PSYCHO-SOMATIC PROBLEMS IN GYNAECOLOGICAL AND OBSTETRICAL PRACTICE*

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The study of the personality of the patient is essential for a medical practitioner because personality of an individual is the sum-total of all the reactions in an individual" says Dr. M. D. Adatia and emphasises in the following article the need for adoption of psycho-therapeutic procedures in the treatment of patients, especially women suffering from gynaecological and obstetric troubles. The author, in support of his arguments, cites several examples from his case records.

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Recently great interest has been taken by the medical profession in psychosomatic problems. Psychiatry may be called the youngest branch of medicine but by no means it is of less importance than any other domain of this science. Every disease has a psychic and somatic component; and the symptoms which appear to be due to organic diseases may be only the result of emotional and psychological disturbances. Cooke goes so far as to say that 90% of the severity of human suffering is mental.

A great deal of Symptomatology encountered in everyday gynaecological practice is of purely mental origin. Most alert observers recognise that a large proportion of women seeking aid for "female trouble" are, instead, "troubled females". It is a well-recognised fact—even by women—that they are more apt to undergo psychological disturbances. The word "hysteria" which is almost associated with "women" has an interesting philological origin in as much as that the word in Greek means "Uterus". The kinship between disorders of genital tract in women and psychological disturbances has been recognised since long.

"A great number of pelvic operations unnecessarily performed and the large quantities of hormones irrationally employed should put a conscientious worker on his guard and should make him watch for a background of emotional disturbance, which may be producing disordered physiology and acute distress in the pelvic region." (Miller and Weaver).

The precise figures concerning the incidence are difficult to obtain, because in a large group of patients the psychic and somatic conditions overlap making accurate differentiation extremely difficult. Yet on the whole the incidence of psychosomatic disorders in the obstetric and gynaecological patients has been estimated to vary from 30% to 70%.

It will be indeed distressing to the patient if every now and then she is to be referred to a psychiatrist for her functional ailments and minor psychiatric problems. Frequent reference will upset her mind and will make her emotionally antagonistic to any of the approaches of the psychiatrist. A little practice, a little elementary instruction and some interest in psychiatry could enable a gynaecologist to handle the psychosomatic aspect of his patients far more competently and with much less psychic trauma to the patients than by referring them to a psychiatrist.

Many of our consulting room patients are suffering from emotional reactions and fear.

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The confidence that a doctor is able to inspire in the patient should be enough to break down this distressing barrier between the doctor and the patient. The patient should be entirely at her ease with maximum of opportunity of self-expression and with all possible attention from the doctor. A thorough history taken personally is an essential part of any gynaecological consultation. A rapid examination carried out with the help of assistants may often mislead us. We may perform a miracle of diagnosis and of operative cure in a case of pathological state; and yet leave the patient a hopeless, life-long invalid because we have failed to employ appropriate prophylactic and curative psychotherapy of a very simple type.

An attempt is made here to briefly epitomise the salient features and basic principles of psychopathology.

The study of the personality of the patient is a great asset to the observer, because personality of an individual is a sum total of all the reactions in an individual. Personality is dynamic from birth to death. Its development begins from infancy. In the course of the development there is a constant struggle between the inborn tendencies on the one hand and the demands of the outside world. Most of our instinctual cravings, our likes and dislikes, our love and hatred have to be inhibited to make ourselves acceptable to the society in which we live. The social conventions and the ethical code of the society force us to modify our desires to suit the requirements of the community of which we constitute a part. The repressed ideas always play upon one's mind and produce a state of psychological tension. This tension may ultimately express itself in the form of psychological disturbance like anxiety state, hysteria, etc. or may express itself in the form of somatic disturbance, In women the reproductive system is often the channel of expression of psychosomatic tension.

Mind divides itself into two parts, subconscious and conscious. Mostly the conversion of psychological conflict into a somatic disorder is not direct or conscious. The patient is not aware of the state of tension existing within herself. Generally, when a conflict cannot be freely expressed, it is suppressed beyond conscious recognition. These repressed conflicts express themselves in the form of a functional disturbance of an individual or of a particular system of a body like genito-urinary system. These symptoms are the expression of underlying mal-adjusted personality.

