children after a certain number of years of
marriage (usually seven years) or in the case of women who reached the end of
her childbearing years, the percentage of that have no children. The levels of
primary infertility are higher in West and Central Africa - including Cameroon,
Central African Republic, Chad, Niger and Nigeria. In some cases, the couple
may have a first child and although there is a strong social pressure to have
more children they can not, given the lack of economic sustainability of the
household. For example, levels of secondary infertility in women 20 to 44 years
are up 20% in Cameroon, Central African Republic, Lesotho, Mauritania and
Mozambique [27]. Of all the direct influences on fertility, contraceptive use is the
single most important for policy makers and health program managers [28].
However, other proximate determinants are important influences on fertility levels
and could affect their future. Thus, the increase in age at first marriage has
contributed to recent declines in fertility observed in many countries, especially in
Asia, Middle East and North Africa [2].

In Europe, along with the widespread use of contraceptives, growing women entering the labor market, changes in marital and parenting experiences and situations of economic crisis have contributed to the postponement of reproductive responsibilities. Portugal presents a complex socio-economic and even peculiar when it comes to some of the factors that produce consequences in terms of reproductive careers. The falling birth rate and increasing the woman's age at the time the first child has occurred later than in central European countries, but at a faster pace and increasingly homogeneous geographical and social. That is, the statistics indicate that the declining birth rates and increasing age of the women were all over the country (although the North continues to have higher fertility than the national average and a higher percentage of births in the age group of 20 to 29 years old) and transverse mode to social classes [18], [20],[28].

Even in Europe, the territorial factor plays a crucial role in human behavior and more specifically in health, though often disguised and apparently barely visible. A facies *sui generis*, a way of dressing or talking suggestive of origin from a rural community in it constitute an obstacle, a factor that affects the accessibility to health care hospital.

The mere fact of living in a rural area or have a different skin color dictates necessarily a lower accessibility to prenatal visits hospital to hospital birth, neonatal intensive care and necessarily consultations for infertility.

Reproductive Assisted Technology is a form of cultural expression, formed
of and forming culture. A paradox about these medical treatments it often serves only to reinforce existing sociocultural practices, norms, and values. Thus, for example, as the hospitals are located in urban benefit primarily the people living there with regard to access to Units of Reproductive Medicine.

The technologically radical is often the culturally conservative. Conceptive technology has contributed toward the redefinition of patienthood, the multiplication of models of infertility, and the reinforcement of existing cultural norms. Mental Health professionals are well-positioned to conduct a kind of technology assessment that places culture and ethics at the center of inquiry. Mental Health professionals can bridge the gap between the dominant culture in the health system and culture in this patient subjectivity. In many ethnic or cultural minorities if a child is not directly conceived through the normal process such a child will not resemble other members of the family. And this is a problem for the couples and their community. It does not speak well of a woman to have a child through mechanical process and it has implication for the future of such a child [10],[14].

In some communities, (e.g.Vietnamese) women are often considered responsible for infertility, and in Nigeria men may divorce their wives or engage in polygamy. Adoption is generally not socially acceptable in Nigeria and other African countries and there are ethical, medical, legal restraints to infertility treatments. While assuming his biological destiny they are equally respecting the cultural impositions [14] [15].
Assisted reproductive technology (ART) may conflict with religious convictions. Religious obligation forbids people to have children through artificial process. Child bearing may be present as the work of God and it is not proper for couples to take up this responsibility. So, may be a sin for man to compete with God in the business of creation.

The psychiatric morbidity in the infertile population

The increasing participation in fertility treatment has raised awareness and inspired investigation into the psychological ramifications of infertility. Consideration has been given to the association between psychopathology and infertility. Researchers have also looked into the psychological impact of infertility per se and of the prolonged exposure to intrusive infertility treatments on mood and well being. There is less information about effective psychiatric treatments for this population; however, there is some data to support the use of psychotherapeutic interventions [16], [17], [18], [19].

