Psychosomatic Approach to Gynaecology and Obstetrics[1]

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The place of psychotherapy in medicine and the importance attached to psychic and somatic factors in illness has varied enormously from time to time. Some years ago we concentrated too much upon the patient's local symptoms without reference to the general picture, and treated these symptoms in isolation. The inter-relationship between the mental and physical aspects of personality was ignored and the tendency was to think of the individual as divisible, with one thing, mind, acting upon another, body, or vice versa. Such a concept is just what must be avoided. As Adler has stressed, the human organism is a whole which reacts as a totality to any given situation, the reaction being conditioned by the personal goal of the individual. Sometimes this goal is at the level of consciousness, sometimes it is below it, but it is always there, directing the activities of the individual. In addition, there is also strong evidence of a spontaneous endogenous striving of the organism to attain a certain end, such as child bearing. Moreover, not only does each of us react to our immediate environment, but we respond also to the total environment; to the wider universe around us. The teleological principle, perhaps Adler's main contribution to psychological medicine, replaces the fatalism of the principle of causation by a far more positive and optimistic doctrine which permits a consideration of individual cases in a more hopeful spirit.

Adler's first book, written in 1907, stated that an organ inferiority is not the cause of the structure of the personality, but rather that it acted as an impetus, spurring the individual to compensate for it in a manner consonant with the goal which he had set himself to attain. This goal was very often extraordinarily high, almost beyond the limit of his power. Adler was not so much interested in the existing inferiority itself, or as Henry calls it, the constitutional endowment of the individual; he was concerned rather with discovering how and in what ways the inferiority would be compensated for or overcome. Adler

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transplanted the biological law of compensation into the sphere of psychology. His basic assumption, therefore, does not reduce the individual to a mere object of causality, but makes him a "free" subject; free to take responsibility, to act according to the normal laws of human relationship in the family and in the community.

The connection between gynaecology and psychiatry seems a very special one since in no other branch of medicine are the psychosomatic aspects so inseparable and ignorance and misunderstanding so widespread. The gynaecologist starts with a very great advantage over his fellow practitioners. Patients who come to him are nearly always ready and often eager to talk openly and freely, perhaps because the nature and seat of their disease involves complete physical exposure. Mental reservations, therefore, might go as well.

Another advantage gynaecologists enjoy is that of having no need to label themselves as psychologists, while at the same time being in an excellent position to recognize signs of psychological disturbance. In fact, by carefully and attentively noting the patient's manner of approach, the way in which she undresses and behaves under examination, we are able to draw valid conclusions as to her marital relations, sexual difficulties, and general attitude toward life. It is essential that the patient should be put completely at ease; she must feel that there is no stress or hurry, however busy the doctor may be, and that she has an interested and sympathetic listener.

The sexual organs are so closely linked to the whole complex of emotional experience that some quite trifling deviation from the norm may cause a disproportionate psychological damage, primarily in the development of an inferiority complex, and secondarily in the resulting repercussions in relationships and the environment. Maladjustment to life, at whatever level it may originate, generally ends by affecting the organism at *all* levels. Marital life, the most intimate form of human relationship, makes the greatest demands upon our powers of adjustment and understanding. Therefore, it is not surprising that many people quite capable of dealing successfully with their work and their social obligations fail when it comes to regulating their sexual life.

Adler saw in every patient the universal human struggle for appreciation. In those suffering from neuroses this struggle was complicated by their overriding desire to avoid any possibility of defeat. This unbalanced desire for success, coupled with the constant dread of failure, served to increase the neurosis which was at the root. Adler taught that the doctor, in treating his patients, must himself believe in their

potential powers of readjustment. The doctor must above all be able to discover and to remove the biased apperceptions in the mind of his patient, generally a most difficult and prolonged task, for neurotic patients tend to cling to their neuroses as the most effective shield against reality.

