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INFERTILITY AND SEXUALITY: THE ROLE OF THE GYNECOLOGIST

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ABSTRACT

Infertility is often the cause of problems that affect an individual's entire life. Stress, resulting from not being obtained of pregnancy, leads to the alternation of emotional reactions, such as surprise, anger, depression, isolation. The discovery of infertility can affect the perception of sexual identity, sexual function and the couple's relationship. The role of the gynecologist is extremely important, at all times, from the diagnostic to the therapeutic phase. Treat the two partners as individuals, involving them in the therapeutic choices, as well as providing correct and complete information, giving them a sense of control over their life and condition. The perception of being protagonists in the search for the child and not only the object of care, can reduce psychological distress and improve the adaptive mechanisms of stress response.

***Keywords**: Coping, Assisted reproduction, Sexual function, Sexual dysfunction, Sexual identity, Infertility*

INTRODUCTION

Infertility can cause problems that affect an individual's entire life, with the alternation of reactions, such as surprise, disbelief, anger, depression, isolation. The negative perception of one's body image and the loss of self-esteem are the cause of profound disturbances in personal and couple life. The discovery of infertility can indeed have a negative impact on the perception of sexual identity, on sexual function and on sexual relationship. In any case, whatever the mode of reaction, it is important that the two partners know how to relate to each other, understanding the needs and fears of the other, maintaining and strengthening their couple balance and their complicity (Darwish et al., 2002). The role of the doctor is extremely important at all times, from the diagnostic to the therapeutic phase. The participation of the couple in the timing and in the therapeutic choice, such as correct and complete information, gives both partners the feeling of exercising control over their condition. The perception of being co-protagonists of the research of child and not only "object" of care, can be useful to reduce psychological distress and improve adaptive mechanisms of response to the stress of assisted reproduction (Freeman et al., 1985).

INFERTILITY AND PSYCHOLOGICAL IMPACT

Our culture still attaches great importance today to motherhood, as an indissoluble element and essential of the female identity. Reproduction it is considered to be the most basic of needs of man, as if the bond of marriage, or the just living together, in themselves, entail an "obligation social and family to give birth to a child ". This explains why the inability to do this can generate problems that involve almost all aspects of an individual's life or one couple (Greil et al., 1989). Infertility leads to the alternation of multiple reactions as surprise, disbelief, anger, depression, rejection, isolation.

The first reaction to the diagnosis of infertility is surprise. Especially for couples who have thought about planning their reproductive life, using contraceptive methods in the past. The couple does not admit that they can no longer control their lives, they cannot manage to get pregnant, with the same ease with which he avoided it, when he did not want it. Infertility is experienced as an experience of loss of efficacy and control over one's life, over one's destiny. The couple most often reject the state of infertility and he feels the unconscious need to attribute the lack of conception to external situations. This leads to

changes in one's lifestyle, both in terms of eating habits and physical activity, and in terms of sexual activity. For example, it is customary, after intercourse, to place a pillow under the pelvis to ensure the supine position and avoid the spillage of seminal fluid. Infertility is an important psychological challenge for the couple, but it is experienced differently by men and women.

In women, the psychological impact is usually heavier and linked to several factors:

1. a greater identification of the woman in a role of mother from the social point of view;
2. to a greater importance that the woman attributes to pregnancy from the point of view of pure natural instinct;
3. to a greater commitment and stress that the reproductive function entails on the physical plane in the woman, even when it occurs in physiological conditions. Even more so when it is included in an assisted fertilization program, having to undergo all that the protocol entails, from repeated ultrasound checks, to blood sampling, from ovarian stimulation to insemination or to the most invasive egg collection with subsequent embryo transfer.
4. look for events in his past life that may be the cause of infertility, especially in the case of previous pregnancy terminations.

In humans, the psychological impact is linked to the millennial identification, deeply rooted in the personal and collective unconscious, between potentia coeundi and potentia generandi. The more specific aspects of the impact of infertility on male psychosexual balance can be summarized as follows:

1. the man experiences the examination of the seminal fluid with anxiety and discomfort, both for the methods of collection and for the need to abstinence from relationships. The anxiety aroused by the examination of the seminal fluid is often motivated by the fear of the judgment that the doctor and subsequently his partner will give of his fertility and therefore of himself;
2. in men the anxious component is much higher in those who have alterations in the seminal fluid, both for the sense of responsibility towards the success of the procedure and for the sense of guilt towards the partner who takes on most of the tests and therapies;
3. the participation of the male partner is, in the diagnostic-therapeutic process, intermittent, discontinuous and often passive, its presence is required in the diagnostic phase and on the day of any insemination;
4. the man more than the woman can compensate for the lack of the son. Men, a little for their attitude, a little perhaps for the desire to show themselves strong and to mask anxiety, tend to get involved in other activities, from work to sport.

In any case, whatever the mode of reaction, it is important that the two partners know how to relate to each other, understanding the needs and fears of the other, maintaining and strengthening their balance of couple and their complicity. Often, especially in women, the sense of frustration and failure results in a real cyclical depressive syndrome, exacerbated by the appearance of the flow or by external events, such as the birth of a child in the family or in the circle of friends. Many couples experience anger against themselves, anger against others who conceive a child effortlessly. Anger sometimes addressed to the other partner, who disregards expectations, who shows indifference, perhaps masking a suffering. Anger towards the medical team, with often aggressive attitudes. But let's not forget that feelings of anger can hide feelings of pain, anxiety and fear. The awareness of one's state of reproductive incapacity translates, in both man and woman, into a negative perception of one's own body image, into a perception of oneself as physically incapable and incompetent, sexually unattractive with consequent loss of self-esteem.

Most couples start a life together he consciously or unconsciously has the expectation to become a parent. If the child does not arrive, the couple may wonder about the value and meaning of their union. One of the two, especially the woman, can develop a sense of insecurity and uncertainty especially if he has the perception of not receiving that emotional support he feels he needs in that moment. This "crisis" of infertility often leads to isolation of the couple from the family and social context that instead it could provide help and support. It is easy to

understand how infertility can trigger in a person a 360-degree deep crisis. The infertility crisis affects the sphere of communication, of sexual activity and future plans. Infertility, therefore as well as causing profound individual psychological suffering can interfere e alter the couple's relationship and communication skills between partners.

CONCLUSIONS

As in other fields of medicine it is important that an empathic relationship is established between the doctor and the couple. The specialist must encourage the couple to express feelings and difficulties, help them identify possible strategies to overcome the most difficult moments of the whole path. Psycho-sexual assistance, with the help of the reference specialist who collaborates with the working group on assisted reproduction, can be indicated when psychosexual factors or problems favor infertility, such as in the case of vaginismus or erectile deficits, or are caused as a consequence stress of the reproductive path. The ability to customize therapy and to involve the couple in choosing the diagnostic-therapeutic path also has an important effect, in terms of the effectiveness of the intervention itself. If infertility is defined as a biopsychic-relational disorder, the procreative process must not forget the current concept of health, which is no longer synonymous with the absence of disease, but with the individual's overall bio-psycho-social well-being.

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