Ethnographic studies of the involuntarily childless suggest that it is the combination of childlessness and infertility that is distressing [6].

It seems evident that fertility treatment are a deeply distressing experience for many couples, namely to the women can be stigmatized if she didn't achieve such family and social goal. The patients have complex psychological difficulties with impact on several aspects of their sexual, affective, social and working lives.
The relationship between psychic states and physiological functions is highly complex, and there is not a simple and linear causal relation. According to the clinical practice, it's not possible to say whether the mental health problems were the result of - or possibly a contributing factor to - patients' infertility. The effects of depression and anxiety on the nervous system could in turn affect their reproductive function. Three types of relationships have been hypothesized between psychological factors and infertility. These include: (1) psychological factors are risk factors of subsequent infertility; (2) the experience of the diagnosis and treatment of infertility causes subsequent psychological distress; (3) a reciprocal relationship exists between psychological factors and infertility [7].

Psychological factors and stress-induced changes in heart rate and cortisol are predictive of a decreased probability of achieving a viable pregnancy [26]. For instance, proposed mechanisms through which depression could directly affect infertility involve the physiology of the depressed state such as elevated prolactin levels, disruption of the hypothalamic-pituitary-adrenal axis, and thyroid dysfunction. Changes in immune function associated with stress and depression may also adversely affect reproductive function. Since stress is the brain-body connection, this raises the possibility that a history of high levels of cumulative stress associated with recurrent depression or anxiety may be an important causative factor.

We know that Depression, Anxiety and certain other mental health
conditions are more common among infertile couples than those who are able to conceive on their own. Depressive disorders are more frequent than in the general population, whereas prevalence rates of anxiety disorder are similar [8].

Depression and anxiety often co-exist, they appear hand in hand, and physical symptoms are significantly more frequent among females and males with a psychiatric diagnosis than in subjects without a diagnosis [9].

In that cases the gravity of the depression increases with the extension of the process of infertility and the accumulation of therapeutic failures. The couples with mild or severe depression had a significantly longer length of infertility. The findings imply that routine mental health screening could benefit patients being treated for infertility.

Fortunately in many circumstances, the careful clinical evaluation allows to conclude that the infertile couples do not carry out the criteria for the formal diagnosis of a given psychiatric pathology. But there is an exception, which concerns the diagnosis of "adjustment disorder," particularly among women. Adjustment disorder refers to symptoms of depression and anxiety in response to an identifiable cause - which, in these cases, was most likely patients' infertility. It's likely that patients' symptoms were a response to their fertility problems.

The outcome of infertility treatment may also be influenced by psychological factors. Our hospital experience, following infertile couples, reveals
that psychological factors affects the reproductive ability of both partners: stress and mood state are predictors of outcome in assisted reproduction. The mechanisms involved in emotional instability and the mood disorders, such as changes in immune function, thyroid dysfunction, elevated prolactin levels and abnormal regulation of luteinizing hormone acts as the interface of reproductive ability. But it does not seem reasonably a straight relation establishes between duration of the infertility and its treatment and psychological instability [8],[16],[17]. The risk factors of depression and anxiety in infertility may include: female sex, age over 30, lower level of education, lack of occupational activity, diagnosed male infertility and infertility duration of 3-6 years [11]. The ethnic element affects the construction of risk by couples in infertility treatment and enlarges the disruptive character of the remaining risk factors.

Unfortunately, the hospital day by day pointed that the majority of subjects with a light psychiatric disorder are undiagnosed and untreated for that disorder, which is also in accordance with what is found in the general population. If in many cases the couples do not verbalize the affective symptoms, they are reluctant to report; in other situations it is the health professionals who are not careful of questioning or identifying the psychiatric problems.