For example, the sexual impulse is a natural and harmless one, yet it must be admitted that there is a great deal of social condemnation of a genital functioning as a whole. The lack of intelligent consideration on the part of the parents and teachers is really deplorable and as a result the genital tract as a body system has fallen in the path of deluge of human emotions of most unfortunate character. For example, we will take a very common illustration. The monthly flow of blood or menstruation is looked upon by so many educated and even cultured people as something that is unholy enough to make the menstruating women sit in seclusion.

The correlation of personality changes and physiological changes in the normal sex cycle of a woman has been studied and there is a general agreement about the findings. As observed by Malleson, Nail Burgler and Ribmiller:—

"The preovulative phase of the cycle is accompanied by a mood of elation and strong hetero-sexual interests. The tension is dispelled with sexual gratification or with the

rupture of the follicle. The phase of the progesterone increase is accompanied by passivity, a desire to be loved affectionately and protected. This gives place to a phase in which fantasies related to pregnancy can be revealed by exploratory techniques. The immediately premenstrual phase is accompanied by emotional tension in a setting of depression and irritability.

The repeated preparation for child bearing is apparent even in the psychological study.

Principles of Psychotherapy.—Rationale of psychotherapy in these psychosomatic disorders is that these disturbances are brought about as a result of repression of psychological conflicts; and if the conflicts themselves are brought to the conscious awareness of the individual, the need for its disguised and vicarious expression in the form of a bodily disease would not exist. If the conflict is resolved at conscious level by finding a suitable way out of it, the symptoms would disappear through sheer lack of need for them.

It has been attempted to give a short sketch of various psychiatric methods attempted by me during the treatment of various patients.

(i) *Rapport.* A confidential relationship between the physician and a patient was established whereby the latter gained confidence and respect for the therapist, and a desire to co-operate with him despite preconceived notions of the origin of her symptoms.

(ii) Ventilation and Aeration. These consisted in bringing into conscious attention in specific details wholesome attitude and reactions, which were usually associated with irritating memories.

(iii) *Desensitization.* This consisted in removing the unpleasant emotional tone attached to the memories by intellectual discussions.

(iv) *Persuasion.* It was explained to the patient how faulty intellectual and emotional attitudes on her part were reactions to certain difficulties, also how such tendencies led to undesirable habits and unhealthy emotional and mental conditions. By reasoned argument it was implanted in the patient's mind the conviction that her symptoms will disappear.

(v) *Suggestion.* The patient was helped by subtly, often indirectly, implanting or inducing the idea or belief that unpleasant disabling symptoms are being relieved.

(vi) *Mental Catharsis.* The therapist listened, without criticism, while the patient related emotionally troublesome mental content, recounted traumatic events that were painful to her and sometimes disclosed socially condemned motivations and feelings which she had entertained.

(vii) *Narcotherapy.* Interview was usually conducted with the patient lying on a couch while the therapist sat beside her. All efforts were made to give a maximum degree of comfort and relaxation. A cheerful and quiet atmosphere of the room was indispensable. A presence of a nurse was allowed in the room to prevent undue embarrassment on the part of female patients. By no means any of the relatives or strangers were allowed in to watch the procedure.

Patient was encouraged to express herself and to say everything that came to her mind, regardless of how inappropriate, irrelevant or personal it may seem to be. She was asked to relax and sleep if possible. At this junction i. V. injection of Pentothal Sodium was started and was continued slowly, drop by drop. All the time the patient was allowed

to talk. Maximum of 10 c.c. of Pentothal Sodium (2.5%) was administered in some cases; but cases respond to much smaller doses. In a matter of seconds or minutes the patient entered a trance-like state of varying depth.

Out of the irrelevant and incoherent mass of details that the patient brought out, certain trends of thoughts were gradually manifested. It was observed that most of my cases were either illiterate or lacking in a good educational background. Their thoughts and words were not trained to express themselves well. Patient had to be guided at times by various suggestions and reassurances.