It must be emphasized that nearly every illness has a *multiple* aetiology. One cannot assume a psychological cause for a symptom unless one can find such a cause, nor can it be assumed that a symptom which appears to yield to psychiatric treatment is therefore of psychic origin. A symptom is not of non-organic origin simply because no organic cause can be found at first. In many cases, both factors play a part. There must be no attempt to fit the individual into the rules. The rules must only be applied insofar as they serve to elucidate the individual or explain the particular syndrome or complex of symptoms without distortion. A secondary explanation must never be discounted without most thorough and repeated investigations. It must be constantly borne in mind that it is a question of the *total reaction of the whole personality to the total environment* in addition to the partial reaction which may be producing the immediate symptoms.

The work of a psychologically trained gynaecologist should start with the *birth* of the child. A normal, painless confinement will help to initiate a natural mother-child relationship. The child will not be exposed over and over again to stories of a difficult labor.

In obstetrics trouble can start before the birth of the baby. Not only physical illness like German measles, but also mental strains and stresses of the mother during pregnancy may have a deleterious effect on the unborn child. Emotional upset and mental unbalance will increase the activity of the baby in the uterus and this hyperactive baby will burn up carbohydrates much more rapidly than is desirable. This will result in many cases in a thin, restless, hyperirritable infant with muscle spasm. The mental worry of a pregnant mother can have a much more deleterious effect on the unborn infant than malnutrition. Two statistical facts tend to prove this point; the mortality and morbidity in unmarried mothers is much higher than in married mothers, and the mortality of illegitimate children in the first year of their life is nearly twice as high as that of legitimate children.

Gynaecologists should prepare the girl for the onset of her periods. Menstruation is one of the conspicuous manifestations of the physiological difference between the sexes. It reveals the existence of an organ of which the girl was previously unaware and indicates its future func-

tions of pregnancy and childbirth. The fear expressed in so many taboos and customs and the exclusion of girls from society during the menstrual period has influenced their reaction to menstruation. Their answer is a sub-conscious rejection. This inner tension might also have the effect of reducing the threshold of pain. Any contraction of the cervix and uterus which is not usually felt, like the contraction of the digestive organs, will be registered by these girls with a lowered pain threshold.

Three of the most common complaints in which gynaecologists are consulted are *dysmenorrhoea*—pain during the monthly periods, *dyspareunia*—pain during intercourse, which is usually caused by *vaginism* —a spasm (cramp) of the muscles surrounding the front passage.

The usual treatment of vaginism is either to advise the patient to use dilators or to perform a plastic operation. In addition, we have, in the last twenty years, resorted to cutting the nerves leading to the womb in cases of severe dysmenorrhoea (pre-sacral neurectomy). This operation is successful only in some forty to seventy per cent of the cases treated, although if we combine this operation with psychotherapy, the results are extremely good; practically one hundred per cent were cured.

Gynaecology offers a constant temptation to the practitioner to operate, for it is possible today to do practically anything to the reproductive tract, from rearrangement to almost total evisceration, without any risk to life or obvious physical damage, whatever psychological harm may result. Although operative treatment is quite successful in some cases of vaginism, I have seldom considered it necessary. In the vast majority of cases, vaginismus is a functional and psychological maladjustment and should respond to treatment without radical interference. In general the attitude of a woman suffering from vaginism is an attitude of physical and mental *fear,* of violent recoil. Like a cat facing her enemy and ready to spring, she retracts, her muscles cramped and tensed in spasm. She must be taught to lose her fear, to meet her partner, to co-operate with him in an act which calls for the fullest co-operation between two equal partners, with the same rights and the same duties. The patient must be instructed how to relax. Non-consummation of marriage is, in most cases, caused by vaginism. If the condition is neglected and the correct treatment is not given early enough, it will often result in the husband becoming impotent. This is a much more difficult handicap to deal with and takes much longer to remedy.

Amenorrhoea is often the result of shock or mental distress, a postulate that is supported by a mass of clinical evidence. Functional gynaecological disorders are seldom clear-cut entities but are found in borderline cases of many specialties. Imagined pregnancy has been reported in about five hundred cases in medical literature, but the mechanism is not quite clear. In all probability the increased output of gonadotrophin and oestrogens is the result of psychological stimuli. It is, of course, well known that illicit intimacy can produce amenorrhoea, a cessation of periods, without pregnancy.