**Gender Roles, Culture and Psychiatric symptoms: different answers to Infertility**

Patterns of infertility-related to stress factors differed depending on gender,
fertility history, infertility diagnosis, and the permanency of infertility. Infertility places a barrier between the couples and their ability to fit into the gender roles prescribed by their culture. The way in which people deal with infertility is at least affected by the values, the social norms and the religion of the community in which they live. In the popular imagination of some cultures women infertile, always anchored in symbolic association woman-nature, can be presented as "hollow", "tree without fruit", "dry tree", "barren land", among others, that in together with the recollections of the infertile woman is incomplete, demonstrate the permanence of the stigma of female infertility in social thought [14], [15],[28],[32]. Moreover, while male infertility can be represented as strongly linked to sexuality, putting in doubt the sexual power of man, with no reference to sexuality when the focus was on female infertility, reaffirming the stereotype of women as a parent be asexual, based on the sexual double standard (also present in sexual dysfunction clinic) that still permeates gender relations, which takes as argument the differences biologically determined.

Faced with the experience of infertility both men and women experience a sense of loss of identity and have pronounced feelings of defectiveness and incompetence.

Ethnic and gender-specific psychosocial support and follow-up for infertile people is needed. In addition to having higher rates of infertility, black women, as other ethnic or cultural groups, presenting for infertility care have a longer duration of infertility compared with white women, suggesting differential access to care based on either economic or sociocultural barriers [13].
In a sample of 862 Sweden subjects Volgsten et al. [16] found that any psychiatric diagnosis was present in 30.8% of females and in 10.2% of males in the study sample. Any mood disorder was present in 26.2% of females and 9.2% of males. Major depression was the most common mood disorder, prevalent in 10.9% of females and 5.1% of males. Any anxiety disorder was encountered in 14.8% of females and 4.9% males. Only 21% of the subjects with a psychiatric disorder according to DSM-IV were entitled to some form of treatment.

In general, in infertile couples women show higher levels of psychological suffering than their male partners, report they have to deal with a greater stigma related to infertility than men and they also provide more information about their difficulties with infertility [3], [4], [8], [10]. After several years of treatment as it is easy verified that infertile women are more neurotic, dependent, and anxious than fertile women, experiencing conflict over their femininity and fear associated with reproduction. In contrast to these reports, a double blind study could not determine the difference in the psychological makeup of women who were infertile because of demonstrated somatic causes and those women in whom no somatic cause could be found and who were considered infertile on an emotional etiologic basis [17], [18].

The clinical accrued experience demonstrates that women presenting for In Vitro Fertilization (IVF), nearly always, are more depressed, have lower self-esteem and are less confident than fertile women and, after a failed IVF cycle, experienced a further lowering of self-esteem and an increase in depression
relative to pre-treatment levels [16]. The probability of a woman to have moderate or severe depressive symptoms depends on the impact of the confirmation of the diagnosis, on the failure of the first attempts of treatment, on the Personality and on the existence of a personal psychiatric history [7], [10], [13], [24].

Psychological interventions aimed at reducing depressive symptoms need to be implemented, especially for women with a definitive diagnosis and for those with durations of 2 to 3 years of infertility. In the study of Domar et al. [17] the infertile women had significantly higher depression scores and twice the prevalence of depression than the controls (healthy women); women with a 2- to 3-year history of infertility had significantly higher depression scores compared with women with infertility durations of < 1 year or > 6 years; women with an identified causative factor for their infertility had significantly higher depression scores than women with unexplained or undiagnosed infertility.

Childless women with infertility experience had increased adjusted risks for dysthymia and anxiety disorders compared to women who had not experienced infertility. Women with infertility experience but with a current child had an increased risk for panic disorder. Childless men with infertility experience had a significantly poorer quality of life compared to men without infertility [18].

Emotional factors may negatively affect fertility in the male. Men’s responses to infertility closely approximate the intensity of women’s responses when infertility is attributed to a male factor, though in the men the depressive complaints not always are visible or clearly confirmed. When the male factor is
present these patients are more mentally distressed than men in couples with other causes of infertility.

