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PSYCHOSOMATIC PROBLEMS IN GYNAECOLOGY*

by

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I consider the invitation of the Bengal Obstetric and Gynaecological Society, to deliver the Sir Kedarnath Das Memorial Lecture for 1966, a great honour and I thank the President and the Members of the Society for doing me this honour.

In writing the Preface to his "Handbook of Obstetrics" in 1914, Sir Kedarnath stated that his experience in obstetric practice was then of over 22 years and his experience as a teacher of over 16 years. Except the late Sir Temulji Nariman of Bombay, Sir Kedarnath was the oldest Indian obstetrician of repute and fame, and when I was studying in London in the thirties of this century, I felt proud when reference to his ability was made by the British obstetricians. His library of nearly 10,000 volumes on Obstetrics and Gynaecology, dating back from the Sixteenth Century, is an unsurpassed single person collection. His collection of different midwifery forceps, from Chamberlain downwards, is also unique. Sir Kedarnath has left behind him in Calcutta, two permanent monuments which for ever will stimulate the future generations of obstetricians to emulate his example.

I am sure, and I hope you will agree, that more than half of gynaecology pertains to functional disorders; yet we are today in an unfortunate position where more and more emphasis is laid on surgical aspects of gynaecology. The present day approach of the gynaecologist towards his patient is largely from a surgical angle, with regrettable neglect of the functional side. The recent surgical advances in the treatment of malignant diseases of the genital organs, genital prolapse, and conservative technics, such as myomectomy, ovarian cystectomy and tuboplasty, are commendable, but regrettable

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when surgical attentions are directed towards functionally afflicted genital organs. The poor uterus does not get a fair deal for its noble function of perpetuating the human race and is either "slung up" (ventralsuspension) or is "lopped off" (hysterectomy) on flimsy grounds. The position as regards dilatation and curettage is even worse. Majority of women are curetted on one or more occasions for irregular bleeding or for infertility, without proper evaluation of the history, resulting in no improvement of the condition. I am convinced that a large number of curettage would not be performed if the history is carefully evaluated and a properly kept menstrual calendar is studied.

The two main groups of functions in which psychosomatic factors play an important role are, *menstrual disorders* and *problems pertaining to sexual function.* As functional disorders cannot be diagnosed by physical examination, a carefully taken history is the only means by which it can be evaluated. The gynaecologist is often too busy to listen to all the "non-sense" the patient wishes to ventilate, yet it is with sympathetic approach that at least some of the "non-sense" can be translated into "sense". I have used the word "nonsense", because more than one busy gynaecologist has expressed himself in this manner. In this connection, the family physician is a useful intermediary, as he has known the patient and her family for many years and is familiar with the family background. The first visit to a consulting gynaecologist is to a person whom she perhaps meets for the first time and it is but natural that she is unlikely to reveal in her history the intimate problems distressing her. Should the gynaecologist not listen to her patiently and with sympathy, the problems remain for ever enclosed in her mind and valuable data for helping and supporting her are lost. It has been my experience, and I have no doubt that it must be yours as well, that a dignified, sympathetic and none too inquisitive approach pays rich dividends. She leaves his office with confidence in herself and respect for him and at the next visit she comes out with astounding facts of her functional problems. Some women desire to consult only a woman gynaecologist, but when it comes to sex problems in which the male is involved, the situation, both for the woman gynaecologist and for the patient and her husband, becomes embarrassing. This is not an abstract belief, as my women colleagues have told me so. For evaluating menstrual disorders, the most important thing is to convince the patient to keep a menstrual calendar. In more advanced countries, majority of women keep a regular menstrual record, but in our country nobody does so and when I tell my patients to keep a menstrual record, I notice an amused look on their faces. I have to explain that each menstrual cycle reflects the function of the ovary for that month and, therefore, a regular record like a school-boy's report from his school, is important and it is only then that the value of a menstrual calendar is brought home to them. In those who complain of 'profuse periods', but with no pelvic pathology to account for it, I get a

routine blood count done every 4-6 months, in the same laboratory. I have avoided a hysterectomy for a good number of patients by regular study of the menstrual calendar and the blood count.