A good knowledge of the emotional background of the patient's symptoms could be obtained in one or more interviews. During further interviews attention was given to amelioration of the patient's symptoms.

Talking to the therapist about their troubles made the patient feel better. Reassurance, environmental manipulation and understanding of the meaning of her own symptoms were further steps in relieving the patient of her symptoms.

(viii) *Continuous Narcosis.*—Few patients were given this therapy which lasted for 48 to 96 hours. Pentothal Sodium dissolved in 1000 c.c. of Glucose Saline was given by drip method continuously day and night. When the patient woke out of this artificial sleep, often the previous complexes were forgotten. Record of pulse and temperature was quite essential. Bladder and bowels were regularly attended.

(ix) *Cardiozol Convulsive Therapy.*—i.v. injections of Cartazol in doses varying (from 5 to 20 c.c.) with the individual were given. Patient was made to lie down comfortably in bed, Two to three assistants were kept ready to control her if any untoward accident happened. Mouth gags were used to prevent injury to the tongue. Injection was given rapidly and within a fraction of a minute convulsions appeared. Accurate dose for a particular patient was determined after careful observations and trials. Respiratory or other embarrassments were not seen. No fracture was recorded. Within a few minutes the patient used to come round; some remained dizzy for several hours, while some complained of pain and backache for several days. About 12 injections were required in average patients. They were given everyday till the quiescent stage was reached, then on alternate days and sometimes even once a week.

(x) *Insulin Shock Therapy.*—Injection of insulin was given early in the morning and an assistant was kept near the patient to watch for the coma. Dosage was decided upon by careful observations and trials. It varied from 30 to 400 units. Onset of coma was noticed within 3 to 7 hours. Coma was never allowed to continue for more than 45 minutes. Progress of coma was carefully watched. Injection of glucose was given to bring the patient out of coma. She was, then adequately fed. Incomplete coma was an indication to increase the dose.

(xi) *Retraining, Re-education and Stabi~lisation.*—This consisted in. guiding the patient to react more or less automatically in a symptomless, efficient and wholesome manner to various stresses in life.

Several times I had to prescribe and work out regimen at home, hospitalisation, occupational and physical therapy.

Attention to nutritional and hygienic needs of the patient was given.

Selection of Cases.—Cases for psychological approach were selected usually at the

first interview. Some cases were given this treatment when they failed to respond to other therapy.

These cases could be divided mainly into three groups: —

(i) Patients came with all symptoms only and no signs.

(ii) Patients came with definite signs, but symptoms were out of proportion to the signs.

(iii) There were definite signs and proportionate symptoms but the background was psychogenic or produced by psychogenic factors.

The following is the record of cases that have been treated by me: —

Menstrual Disorders: Amenorrhoea.—4 Cases. Mental shock often brought about this complaint in several women.

1. A young girl, name C.J.T., age 19 years, was brought to me for amenorrhea two months after her marriage. On physical examination there was no evidence of pregnancy, or of any other apparent cause of this complaint. Patient had two leuco¬derma patches on the waist; and on further questioning very interesting history was elicited. The husband of the girl had threatened never to take her back to his home because of those small whitish spots. Pentothal interview correlated the above findings. The husband happened to look upon the patches on the very first night after marriage. Early next morning he took her back to her father's place, and raised a big quarrel about his being deceived about his wife's appearance.

Treatment of leucoderma and appearance of the pigment brought back the normal menstrual cycle.

2. A Christian lady, name M.C.T. age 38 years, wife of an insane husband, had sex relations with her boarder without contraceptive on the 28th day of her cycle. She developed pregnophobia which could be relieved by hypno-analysis.

3. An unmarried lady, name S.K.M. of 28 years had amenorrhea for three consecutive periods after the death of her brother who was the sole earning member of the household.

Sympathy, explanations and settling her in some decent job started the normal menstrual cycle.

Dysmenorrhoea.—Psychic magnification of basic pain was found to a variable degree an element in practically every case of long standing dysmenorrhoea. An attempt was made to evaluate and to reduce or eliminate this element in every case.

I have about 7 cases on record, two of which are more interesting to narrate.