The concept that emotional stress (through the hypothalamus-hypophyseal axis) might lead to oligospermia is based on the assumption that anxiety and psychic tension brought this organic change. The variability in assessments of depressive and anxiety symptoms is largely determined by differences in the time points of the assessments (before, during and/or after infertility treatment), and methodological issues such as the use of different standardized psychometric self-report instruments and the use of different threshold scores [22], [24].

There are also differences between genders regarding the perception of the availability of social and marital support, another factor that, besides the psychological instability, can contribute to the dropout of the treatments. In a sample of Turkish infertile women Guz et al. [19] found that within the infertile group, depression and anxiety were more frequent in the women who received negative reactions from their husband, their husbands’ families and social group.

**Infertility May Contribute to Sexual Dysfunction**

Psychosexual dysfunction and infertility was found to occur, in a large number of couples, together in association. Most common cause for this clinical problem seems to be ignorance and lack of sex education. Countries like Portugal that integrates, at present, populations of several cultures there are still
not sufficient studies that allow fitting, in the clear and concise form, the sexuality in the ethnic and cultural sources.

The clinical accrued experience demonstrates that sexual problems may induce infertility by contributing to limited or absent sexual activity. Preexisting sexual dysfunction is an under-reported cause of infertility. In fact, couples may seek infertility treatment rather than address the fact that they are not sexually active. The consultation of infertility will be the first one to be confronted with the sexual dysfunction. Over the last decade our hospital experience showed that sexual dysfunction has been reported in up to 20% of infertile males. Decreased sexual drive, erectile dysfunction, premature ejaculation and failure of intromission are all potentially correctable causes of reproductive failure. Decreasing libido and erectile dysfunction may reflect low serum testosterone levels with an organic cause. Performance anxiety is also often reported and often abated with reassurance [20], [22].

Women with sexual dysfunction are in high risk of infertility. Disorders of desire, arousal, orgasm, or pain can be a causal factor of infertility because sexual activity may be limited or avoided, especially around the time of ovulation. Vaginismus and dyspareunia are two sexual disorders that are frequently implicated as a direct cause of infertility. Vaginismus, or hypercontractility of the pelvic floor muscles, can cause significant discomfort during sexual intercourse. Many women with this disorder will avoid vaginal penetration. Dyspareunia has multiple aetiologies. Some of them are associated with development of infertility, including endometriosis and uterine pathology.
These women tended to have intercourse less often and have a lower average score when it came to rating their sex-life satisfaction.

On the other hand, infertility may result in a decrease in quality of life and an increase in marital discord and sexual dysfunction. Infertility may interact with a couple's sexual expression by causing or exacerbating (couple's or individual's) previous sexual problems as a consequence of the diagnosis, investigation and treatment of infertility.

The confrontation with a diagnosis of infertility marks the difference in the way like the couple organizes his intimacy, particularly its sexual life. Independently of the cause of the Infertility, after the diagnosis nothing is equal. The communication is altered in the couple. The subject of the infertility starts to occupy the daily conversations, as it is the center of a constant preoccupation. The affectionate exchanges lose the spontaneity. The libido is decreasing and suffers the interactions of the dominant mood. The instability has consequences in the partner in whom the infertility was diagnosed and also in the other of the couple partner [22], [24].

