

Female infertility: A Psychosomatic Approach

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Abstract

This study aimed to clarify the psychological factors that contribute to female infertility when the diagnosis of an obstetrician and gynecologist confirms the absence of any organic cause in either partner. Here, we sought to clarify the psychological factors contributing to female infertility through a psychosomatic approach, based on classical and modern theories based on psychoanalysis. These factors are related to early psychological conflicts and unconscious repressions related to femininity and motherhood. We will review the most important psychological factors that can clarify and open the way for psychotherapy instead of the traditional reliance on medical treatment alone. We will also instill a culture of therapeutic integration (both medical and psychological), thus increasing the chances of pregnancy for women suffering from infertility without a notable organic cause.

Keywords: Femal infertility, Psychosomatic, Psychological factors, Psychotherapy.

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Introduction

With scientific and medical advancements, the problem of infertility has found numerous effective treatments and solutions for couples. These treatments involve accurate examinations that allow for precise diagnosis, revealing the true problem in the couple and, consequently, finding solutions, such as artificial insemination and medication.

Despite this significant progress in the medical field of infertility, in many cases there is no organic cause to explain the couple's infertility, yet the woman remains unable to conceive. This has led doctors to acknowledge the role of psychological factors in influencing fertility. Here, we have focused our study on the psychosomatic approach, attempting to explain infertility in women. Accordingly, we seek to answer the following question: What are the psychological factors that contribute to infertility in women?

I. the Medical Approach to Female Infertility

Before addressing the psychological aspect of female infertility, it is essential to clarify infertility from an organic perspective, outlining its types and the primary factors contributing to its occurrence.

1. Definition of Infertility

The World Health Organization (WHO) defines infertility as "the inability of a couple to achieve pregnancy after 12 months of regular sexual intercourse without the use of contraceptive methods" (WHO, 2025). This excludes cases where the woman has reached menopause or has never been pregnant before. Infertility may result from disorders in reproductive hormones, the pituitary gland, or ovarian issues, among other factors (الراس، 2001).

2. Types of Infertility

2.1 Primary Infertility

this refers to the absence of pregnancy after one or two years of sexual activity without the use of contraception. It typically affects women at the beginning of their marital and sexual lives. Causes of primary infertility include hormonal or glandular disorders or incomplete development of reproductive organs due to congenital factors. Its prevalence ranges from 11% to 41% (Girard, 2006).

2.2 Secondary Infertility

This occurs after a previous successful pregnancy or miscarriage and can result from various factors. In such cases, psychological factors are likely and are confirmed through specialized medical examinations

Strachah (2006) defines it as the inability to conceive again over the long term after having one or even two children, with subsequent failed attempts at conception. Its prevalence is estimated at around 3.81% (Girard, 2006).

2.3 Physiological Infertility

this is the most severe form, where the ovaries are underdeveloped or absent. Menstruation in such cases occurs late, is irregular, short in duration, and scanty in volume (Deondt-Gadet, 2011).

2-.4 Psychological Infertility

This refers to infertility with undetermined causes, attributed to psychological factors. It may result from psychological traumas during early childhood, fear of pregnancy, or relational disturbances and marital conflicts (معاليم، 2008، ص117).

3. The Difference Between Fertility, Subfertility, and Infertility

Fertility is defined as the ability to reproduce, specifically the female's capacity to conceive. It begins with the onset of puberty, menstruation, the appearance of secondary sexual characteristics, and the ovaries' release of eggs.

Subfertility refers to the temporary inability to conceive during a specific period due to certain factors. Treatment is possible if the cause is identified, and the woman may subsequently conceive without difficulty. Thus, subfertility can be considered relative infertility.

Infertility is defined as the complete inability to conceive, a condition where treatment has been ineffective. However, with advancements in medical science, many previously untreatable cases of infertility can now be addressed, such as blocked fallopian tubes or low sperm count (Thompson, 2013, pp. 40-41).