1. A young married lady name Mrs. K.D.T. of 22 was referred to for severely painful periods. The symptoms originated after her marriage and had lasted for about 12 months. The pain used to be relieved by Morphine or Pethidine only. Hormones, diathermy, infra-rays, aspirin all were tried but in vain. No somatic cause for the pain was elicited.

On direct persuasion under hypno-analysis the patient showed hostility to mother-in-law, father-in-law, husband and needed urgent change of environment.

By psychotherapy, the pain threshold was raised and deep psychogenic factors were relieved.

2. In the case of an unmarried girl name M.B.H, of about 25 years, dysmenorrhea

developing late in life was the expression of frustration, inferiority and mal-adjustment.

Very significant facts were brought out on hypno-analysis. She had secret love relation. Her great depth of the feeling for the man could not be adequately dealt with in various contacts which she had with him. She felt tremendously guilty of her emotions about him. The closer she came in contact with him, more and more psychic and physical pain was evoked. The ordinary expressions of love, such as kissing and other physical contact, gave rise to marked conflict in her. Her body felt tense and dysmenorrhea began. She was unable to relax and become care-free in the presence of the opposite sex. She knew that she needed them greatly but did not know how to deal with them in a way that left her physically relaxed.

At college she could not concentrate on her studies.

Loving a man conflicted with her ideals. In her own words, "It makes me tense and intolerable, I cannot stand it. It has come to the point where I have the same tension in my insides and in my head. I guess that's why I can't study."

Faulty sex education and sex prejudices harboured by the orthodox parents were also suggested. After hypnosuggestion she responded with these beautiful words: "I am tired of binding myself to social conventions, I am going to feel like a free human being and enjoy life." On further education and instruction she was far better. "When I relaxed emotionally I relaxed down there (meaning her pelvis). Everything about me flows easily now. I feel free to be a woman in every way. Menstruation flows more easily; my emotions of sex and love are easy and free and no longer associated with pain."

Leucorrhoea.—Eight cases are on record. Most of them were of unmarried girls. Leucorrhoea is like a headache of the lower abdomen, and were very resistant to treatment in most of these cases. Unconscious sexual ideas led to hyperaemia and hypersecretion in the genital region with a decrease of tonus of the smooth musculature. Following marriage and satisfactory sexual adjustment and the living out of the sexual fantasies and erotic desires, the leucorrhoea also disappeared.

The case of a Parsi woman, name K.N.T. age 27, having severe diarrhoea and marked white discharge per vaginam is very interesting. The symptoms had appeared six months after her marriage and the patient was brought to me by her husband.

No somatic cause was detected to account for the severe and irritating leucorrhoea.

One significant fact stood out of all unconsequential details. The discharge was more in the presence of the husband and had appeared only lately before 6 months soon after a plane accident in which her husband was involved. The accident had greatly mutilated the face of her husband and he had undergone various plastic operations.

The wife showed a repulsion and hostility towards the husband. Her repressed feelings about him were expressed in this unpleasant symptom of vaginal discharge.

Divorce relieved her of the complaint.

Urinary Disturbances.—Two cases had been noted.

1. I was called upon for consultation in a very aristocratic family to examine an unmarried girl name S.S.R.E. of 26 years. Her complaint was that of frequency of

micturition, lack of control and sometimes incontinence. No organic cause could be detected.

On hypno-analysis, following revealments were obtained. A strict, orthodox father resented the idea of her freely mixing with the opposite sex. Prohibition of society resulted in suppression of emotions which led to frustration of her sexual activities. Urinary symptoms represented at a conscious level the substitute for normal sex activity. Frequency of micturition was far more marked in the presence of opposit sex.

Re-education in thinking and feeling rightly to sex resulted in removal of frequency and urgency of urination.

Frigidity.—In the presence of a complete physiological normality the frigidity was in most of the cases the result of an abnormal mental attitude.

Five cases were noted in this respect.

Abnormal mental attitude towards sex relations covered tremendous range of patients; and in most of the cases the causes were the inhibitory factors which affected the female.

Physically and emotionally healthly women did not have a capacity to indulge in marital relationships of sexual function with pleasure. The ideas and the emotions with respect to this function were not rational and well integrated.