Functional Menstrual Disorders

Hypothalamic amenorrhoea

The amenorrhoea is essentially due to emotional stress. It is also sometimes termed 'amenorrhoea of anxiety'. Prolonged periods of amenorrhoea are induced by such factors as *hope of pregnancy* (pseudocyesis), *fear of pregnancy, environmental factors,* such as, *excessive mental anxiety* or *sudden change in one's environment.*

Hope of pregnancy (pseudocyesis)

It is a striking example of hypothalamic amenorrhoea. In the hope of pregnancy, the woman not only has amenorrhoea, but other symptoms of pregnancy, as nausea and vomiting, breast changes, swelling of the abdomen and increase in weight. Pseudocyesis is mostly seen in a woman of longstanding sterility, approaching the menopause. Her belief in having conceived is so deep-rooted, that it is almost impossible to convince her, until realisation comes when childbirth does not occur after ten or eleven months of amenorrhoea. Even then, some of them remain unconvinced. One of my patients maintains till this day that she was pregnant and that the 'dried' foetus is still within her womb. Theirs is a sorry plight, because they make all preparations for the arrival of the baby and the frustration resulting from non-fulfilment of their hopes is most distressing. One of my patients became mentally unstable and required prolonged psychiatric treatment. One fails to understand the value of examination under anaesthesia, because the relatives are convinced when the abdomen becomes flat under anaesthesia, but the patient usually remains unconvinced.

The fear of unwanted pregnancy is frequently the cause of secondary amenorrhoea. The following case illustrates this type of arrest of menstruation. A young unmarried European woman was travelling by ship from Australia to Europe. She had sexual relationship on the ship about ten days before the ship touched Bombay. She got off the ship and made arrangements to sail after ten days. She came to see me and wanted to be certain as to whether she had conceived. She had about six weeks' amenorrhoea. On bimanual vaginal examination, the uterus was of normal size. I got a biological test done on two different animals, to exclude any false positive result, as also to reassure her. The tests were negative and that very night, menstruation started.

Loeser, in 1943, reported in Lancet, four cases of secondary amenorroea following aerial bombardment of London during the Second World War. An interesting feature observed in the endometrial biopsies was that the endometrial pattern was such as would be expected at the time of shock, which suggests that psychic trauma suddenly interrupted the hypothalamic-pituitary-ovarian function. From Loeser's

cases, it appears that ovaries can be directly influenced by the hypothalamic stimuli resulting in immediate inhibition of hormones secreted by the ovaries.

Let me give one more striking example of secondary amenorrhoea of psychogenic origin. Those of us who were in practice at the time of partition of India, in 1947, will remember the large number of refugee women in our out-patients department, suffering from secondary amenorrhoea. Several environmental factors, such as malnutrition, poor hygienic conditions, anxiety arising from death or separation from their dear ones, loss of property, contributed towards this affliction. Many of them remained amenorrhoic until they were rehabilitated.

Primary dysmenorrhoea

In many cases of spasmodic dysmenorrhoea, psychosomatic environmental factors play a prominent role. All of us are aware that spasmodic dysmenorrhoea is seldom met with in the low socio-economic hospital group of women, while many more cases are observed in women of higher social status. This difference is because women of low socio-economic group have many privations and, as a result, their pain threshold is high, in contrast to the women of the upper social class living in comfort and ease.

The importance of psychosomatic factor in primary dysmenorrhoea was realised in European countries during and after World War I. Due to shortage of man power to work in industries large number of young women were employed. It was found that the introceptive attitude of the women towards primary dysmenorrhoea resulted in loss of enormous number of working hours and in efficiency. This realisation brought the present day treatment of emphasis on fresh air, outdoor games and exercises. We all know what marvellous change this has brought about. Loose clothing in place of tight corsets, attention to regular bowel action and general body hygiene were other contributory changes.