The menopause is often anticipated with exaggerated fear and anxiety in our civilization due to our over-estimation of the role which the sexual factors play in life. Nothing *changes* in the menopause. The production of the ovarian hormone continues. Although production of mature ova gradually ceases, it still can occur, even after the period has stopped. The oldest woman in medical literature to become pregnant—without taking into account the records of Biblical times— was sixty. We often encounter in practice the fact that sexual desire in women over fifty does not disappear but in many cases increases. This seems to prove that the psycho-dynamic point of view differs from the biological and hormonal one. Physiological changes are a stimulant, just as are environmental influences, and they can make the pendulum swing in opposite directions; towards a regressive or a progressive adaptation of the individual woman. She can either adapt herself to the new facts of life and work in the spirit of social interest or she can look back and long for the days of her youth when she was admired, desired and a center of attraction. Now missing it, she becomes a nuisance. When we can convince the lady of the menopause that she still possesses the power of attraction and that the charm of woman is ageless, the problem will cease to exist.

The menopause often coincides with the time when children are becoming independent and themselves marrying. This produces in some mothers the feeling that they are no longer wanted and that they are losing their children, while others who have not achieved the goal of femininity may be seized by fear of aging or of losing their sexual attractiveness, and as a result they become anxiously over-active in an effort to start life afresh. In primitive societies the women gain in status after their menopause, while in China the mother achieves power in her family only after her son has married.

In fact, it is rather paradoxical that women should not be pleased and relieved once they get rid of their periods, commonly called the

"curse," with all the attendant inconveniences.

Sexual libido and frigidity are not congenital entities which can be measured mathematically, but are parts of the psychosomatic make-up, the indivisible unit which we call the individual. Benedek and Rubenstein have attempted to prove that the first two weeks of the menstrual cycle are associated with elation and strong heterosexual interests; the second half, which is the time of progesterone excretion, is associated with passivity and a desire for affectionate protection. In practice I have not been able to confirm these statements. As a matter of fact, I consider these findings which have lately appeared repeatedly in psychoanalytical literature to be a rather dangerous and materialistic conclusion, since the human mind, its emotions and actions, are thus made to appear solely dependent upon the level of hormones present in the blood.

Problems of marriage did not bulk so large nor were they so complicated centuries ago when man was the unquestioned master and his wives were slaves. Slave drivers still exist in more or less modern form. There are fundamental causes of such masterful behaviour. Men get married and, after awaking from the honeymoon, find themselves suddenly loaded with responsibility. They are expected to take full financial responsibility for the family, to provide intellectual stimulation, to satisfy their wives sexually and to produce a family. This is a lot for a young man to shoulder when we consider the physiological handicap from which he suffers; a handicap which I would like to explain more fully since this is, in my opinion, the cause of very many broken marriages. A man often has a much greater sexual inferiority complex than has any woman, due to the fact (which a Russian physiologist called the "Male Tragedy") that a man is unable to have intercourse at any time that he might wish. This is of very great importance. A devoted husband, keen and eager to do everything possible for his wife, but with rather limited sexual powers, can be self-conscious on the subject of this inferiority, and by bullying his wife and not allowing her to do what she wants, think he is successfully asserting his masculinity. Hobbies, professions, intellectual pursuits, when carried to excess, and sexual adventures, are often attempts by a husband to escape from loneliness and his feeling of sexual inferiority, which he is ashamed to confess.

At this point I would like to stress the fact which Adler so admirably analyzed—things are not always what they appear to be; the facts below the surface may be exactly the opposite to appearances. A

man may act the role of "He-man" when exactly the reverse is true and he actually feels afraid that he may be unable to satisfy his wife. I would like to correct the mistaken assumption of so many women with regard to the so-called "He-man," as this idea is the cause of many thousands of broken marriages and divorces. The loneliness and boredom, which so often lie at the root of increasing unhappiness in marriage, might be dispelled by the sympathetic understanding of wives.

In conclusion, I would like to plead for a much more intimate connection between psychiatry and medicine, more particularly in my special field. Not only doctors, but nurses, sisters and midwives should be trained in the technique of psychosomatic approach to the ills of their patients, mental and physical. The patients themselves need more instruction on varying problems which may face them in the course of their married lives, and here, pre- and ante-marital clinics could have as great a part to play as pre- and ante-natal clinics.