Even the husband never thought of woman's satisfaction in his act. He had some fancy notions that women were not probably meant to feel the same way in sexual relations as men.

It was explained to him then that there is no human relationship in which so much can be shared, so much of emotional and spiritual value given to each other as in the sexual relationship, if the attitude towards each other as man and wife is normal.

Pregnophobia, conscious or subconscious, was found to be the common cause of any degree of frigidity.

Abuse of Surgery.—Two of my cases are good illustrations how surgery in vogue is fruitlessly attempted without any consideration of the psychosomatic aspect of the patient.

1. A lady, Mrs. M.C. aged 39, complained of pain in the abdomen, backache, nervousness and fatigue. She was operated twice for the relief of similar complaints and was even ready for a third operation.

On rapport and ventilation she seemed to resent her normal environment and enjoyed hospitalisation and being attended to and cared for.

Psychoanalysis suggested that she had no satisfaction from the husband and that is why she wanted to change her environment. Education of the husband and assurances and adjustments of her emotions brought much-needed relief to her.

2. A young girl, name S.M.J. age 18, had to postpone her marriage date four times because of severe right sided abdominal pain. She was operated and appendicectomy and D & C were done. But still on the next wedding date her complaints reappeared. On psychic examination she was found to be emotionally immature to face the sexual relationships.

Sterility.—Too much eagerness to get a child was seen to bring premature ejaculation of ova, and the fertilisation was then never fruitful.

Adoption of a child and dissipation of worries was of help in starting the normal physiological functions.

1. A rich lady, Mrs. M.M.S. age 48 years, had been to almost each and every gynaecologist of repute in Bombay for her sterility. In despair, she adopted a child and sought consolation for her troubled mind. Her emotional tension was relieved, the injurious influence on the follicular apparatus disappeared and she was able to conceive at the age of 48, exactly 32 years after marriage.

Pregnancy.—True hyperemesis was always a magnification of the basic nausea of pregnancy. Abortion and premature labour were seen to be precipitated by profound emotional shock alone.

I have 5 cases on record.

1. The patient's name K..S.P. age 18; did not want a child, as she was far more devoted to music and art. As soon as the knowledge that she was pregnant dawned upon her she started vomiting, believing that through vomiting she may be able to do away with pregnancy.

2. A multipara name S.J.M. age 36, suspected that her husband was too busy and was not paying proper attention to her. She started vomiting as soon as she was known to be pregnant. Her symptoms were projected in the hope that her husband would stay at home and look after her.

3. A patient, name L.S.P., age 39 who had her previous delivery by caesarean section always worried that her present labour would terminate in the same manner. Her fear and doubts were removed by sympathetic assurances.

4. A primipara, name M.M.S., age 48 was diagnosed to be pregnant. During consultation with some other gynaecologist she was told to the contrary. She never brought herself to believe the truth about her condition until all possible confirmations were tried. Hypno-analysis and suggestions at the end satisfied her.

5. A patient, name R.M.A., age 32 who had a deformed child in the previous labour, suspected that similar fate will befall her again. By psycho-suggestions, proper consolations she was taken out of this phobia and carried to the last days of pregnancy.

Pseudocyesis.'—The condition was precipitated by either pregnophobia or intense desire to become pregnant.

1. The patient, M.R.R. age 36, believed to be pregnant was supposed to be in labour pains, but I was able to relieve her pains by injection of moryl and by passing a flatus tube.

2. According to her own calculation a patient, name Z.H.S. age 40, was in the eighth month of pregnancy, she had also registered herself at a well known hospital, on examination she showed sings of congestive cardiac failure and ascites. She also reported having felt the foetal movements.

3. A patient, name T.L.Z., age 32, had undergone D & C by me twelve years after her marriage. She missed her period and became suspicious, at the end of four months, the breasts showed fairly large enlargement and also some milky discharge, the uterus showed doubtful enlargement. I called her after a fortnight for further check up with a word of hope that she might be pregnant. Overjoyed as she was she spent a lavish sum on some religious ceremony. On subsequent

examination, I was of the opinion that she was not carrying. Her condition became critical and she had to be brought round by gradual and careful psychosuggestion. Gradually the enlargement of the beast, milk discharge, slight distention of the abdomen and vague feeling of foetal movements disappeared.

