Introduction

Infertility is not solely a medical problem. The psychosocial aspects of being childless have been well described (Pfeffer and Woollett 1983; Houghton and Houghton 1984). The couple may feel isolated from friends and relatives and find it difficult to talk about their problem, especially to their own parents. Houghton and Houghton (1984) explain that in childless couples there is more dependence on the partner for love and support. Failure to conceive may create a sense of helplessness and loss of control over the future. The couple experience "genetic death" and there may be regret in not perpetuating a family line or name. Later there may be a fear of lack of support in old age. The authors, themselves childless, point out that for some the regret may continue into later life.

The last 10 years have seen significant and widely publicised developments in reproductive technology, including in vitro fertilisation (IVF), gamete intrafallopian transfer (GIFT), etc. There is a need for psychological understanding to parallel these advances in medical technology (Alder and Edelmann 1989). Public awareness of infertility, and expectations about the availability and efficacy of services, have increased greatly. Success rates remain low, and even if these procedures were to be widely available still only one-third of the infertile population would conceive as a result of medical intervention (Lilford and Dalton 1987). Infertility investigations and treatment may prove expensive; they are often intrusive, frequently lengthy, sometimes stressful, occasionally counterproductive, and for the majority of couples, ultimately unsuccessful. Yet alternative means of experiencing parenthood, such as adoption, are increasingly unavailable (Humphrey 1984).

Knowledge of the relationship between psychological factors and infertility carries implications for clinical management (Bell 1983; Wright et al. 1989). Despite continuing methodological flaws in research (Ellsworth and Shain 1985; Edelmann and Connolly 1986; Pantesco 1986; Wright et al. 1989), some progress has been made since the first edition of this book was published. The number of controlled studies has increased (although the debate over who constitute the best control group continues); studies using longitudinal designs have been completed, and others are in progress; measures of psychological variables have increased in sophistication; and sample sizes have increased. Some conclusions can be drawn from what is now a sizeable literature.
Psychogenic Infertility

It has long been suspected that psychological problems might play a causal role in some cases of infertility, this link being mediated either simply by a behavioral mechanism (that is through interference with the sexual relationship) or a psychosomatic mechanism (Mai et al. 1972). What is the evidence for this hypothesis?

1. **Reportedly higher rates of emotional disturbance in patients with unexplained infertility than in comparable controls.**

First, it should be noted that as a result of advances in diagnostic procedures less than 10% of couples have unexplained infertility (Templeton and Penney 1982).

It would be wrong to diagnose psychogenic infertility solely by the exclusion of physical causes. Apart from some evidence of heightened anxiety, few differences in mood, personality pathology or adjustment have been found between those with unexplained infertility and other subgroups (Brand 1982; Edelmann and Connolly 1986; Callan and Hennessey 1989b). Some studies have even found higher distress rates in those with organic causes, the opposite of the pattern predicted by the psychogenic hypothesis (Paulson et al. 1988; Wright et al. 1989). Certainly no single psychological factor characterises those with unexplained infertility.

2. **Higher rates of emotional disturbance in the infertile population than in comparable control groups.**

Although the evidence supports this (Wright et al. 1989) the prevalence of distress in infertile subjects cannot be taken to imply causation: in the absence of any evidence that it predated the infertility it could equally well have resulted from the condition and its management. There has been no prospective study evaluating emotional disturbance before infertility has been suspected or diagnosed and it is hard to envisage how such a study could be undertaken.

3. **Psychodynamic case reports and interview studies of female infertile patients noting "conflicts" about parenthood, resolution of which precedes pregnancy.**

Amongst other lingering psychoanalytic ideas (Pantesco 1986), there persists the notion of infertility as a “somatic defence against the stress of pregnancy and motherhood” (Benedek 1952). This rests largely on reports of “conflict” over motherhood (Jeker et al. 1988), or of “neurotic” motivation for parenthood, in women with unexplained infertility. Ambivalence and conflict are not, however, confined to the infertile (Mazor 1980), and there is no single unidimensional “genuine generative urge” (Christie 1980). Motivations vary, in number, nature and strength, in those who have achieved a pregnancy, as well as among the infertile (Bell et al. 1985).

4. **Correlation between some pretreatment psychological data and subsequent pregnancy rates.**

Of the few studies which have tested the value of pretreatment psychosocial data in predicting subsequent pregnancy rates, only one found a significant correlation, in a subgroup of women with unexplained infertility who experienced intermittent mild hyperprolactinaemia (Harrison et al. 1986). A donor