4. Factors Contributing to Female Infertility

4.1 Organic Factors

4.1.1 Factors Related to Ovulatory Disorders: These include **hypothalamic dysfunction, excessive prolactin secretion, and primary ovarian insufficiency.**

4.1.2 Factors Related to Fallopian Tubes (Tubal Infertility): Damage or blockage of the fallopian tubes prevents sperm from reaching the uterus. Causes include:

- Pelvic inflammatory disease or infections in the uterus and fallopian tubes.
- Previous abdominal or pelvic surgeries.
- Pelvic paralysis, a primary cause of tubal infertility.

4.1.3 Factors Related to Uterine Disorders: Damage to the uterine lining can lead to the growth of additional tissue, blocking the fallopian tubes and disrupting the implantation of fertilized eggs. This can indirectly affect fertility by damaging eggs and sperm. Uterine tumors are also common, some of which may block the fallopian tubes or interfere with egg implantation, negatively impacting fertility.

4.2 Unexplained Infertility

In some cases, no clear cause of infertility is identified. It may be attributed to other factors related to the relationship between partners (psychosocial). Despite the frustration experienced by both partners, the chances of conception are higher compared to other complex organic cases (Fabienne, 2004, p. 80).

Here, we open the door to the psychosomatic aspect to explain infertility from a psychological perspective, which will be detailed in the following sections.

II. The Psychological Approach to Infertility in Women

There are numerous cases among women who suffer from infertility, and after medical professionals confirm the absence of any organic defect in either the husband or the

wife, the woman still cannot conceive. This condition is known as medically unexplained infertility, which we can refer to as psychologically induced infertility. Psychological studies have thus emerged to interpret the causes of infertility, recognizing that each woman has her own unique set of challenges. Consequently, the contributing factors to the emergence of infertility are highly diverse. Analytical perspectives have been divided into several factors, with some addressing it as a hysterical symptom. Through the psychosomatic approach, we will attempt to highlight the most significant explanations for this phenomenon.

5. Definition of Psychologically Induced Infertility

Châtel defines it as: "Psychologically induced or medically unexplained infertility is the inability to conceive despite the absence of a medical explanation, and in some cases, despite attempts at artificial insemination or hormonal consultations. Since ancient times, infertility has been considered a significant phenomenon affecting women alone, holding them responsible for this incapacity" (Châtel, 1998, p. 25).

6. Infertility and the Desire for a Child

The desire for a child activates other repressed and infantile desires, such as the wish to possess a phallus like a man. This process allows a part of the woman's narcissistic masculinity to transition towards femininity, thereby rendering her ineffective in her sexual function as a woman. The desire for a phallus can create a masculinity complex. Freud (1925) described cases of women who had strong relationships with their sons, to the extent of desiring a child from them without linking this situation to infertility.

In his book *My Life and Psychoanalysis*, Freud stated that the desire for a child is a supreme desire that ends all other desires.

From Pargier, we extract the characteristics of the desire for a child in infertile women as follows:

a. Initiating Treatment as Evidence of the Desire for a Child:

The child is not desired for itself but as a representation of the phallus it carries. Women attempt to embody their mothers, perceived as complete by Diffuses. Infertility leads to an emotional need that must be fulfilled at any cost to repair narcissism. It is not so much about the desire for a child as it is about the will to be a mother (Pargier, 2003, p. 108).

b. Reviving the Desire for a Child in Infertility:

Motherhood is not merely a mother-child relationship but a conscious and unconscious desire, a story of identifications and the recall of personal history. The desire for a child revives issues stemming from primary homosexual sexuality but also feelings of hostility towards the mother. According to Pargier, the child is directed towards the mother (Pargier, 1987, p. 60). In the same vein, Haincault confirms that her analytical experience has shown that the separation between mother and daughter is the most difficult separation, where mourning is absolutely impossible (Haincault, 2006).

c. Infertility in Childlike Women

These women are always in need of support from others, initially from their mothers and later from their husbands, due to their immaturity. These women cannot perceive themselves as mothers.

d. Infertility in Women with a Strong Maternal Instinct:

These women realize that their partners do not genuinely desire a child. They invest particularly in their marital relationship, becoming a substitute mother for their husbands and preferring erotic harmony in the marital relationship.

e. Women Who Feel Their Maternal Capacity is Distinguished but Focus on Other Goals:

Here we find the erotic feminine woman who is not strongly concerned with her erotic life.