A girl among several brothers or a girl who is the only child is usually a pampered child and nearly always suffers dysmenorrhoea. Over-anxious parents or relatives and, more so, a fussy family physician, make the condition much more difficult to treat. I have one simple working rule which helps to create confidence in the girl and her parents and that is, that after listening to the patient's history, I suggest and impress them in a confident tone that this type of menstrual pain is a sign of good health and occurs in healthy girls. This, I have observed, nearly always helps to create confidence all round. A fussy family physician who wants to be in the good books of the girl and her family, is a much more difficult person to deal with. The following case illustrates this very well. A very rich girl, the only daughter among a family of four brothers, suffered severe dysmenorrhoea. She was made so introceptive by her family physician that she was a nervous wreck each month for nearly a week. Before me, two experienced gynaecologists had seen her and tried to give her confidence, without success. After listening to her history and examining her, I made an attempt to gain her confidence, but

she remained unconvinced and said, "You consultants have no use for me. My family physician knows how serious is my case. He is so attentive and sympathetic and pays a visit several times a day, while I have this pain". What object several visits serve in the treatment of dysmenorrhoea is only known to him, but one can make a good guess but not spell it out.

In the majority of cases, reassurance, reorientation of their outlook on problems of adolescence and improvement in general health, are all that is necessary. Habit-forming drugs, such as pethidine, should be strictly avoided. Injections for relief of pain are likely to make the young girl more introceptive and therefore, should not be administered. As a rule, an analgesic tablet at the commencement of pain, a second after four hours and a third six hours after the second by cumulative action, is usually sufficient to tide her over the painful 18 to 24 hours.

Extravagant claims for hormonal treatment have been made from time to time. As the basis of treatment is the production of anovulatory cycle, the relief is necessarily limited to the cycle treated. In a married woman, prolonged induction of anovulatory cycles is undesirable as a pregnancy would perhaps achieve more.

What is most objectionable is the frequent resort to surgical measures. A simple dilatation of the cervix is allowable, but to do ventralsuspension and presacral neurectomy lightly is not only unnecessary, but psychologically harmful, because relief is obtained only in a small percentage of cases and those who do not get relieved, despair and become more introceptive. When the uterus in underdeveloped and retroflexed and is the cause of pain, can turning the uterine axis through a right angle be of any use?

Premenstrual tension

Women who are well-adjusted psychosomatically, suffer from minor premenstrual disturbances. Premenstrual tension state is frequently observed in women of highly civilized communities. We rarely come across a case of premenstrual tension in hospital class of women.

There is some fundamental constitutional or inherited weakness which makes the woman fail to stand up to the stresses of life. States of anxiety and emotional instability aggravate the situation. One constant feature of the condition is increase in the extra-cellular fluid and retention of sodium. How this is brought about is not established, but one thing is certain and that is, that it is in some way related to the secretion of steroid hormones.

Though the recognised forms of therapy, such as restriction of intake of fluids and sodium, chlorothiazide as diuretic, help to relieve the distress the most important line of treatment is the sympathetic approach to find out the underlying cause of anxiety and emotional instability and when this psychological basic cause is removed, the results are gratifying.

Sex problems

All of us are aware of the important role of psychosomatic sex problems. In contrast to animals, sex in human beings is an emotional as well as physical experience, and sexual

disorders and maladjustments result from neglect or ignorance of this happy combination. Marriage frequently is an episode in the life of man, but it nearly always is an epoch in that of a woman. Therefore, the problem of happiness in married life is of much greater consequence to women than to men. It has been aptly said that "marriage is a lottery in which men stake their liberty and women their happiness".

A busy gynaecologist is often concerned with the physical side of the problem only, without taking into account the underlying emotional aspects. Sex problems are intimate and personal and the male, and more so the female, does not reveal the emotional problems worrying him or her until discreet inquiries are made and sympathetic consideration given. Is it not our experience that a woman is often too shy to reveal that coitus has not been possible since marriage for several weeks, months or even years, or that she is infertile, but hides her real complaint beneath vague general symptoms? Frequently, the emotional problem is not mutual but is worrying one or the other partner and is not brought out during a joint interview with both the husband and the wife. Once, however, the husband or the wife has gained the confidence of the gynaecologist, emotional distress is freely unfolded at a separate interview.

A couple who have known each other for many years are often disillusioned after marriage in enjoying a full pleasurable sex life. Sex problems are related to ignorance about sex education, fear, emotional factors and physical repulsion.