Usually, in these cases a not much gratifying standard of sexual experience is present. The frequency and the quality of the sexual practices are damaged; they are less likely to experiment with different coital positions and we know that unvaried coital position may contribute to infertility. The clinical practice does not give support to the association between lack of orgasm capacity and infertility, the majority of infertile couples obtained sexual satisfaction. As it was observed in such patients a higher frequency of male sexual disturbances expressed as
erectile dysfunction, ejaculatory disorders, loss of libido and a decrease in the frequency of intercourse. In the case of new-onset sexual dysfunction associated with infertility, it is not always evident whether the diagnosis or treatment of has the greatest influence. Both can significantly affect the emotional well-being of a couple. Men may experience less intercourse satisfaction, perhaps because of the psychological pressure to try to conceive or because of the forced timing of intercourse around the woman's ovulatory cycle [26]. A more obvious effect of the emotional stress infertility places on the male is the occurrence of impotence. In a polish study clinically relevant erectile dysfunctions were diagnosed in 23.9% of infertile men and in 13.7% of the controls. Male infertility had the most significant negative effect on men's sexual functioning [20]. Specifically, the clinical practice shows a correlation between the diagnosis of azoospermia and temporary impotence or premature ejaculation.

The diagnostic of male factor in infertility duration of 3-6 years are connected with the highest relationship instability and the lowest sexual satisfaction both in female and male infertile [21].

Women undergoing treatment for infertility may be less satisfied with their sex lives and have a greater risk of sexual dysfunction than women with normal fertility. Namely, the infertility patients do not differ from fertile women in physical symptoms like vaginal dryness or pain during sex. Nor do they report more difficulty reaching orgasm. They only report more problems with desire and arousal [21].

The act of timed sexual intercourse during fertility treatment can bring
about sexual dysfunction by eliminating the spontaneity of the act. The psychological pressure to conceive stemming from “sex on demand” can lead to decreased satisfaction with intercourse and the subsequent potential for the loss of a couple’s intimacy.

The importance of the sexual disorder to the individual (and couple, when applicable) needs to be determined. It is important to bear in mind that a sexual problem is a disorder only if the couple perceives it to be so, with impaired sexual desire as the most common presentation. Decreased sexual function is important only if it is a cause of concern for the couple. Also, partner sexual dysfunction is a recognized risk factor for the development of situational sexual dysfunction in both men and women. Therefore, partners of an infertile couple may develop sexual dysfunction following the diagnosis or the treatment.

It is incorrect to affirm that there is a relation of cause and effect between infertility and sexual dysfunction or between infertility and marital dissatisfaction. Our experience pointed that the couples with infertility show a significantly better partner relationship as compared with fertile couples and the sexual dysfunction, when appears, it is the final product of multiple factors (personals, relational, pathological and iatrogenic).

Sexual dysfunctional it is the weakest link of a system that has different fragility. Sexual dysfunction that is not addressed adequately may lead to conflicts or potential breakups.

Clinically relevant sexual disorders in the infertile population most frequently affect couples, with a lower educational level and with previously diagnosed
sexual dysfunction. When the cultural impregnation of the sexual experience was given it is not amazing that when the husband was sexually dysfunctional, the couples preferred to label their situation as ‘infertility’ in order to avoid stigma.

In this line of reflection, Lee, Sun and Chao in a sample of couples from Taiwan, found that the female members of couples in which both partners were infertile expressed less marital and sexual satisfaction than their husbands. But no differences in marital and sexual satisfaction were found between wives and husbands with unexplained infertility [22].

Lee & Sun [23] in an other study with fifty-nine infertile couple subjects that completed an Infertility Questionnaire, Marital Satisfaction Questionnaire, and Sexual Satisfaction Questionnaire have studied gender differences in facing infertility problems. Results revealed that husbands expressed significantly less distress than that of the wives. The husbands' self-esteem was higher than that of the wives. The husbands' marital and sexual satisfaction was also higher than that of the wives. These results propose that although differences exist in cultural, ethnic, and religious norms between Chinese society and Western society, the Chinese couples' pattern of response to infertility is similar to that of Western couples. The major difference is that the in-laws play an important role in Chinese society, especially in marital satisfaction.