Masculine Women Who Fail to Embrace Their Femininity, Emotionally Distressed Women Who Recognize the Poverty of Their Emotional Lives and Feel Incapable of Bearing the Burden of Pregnancy

7. Femininity and Motherhood in the Process of Infertility

In reality, we find a strong association between femininity and motherhood, and many authors have attempted to clarify the relationship between the two. Cosnier (1987), referencing Freud's ideas on femininity, argues that Freud does not associate femininity with a passive position, which he views as the result of a woman's identification with being castrated. For a woman to be feminine, she must repress her active phallic desires. In the internal psychological reality, femininity is something alien and unknown, reflected in the woman's body.

Bastien, building on Freud's ideas of bisexuality, explains that both men and women possess elements of both genders within themselves, and neither belongs entirely to one gender. To understand what it means to be a woman, we must understand how a girl becomes a woman. The girl is compelled to shift her erogenous zone from the clitoris to the vagina, as well as to change the object of her love. The love directed toward the mother during the pre-Oedipal phase gives way to hostility toward the mother and love for the father, as the girl hopes to find in the father what she did not find in the mother.

However, the early attachment to the mother does not completely disappear; it is merely a state of comfort that is revived when a woman encounters motherhood. The discovery of castration leads to the desire for the penis, and the girl embraces her femininity when she substitutes the desire for a penis with the desire for a child as a symbolic equivalent of the penis.

According to Bastien, women experience physical and psychological disturbances during attempts to conceive and face real problems in their marital lives. The transition to motherhood often leads to a loss of desire, rejection, and even fears of sexual intimacy (Bastien, 2008, p. 116). Bastien suggests that the source of this loss of libido is the woman's fear of being unable to repay her oedipal debts (Bastien, 2008, p. 115).

In the same vein, Bècache (1987) argues that femininity is the essence of womanhood, and motherhood is its fundamental characteristic. A woman cannot become a true woman until she becomes a mother. According to Freud, women are more narcissistic, which is evident in their constant need to be loved by men.

For Dolto (1998), femininity equates to a passive capacity, meaning the specific negative dynamism of women. Pregnancy, in her view, is a symbol of femininity, and the process of infertility is a result of a woman's rejection of her femininity. Bastien further emphasizes the depressive response of women who attempt to conceive without success, building on Freud's idea that pregnancy is reparation for what the girl was deprived of—the penis. Degasses highlights the importance of distinguishing between the desire for a child and the desire for motherhood. Although related, the desire for a child is a projection of the desire for continuity and self-fulfillment; this desire is more feminine than maternal. In contrast, motherhood equates to a personal necessity to give to the other, whether psychologically or physically.

Here we observe that a woman's desire is highly complex, and every desire represents an unconscious force that does not abandon itself, as is the case with the desire for a child. The concept of the desire for a child is itself ambiguous and questionable. According to Dalon, the concept of the desire for a child is, above all, not necessarily accurate despite its widespread use. The desire for a child exists on multiple levels, including a woman's speech, but we cannot take the genuine desire to have a child solely from verbal expressions, as the body also speaks and can reveal underlying suffering in the preconscious or unconscious. These different levels are often contradictory, and this contradiction reflects the emotional life. Instead of speaking of desire or rejection, it is better to speak and think in terms of conflicting contradictions (Revault, 1991).

Modern contraceptive methods and new medical treatments for infertility have enabled a better understanding of biological phenomena. However, the human factor remains problematic, as rational projects are still driven by unconscious forces. The conscious desire to have a child is put to a difficult test by the unconscious. The Child as a Program for the Couple: Psychological Perspectives on Infertility.

The child is often perceived as a programmed outcome for couples, attainable at any time with their assurance of having absolute control over reproductive decisions. However, repeated frustration can ignite an internal conflict within the woman, oscillating between the desire to have a child and the simultaneous rejection of this desire. This contradictory struggle is often expressed through the process of infertility, which medical professionals are unable to explain organically (Debray, 1987, p. 13).