Ignorance about sex education is not infrequently the cause of inability to effect sexual intercourse. Clumsy and perhaps forcible attempts to penetrate are due to inexperience and often stem from embarrassment and the ego in him. It produces spasm of sphincter vaginae and levatores ani, and in severe forms, spasm of the adductor muscles of the thighs makes the vulva inaccessible. Vaginismus is the commonest cause of dyspareunia. Except in a few cases where the hymen is cribriform or thick and fleshy, inability to penetrate is functional. Being a delicate and personal matter, months and even years are allowed to pass without consummation of marriage before the girl confides to her mother or mother-in-law. It is seen more frequently in pampered, highly strung, anxious women and fear of pain during the first coitus is the background of vaginismus. Even before the fingers are brought near the vulva to open the labia, adductor spasm occurs, with raising of the hips and arching of the back.

Vaginismus in a newly married woman is usually due to the fear of pain during initiation. In a parous woman, it is more frequently due to some tender organic lesion. Narrowing of the introitus as a result of suturing of a perineal tear, a tender perineal scar, painful carunculae myrtiformis, an inclusion dermoid cyst at the introitus or excessive fibrosis following trauma during childbirth, are the common causes. I had an unusual case of dyspareunia and vaginismus following childbirth. Three weeks after a spontaneous vaginal delivery, I was called to see

the woman, because she had intense pain in the episiotomy scar. The scar was extremely tender and the patient would not allow even one finger to be inserted into the introitus for inspection. She was treated conservatively for several weeks and local anaesthetic injection was given without relief. I then suggested excision of the scar and resuturing. During excision of the episiotomy scar, the blade of the scalpel seemed to "grate" against some metal. On careful dissection, a broken needle was removed. She was completely relieved of her pain after that. On inquiry, I was informed that delivery took place at 2.00 a.m. on Christmas day and the doctor attended on her straight from a Christmas Eve party. Recently, I had a case of small inclusion dermoid as the cause of severe dyspareunia in a married woman having had two normal deliveries. Excision of the cyst completely relieved her discomfort. Dyspareunia and vaginismus in a sensitive woman who has not been initiated, requires good deal of tact and patience. The introitus can be widened under anaesthesia, but often the fear of pain during penetration persists. I therefore usually do dilatation without anaesthesia. The woman is instructed to relax the pelvic floor muscles and then graduated, well lubricated, vaginal dilators are passed. At the end of each treatment, she is shown how wide a dilator she has allowed to be passed and that is very reassuring to the patient. Very seldom is it necessary to dilate under anaesthesia. I recollect a woman who was so highly strung that dilatation without anaesthesia was out of the question. Even after dilatation under anaesthesia, coitus was not allowed. Several years after marriage, she allowed coitus and is now the mother of two children. As is to be expected, both were abdominal deliveries.

In practice, one comes across instances of what might be termed "sex hostility". To some, married life as far as sex is concerned is disgusting and repugnant, though the couple is well adjusted in other spheres of activity. Many factors contribute towards frigidity in one of the partners. Foul smelling vaginal discharge, foul oral breath, objectionable body odour, profuse growth of hair at sites where hair normally is not present, trichomonal and monilial vaginitis, causing smarting and 'pricking' sensation to the male during and after coitus, are a few examples. Psychological maladjustments are equally varied and important. Occupations requiring considerable mental strain, disinclination due to long hours of work, living among unpleasant environments in a joint family, are a few examples. Let me give just two instances. A solicitor and his wife consulted me for barren marriage of three years. I examined the female in the usual routine manner and did not find any cause for her infertility. I suggested a male spermatic fluid report and dilatation of the cervix, patency test and curettage. The following, day, the wife came alone and said "You want these tests, but we have never had sex life since marriage. We live in a joint family and every time I close our bedroom doors, my husband promptly opens them and, as a result, we have never been close to each other". Soon after she left, I tele-

phoned to the solicitor's office and requested him to come and see me. He promptly responded, but he would not answer any of my questions as to why he was behaving in this manner. Nothing more was heard from the couple for nearly six months, when the solicitor surprised me by asking for an appointment. He apologised for his indifferent behaviour on the previous occasion and revealed that sex was repugnant, because his wife had a terrible foul breath. He did not want to hurt her feelings and suggested that I do something. He arranged for his wife to consult me and then I observed that there was foul odour noticeable at a distance of three feet. On my suggestion, she consulted a dental surgeon and was cured of her foul breath. Soon after, they took a boat trip from Bombay to Japan and on their return, she was one week over her expected menstrual date. In the fifth month of her pregnancy, her sister-in-law, also childless, became jealous of her good fortune and had a terrific argument. Within twelve hours, the psychological upset started vaginal bleeding and she aborted. Here, ladies and gentlemen, is a good instance of "man proposes, God disposes".