Also Peterson et al. [24] in a sample 306 women and 295 men referred for in vitro fertilization and intrauterine insemination found that women reported greater anxiety and sexual infertility stress than men. However, men and women showed a similar pattern in the way anxiety symptoms were related to sexual
infertility stress, with subjective anxiety and autonomic anxiety having the strongest relationship. Anxiety symptoms accounted for a significant proportion of the variance in sexual infertility stress for both sexes and predicted sexual stress to a considerable degree in men. There is more similarity than difference in how men and women experience anxiety and sexual infertility stress, the strong linkage between anxiety and sexual stress in men was surprising, because men tend to report less sexual stress and also less anxiety. Sexual stress among infertile men may be more closely tied to performance anxiety rather than to a more general deterioration in sexual satisfaction associated with infertility.

**An integrated model for treating sexual dysfunction in infertility couples – the role of mental health professional**

Social, sexual, and relationship concerns related to infertility are more effective predictors of depression and marital dissatisfaction than expressed needs for parenthood. In the Western world, the reformulation of the familiar standards helps to understand the growing investment of the individuals in the well being and in the marital satisfaction, leaving in the secondary plan the social pressure for the procreation.

The clinical practice led us to try to understand the experience of infertility. It suggests that infertility, sexual health and mental health problems are related in many ways.

The gradual unravelling of the complexities of neuroendocrinology has permitted increased understanding of the role that stress might play in infertility.
Catecholamines, prolactin, adrenal steroids, endorphins, and serotonin all affect ovulation and in turn are all affected by stress. Such stress might result from infertility. Infertility is frequently perceived by the couple as an enormous emotional strain, and counseling may prove helpful as a part of the initial infertility evaluation, an adjunctive measure during treatment, or a final measure to help patients cope with acceptance of their infertility problem.

Nearly always, women described greater global stress than men and higher specific stress in terms of sexual concerns, and need for parenthood. They received more social support than their partners, who experienced the fulfilment of the male role as well as the social role to become a parent as the most central aspects of infertility.

In a situation of infertility the mental health professionals can act at several different levels: facilitating information gathering and its analysis, helping in the decision-making process, psychological evaluation, support and therapeutic (treating sexual dysfunctions and/or couples conflicts). An important moment concerns to the psychopathologic evaluation of the couple and its psychological and sexual interaction. All patients must have one or more clinical interviews with the couple therapist (general rule, a psychiatrist, a psychologist or a sexologist) in order to analyze the real desire for pregnancy and the kind of intimacy and to facilitate a good relationship between the medical team of the Infertility Clinic. The psychopathologic evaluation helps to detect clinical psychiatric situations that constitute formal impediments or counter indications for the beginning of the
infertility treatments.

In some cases, so many times, the professional of mental health has to prepare a report for the Committee of Ethics on the capacity of the person to be able for such treatment. It is suggested that health care providers, specifically those who have skills in Therapy of Couple and in Sexology, can more effectively address the needs of couples with infertility by taking a sexual history as part of an initial infertility assessment, and by encouraging couples to temporarily view sexual functioning and the quest for pregnancy as separate issues. Most those therapists have a particular awareness of sexuality and intimacy that rises above personal opinion or personal experiences.

Not always the couples accept spontaneously to begin the psychotherapeutic process. When that happens, the infertility team must discuss the case and consider other alternatives, mainly psychopharmacologic treatments, particularly in cases of Major Depression.

It does not surprise that some patients reject the counseling or the psychotherapy. Low rates of counseling have previously been reported by Boivin et al. [25] in a sample of 143 infertile patients (49 couples plus 45 additional women) who were in their mid-thirties and had been infertile for approximately 6 years. The authors found that only 11% of females and males received counseling while attending an infertility clinic and noted that patients relied primarily on their spouse and family when distressed, rather than on formal support resources such as psychosocial counseling. The principal reason preventing patients from using counseling varied as a function of current distress
level. Less distressed patients reported that the coping resources available to them were sufficient to cope with the strains of infertility, while the more distressed patients failed to initiate contact with a counselor because of practical concerns such as knowing who to contact and/or the cost of counseling [25].