Thus, the unconscious draws upon everything the woman has retained since birth, particularly her identifications with her mother. When a woman fails to conceive, the demands of her strict superego harden against repressed aggressive impulses, which she finds difficult to process and endure (Debray, 1987).

The occurrence of separation from the mother in the early stages of life is crucial for a girl to transition into her femininity. The mother's transmission of femininity makes the encounter with the imaginary child possible, thereby enabling her to become a mother herself, and vice versa.

The desire for a child drives the narrative of a woman's life. The contradiction between the desire for a child and the simultaneous lack of desire reflects the existence of the child's image within every woman's psyche. This child represents the completion of her

incomplete self and serves as an object of love to fulfill her desires. The imaginary child, present in every woman's mind, and the contradiction between desire and its absence, translate into the impossibility of substituting this imaginary child with a real one (Revault, 1991, p. 280).

In the same vein, Bydlowski (1978) emphasized that the child, before becoming a reality, is first and foremost an imaginary construct. Every woman is expected to desire a child, as procreation signifies the recognition of the mother within oneself. This narcissistic aspect of the desire for a child can explain some cases of infertility as the impossibility of giving life to the child. The attainment of a child and the realization of motherhood are made possible through the interplay of three fundamental components: the daughter's identification with the mother in early life, the desire to have a child from the father (as her mother did), and the sensual sexual desire directed toward a man other than the father, which allows her to attempt to fulfill her earlier desires in the project of having a child. This, in turn, necessitates the work of mourning her love for her father and transcending the incestuous relationship.

The failure of the oedipal conflict leads to the absence of the internalization of the incest taboo in the child. The consequences of this failure vary in their impact on the child's future emotional and sexual life, taking on relatively pathological expressive forms. This is what Racamier (1992) referred to as the persistence of incestuous desire at the level of imagination due to its non-realization in reality.

Revault (1991) pointed out that the transition to motherhood is an unconscious process rooted in the girl's developmental history, which is constructed during childhood primarily through the initial experiences with the mother and subsequent separation from her (Revault, 1991, p. 202).

The quality of internalizing the incestuous relationship affects reproduction positively or negatively. If a woman successfully navigates these conflicts and integrates them at the mental level, she can achieve motherhood and adapt to her maternal experience. However, if she fails and the conflict persists, she remains in a state of immaturity, with her motherhood awaiting the maturation of her femininity.

Analytical studies in the field of infertility have shown that the issues associated with the process of infertility range from narcissistic to hysterical conflicts.

Pargier (2003) considers childhood stages fundamental in shaping an individual's personality and way of being. The manner in which the Oedipus complex is resolved leaves unknown traces in the individual, yet it determines their emotional life, preventing the child from investing in one parent at the expense of the other and renouncing the loving relationship with them (Pargier, 2003, p. 260).

8. Psychoanalytic Theories Explaining Psychological Infertility

8.1 Early Theories

Freud, the father of psychoanalysis, did not study infertility in depth. In reality, he only referred to this issue twice in his works. The only direct mention of infertility is found in a letter (Fliess, 1895), where he describes a case of a patient suffering from hysterical infertility. His analysis suggests that infertility manifests as a result of the desire to kill the father and the desire for power. Freud establishes a connection between female infertility and forbidden love for the father, as well as the desire for power, which necessarily diminishes the femininity of the woman in question (Tort, 1992, p. 67). Having a child, in this context, implies a loss of sovereignty and power.