Recently, I had a childless couple whose sex life was not adjusted due to an extraneous cause. The couple lived separately from the in-laws, but every evening they used to go to visit the parents of the husband. The husband's mother was a gentle woman, while the father was a dominating, inconsiderate person. Practically every day, there would be unpleasant arguments between the father and the son. After returning home, the son never felt like being intimate with his wife, brooding over his mother's state.

Recurrent abortions

A woman whose first pregnancy terminates in an abortion, is fearful of her second conception and psychosomatic influence plays some role if the second one also ends in an abortion. I do not wish to underestimate the local genital or hormonal causes of recurrent abortion. A maldeveloped uterus, an incompetent cervix or a grossly underdeveloped uterus, essential hypertension and such other well-recognised causes need appropriate medical or surgical treatment. In spite of intensive research to evaluate the role of endocrines in recurrent abortions we are nowhere near any definite conclusions. Results of treatment by oestrogens and progestogens or gonadotrophins have produced more or less the same reports. Some treat these cases by giving large doses of Vitamin E, others by penicillin, on the assumption that the aetiological factor might be syphilis. I have treated these cases with 7-days' course of penicillin in the third, fifth and seventh months of pregnancy, with satisfactory results. Since a few years, I prescribe, instead of penicillin, liver or vitamin injections and the results have been just as satisfactory. Even a change of medical attendant, who does nothing particular, results in carrying pregnancy to term. Does not this suggest a psychosomatic influence, the good results being due to restoration of the woman's confidence

that she is under good supervision? I have had several cases where women have been so apprehensive that they have pleaded to be kept in a Nursing Home for several weeks where they feel secure and confident. Here a tactful resident staff is very helpful. Let me just give one striking case. A woman married in her early twenties had her first abortion at ten weeks, following a nightmare in which she found a bunch of snakes crawling over her body. She started bleeding and aborted in a few hours. She was with me for the second and the third times and the same nightmare about the same term precipitated abortions. She changed over to another gynaecologist who, I fail to understand, did a ventralsuspension and Cott's sympathectomy. She conceived, but the same nightmare occurred and she aborted. She came to me again, but she was so fearful, that she refused to have another conception. Now she is 43 and childless.

Backache

There is an inclination to regard low back pain without any apparent cause as a functional condition but this attitude is likely to lead to serious consequences in an occasional case later on. Many years ago, I was shown a young unmarried woman for excluding a gynaecological cause for her low back pain and a slight limp. There was no apparent gynaecological cause and orthopoedic investigations were negative at that time. She was labelled as a neurotic, overanxious person. As the pain worsened over the next six months, another orthopoedic investigation was done and the diagnosis of early Koch's infection of the hip joint was made. In a parous woman though no apparent cause can be found for the low back pain, it is very likely that stress and strain of childbirth might bring on some fibromuscular changes in the region. Psychiatrics consider such pain as an expression of repressed hostility against some member of the family, more often to the conventional mother-in-law. Though such back pain may be a bodily reaction to the need for attention and sympathy, one must constantly bear in mind the likelihood of a cause, not apparent now, to develop later.

Leucorrhoea

There is no doubt that in some women excessive vaginal discharge has a functional origin. Women do suffer from excessive vaginal discharge whenever there is mental anxiety. Leucorrhoea in school and college-going girls about the time of the examinations is not at all uncommon and soon after the strain of examinations is over the leucorrhoea regresses spontaneously. Unsatisfied sexual gratification is another cause of leucorrhoea of functional origin. The discharge ordinarily associated with sexual climax is replaced by mild persistent leucorrhoea.

I am conscious of the fact that by delivering this Oration, my senior colleagues must not have found anything new and spectacular, but I hope it has helped them to refresh their memories of many such cases. To my junior colleagues, I hope these few remarks will stimulate them to pay greater stress on psychosomatic factors, not after they have come to

the end of the rope of medical or surgical treatment, but before, during the preliminary investigations.

I thank you all most sincerely for having given me the opportunity to pay homage to one whose name we are all proud to remember, not for a generation, but for future generations also. I shall remember this day all my life.