4. An old lady aged about 62 years, name J.S.S. was referred to me by her sons. She complained of severe vomiting and pain in the lower abdomen. On examination there was slight rigidity and a lumpy feel in the abdomen, but there was no evidence of pregnancy.

Hypno-analysis and pentothal interview revealed pregnophobia. A false D & C under hypnosis relieved her of all her complaints.

Menopause.—It is the time of involutional epoch with all its psychological and physical implications. In suggestions they were taught that there is nothing to enforce their tendency to ascribe their condition of nervousness exclusively to their pelvic organs.

Four of my cases on record showed psychotic tendencies, rowdiness and disturbance to other members of the family. Every one improved with a course of six cartazol shocks.

One of these cases was a wife of a Sanskrit Preacher, name M.S.S., age 42, she developed hostility towards her husband during menopause, started quarrelling and finally even attempted to injure physically her husband. She became quiet and temperate after a course of cartazol shocks. Small doses of estrogens are still being continued.

Psychosis.—Eleven cases are on record. The following classification of these cases is interesting:

Psychosis with early pregnancy	...	3 cases
,, ,, pregnancy 6 months	...	2 cases
,, ,, puerperal & post puerperal		3 cases
,, ,, gynaecological complaint		3 cases

All cases improved with heavy sedatives and cartazol shocks. Tuinal and paraldehyde were the drugs of choice for sedation. I have given more than six capsules of tuinal gr. 3 in one day and about sixty c.c. of paraldehyde intramuscularly without any harmful effects. Two cases were given continuous pentothal narcosis to bring them under control. Supportive therapy with liver and vitamins and hygienic care of the patients were carefully attended to. Nasal feeding and intravenous glucose saline were often given. Enema and catheterization were also necessary in some cases.

The cases with gynaecological complaint were given cartazol shocks and insulin subshocks on alternate days.

A regular follow up of these cases is still maintained. Some patients still need the monthly cartazol to keep them well adapted to society. Two important obstetrical points are worth mentioning. A patient having maniacal psychosis during her first delivery was seen to be having the same maniacal symptoms during her next labours. On the contrary, I have had two cases with histories of psychosis during previous deliveries, but under my care none of these symptoms were seen.

The question of sterilisation in a psychotic woman is disputable as congenital effect on the child is still not proved by scientific valuations.

Conclusion.—It has been aptly observed by A. Mandy, T. Mandy, Farkas, Scher and Kaiser that "The incidence of this psychoso-

matic illness is probably in excess of any estimate thus far published, since it appears likely that nearly every woman will at sometime develop such disorder due to the complex disintegration of her emotions and sexuality. Unfortunately much more is involved than a mere medical problem. Deeply significant are the broad sociological implications underlying countless broken houses and several divorces and the many unrecognised neglected or mishandled emotional disorders. Few with a serious psychosexual disturbance are capable of providing the proper environment for either bearing or rearing emotionally healthy children."

I have attempted here *to* put before the society my experience, and few case reports of a group of patients who obtained relief with the above line of treatment. My collection is of only 59 cases.

My interest in the subject grew partly because of my association with Dr. Vahia who has been of use to me sometimes in guiding me and sometimes in directing the line of treatment for the cases. Every gynaecologist or obstetrician is justified in handling these patients by himself and thereby reducing the burden of the very few and scarce psychiatrists in our country and sparing their time for deeper therapy. More often one uses these psychotherapeutic procedures, more successful will be his efforts in eliciting proper knowledge about the patient's condition. My technique and approach may still be faulty. I invite all suggestions for improving the work that I have been carrying on with the few resources that I can command at present. My ultimate aim, is to give uptodate and satisfactory service to this group of patients, who have wandered about from one specialist to the other in the hope of relief for their innumerable, bizzare symptoms, and to bring them as rapidly as possible to their families and occupations with a better capacity for adaptation, before they develop deeper psychosomatic disturbances.

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