Other factors such as personality traits and coping strategies are presumably more important predictors of psychiatric morbidity than fertility history. Doctor-patient relations that target these domains appear likely to offer maximal therapeutic benefit. While treating the patient separately we reach again the couple. At this stage it may be useful to develop activities under the Sexual Education. Thus, some men believe that if they do not have problems having sex, then they must be fertile. It should convey that there is no relationship between virility and fertility. In other cases, some men are told that of they masturbate excessively then it will make them sterile.

In a perspective of Couple’s Therapy there is the requisite of meaning this experience of the life of the subject and the first message that imports to transmit to the couples is of tranquility and comfort. They are preoccupied by their fertility? The first thing what they need knowledge is that they are not alone.

In time, many couples become increasingly isolated. They may stop sharing with others in order to avoid raising hopes and expectations that will force them to face new rounds of questions. Although maintain the routines of the everyday, they throw out everything that gives them pleasure: avoid social occasions (e.g. family parties). It is crucial that couples reject becoming isolated.
In many couples the frequency and the sexual performance even are not exceptional. The sexual problems can appear the less if it waits. But they must not face that like a tremendous obstacle, anything that has no solution. Sex therapy views sexual issues as being resolved by specifically addressing them, rather than by the assumption that when the individuals in a relationship work out the relationship issues, the sex will just fall into place.

Though the necessity of the intercourse exists, the coital involvement must not be assumed like an obligation compulsory and ill-timed. The infertility treatments are not a "bigger brother" to coerce a person who wants less sex into wanting more.

The intimacy fulfills a crucial paper in the reorganization of the sex life of these couples. Besides the emotional intimacy it matters to value the physical intimacy. But, body caressing is an important tool in all clients seeking to overcome infertility sexual dysfunction. Massage should be a common language that couples speak to each other. Body caressing is an integrant part in the approach of infertility sexual dysfunction. General rule, the physical wellness allows to raise a clear communication between partners, each of them feels free to express what is sensory pleasurable and gives more sex pleasure. Verbal feedback from the partner helps to discover in which measure the touch is understood like a gratifying activity. Couples often transfer other conflicts to their sexual life. Intimacy helps to increase the love consistence and induce the resolution of conflicts, helps to forgive and to integrate the other in our affective life.
Cognitive behavioral psychotherapy and support groups decrease stress and mood symptoms, as well as increase fertility rates. Cognitive behavioral approach help patients to overcome difficulties in intimate sphere by active correction of their irrational representations, unrealistic belief and hopes concerning a sexual life, paying the greatest attention emotional and displays of sexual disharmonies and improvement of interpersonal relations of spouses. Although there have not been systematic studies in infertile couples examining the impact of the different types of psychotherapy, treatments that decrease psychiatric symptoms, stress and sexual dysfunctions in the general population will likely benefit this population.

When partners have different social, cultural, religious, racial or educational backgrounds, they often face additional challenges for a successful relationship. To treat the infertile sexual dysfunction is an opportunity to transform the involved patients and to deal with some cultural barriers as happens in many specific cultural group.

This aspect is so much more pertinent being known that psychological conflicts involving infertility reach the deepest layers of psychism, invade the couples' interpersonal domains and the sexual space and spread to the sociocultural and working life and to the definition of family [3], [5].

Keeping the pertinence of the psychotherapeutic and psychosexual work is central to know: does psychotherapy increase the fertility rates? The clinical evidence pointed that Group and individual/couple psychotherapy may reduce
depression and anxiety associated with infertility. The intervention led to decreased thoughts of helplessness, decreased marital distress, and improved pleasure in sexual activities. Decreasing stress, changing maladaptive beliefs related to intercourse, and encouraging intercourse during the fertile period of the menstrual cycle can increase the chances of conception as well as decrease marital distress. However, psychotherapy and sexual counseling by itself may not improve fertility rates. More and better-designed studies are needed in this area that should include a specific attention to the couple sexual health and its cultural environment [12].

References


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