Deutsch (1949) studied what she termed psychological difficulties in reproduction, where psychological factors, particularly the physiological mechanisms of motherhood, are evident. She questions the persistence of infertility despite hormonal treatment,

seeing this as evidence of psychological effects. These effects primarily manifest during marital sexual relations. Deutsch argues that female passivity plays a significant role and contributes to infertility. She identifies an unconscious fear that affects both reproductive function and the sexual process itself. The core element of this fear is a sense of guilt. It is worth noting that, within the framework of psychoanalysis, parental investment in the child involves granting the child omnipotence. Parents see in their child a demand they had previously relinquished, and as a result, they now see themselves in their child as they once imagined themselves. Parents project their ideal self onto their child, who in turn projects it onto their own child. In reality, by projecting their own narcissism onto their child through identification, parents inadvertently project parts of their own childhood selves, including negative and conflictual aspects or parts of their own parents' conflicts (Lenestour, 2003, pp. 36-37).

Deutsch clarified that some infertile women have a special relationship with their mothers. The emergence of guilt feelings must be traced back to childhood, when the pregnant mother was a source of emotional disturbance in the child's affective life. The birth of a sibling triggers various anxiety crises, such as the fear of losing the attachment relationship with the mother. These fears generate aggressive feelings in the child, who may wish death upon the mother and the new sibling, leading to guilt feelings later on. This includes the fear of losing one's identity to the child, which may be a primitive fear of death, anxiety about losing erotic value, fear of being unable to fulfill the real and forbidden duties imposed by pregnancy, and fear of intellectual or emotional weakness, which motherhood is supposed to overcome.

Groddeck (1955) emphasizes that the id creates diseases in women, including infertility. The ego imposes the following thought: "It is better not to have children." Then, when fertilization is possible, it prevents it. A woman can only conceive when the id is convinced that her aversion to pregnancy stems from certain childhood concepts rooted in early childhood (Groddeck, 1955, p. 48). He also highlights the importance of aggression toward the mother in cases of infertility, where mutual resentment is always present between the mother and the daughter. Morality imposes love for parents, or else severe punishment follows, accompanied by feelings of guilt, such as the fear of giving birth to a deformed child. This fear can manifest as infertility. On the other hand, resentment toward the mother means rejecting the nature of reproduction, as the daughter's resentment toward her mother signifies aversion to the symbol of the genital organ—the reproductive nature of being a woman (Groddeck, 1955, p. 49).

8.2 Modern Theories Explaining Infertility

Revault and D'Allonnes (1998) discuss the pathological role that ideal mothers play in their daughters' motherhood. This dominance leads the daughter to doubt her ability to become a mother. Motherhood enters a framework of competition that seeks an impossible satisfaction. The ambivalence toward the mother, where feelings of guilt come into play to reinforce the mother's image, is the core issue. The fundamental problem lies in the identification with the mother and the ambivalence of love-hate, which are childhood issues related to the mother's power, equated with the child's total dependence. This gives rise to the passivity resulting from the mother, the fear of her, and the simultaneous desire and love for her. The Oedipus complex reinforces this feeling, as resentment toward the mother and closeness to the father generate guilt. These characteristics of the oedipal situation indeed stem from the pre-Oedipal fascination with the mother and the active renunciation of oedipal desire in favor of the mother (Revault, 1998, p. 100).

In the context of Tort, infertility is not considered a symptom in itself. What can be symptomatic is the individual's relationship to the reality of the body. The body expresses what language cannot, even though we only consider the discourse of the unconscious when medicine fails to address a successful treatment request (Tort, 1992, p. 165). Infertility is seen as an unconscious, forbidden wish imposed on the individual's body, originating from the mother, grandmother, or other significant figures in the infertile woman's life. Here, we find a rejection of the child on the woman's body, which could not be realized on the mother's body. The infertile woman cannot separate from the phantasmatic mother, even after the mother's death, because she does not have the right to give what her mother did not receive, whether the mother was depressive, absent, failed in her maternal role, or experienced her pregnancy as a destruction. This suggests that infertility cannot be linked to a specific psychopathological structure. Instead, infertility appears as a compromise between the desire for a child and conflicting desires. The search for a psychological origin of infertility seems complex because each case of infertility appears to stem from a unique problematic. Bydlowski (1997, p. 35) argues that the absence of a child is not an illness in itself and that infertility represents a boundary area with medicine. With the development of assisted reproductive technologies (ART), physicians have distinguished between infertility with physical causes and unexplained infertility. Bydlowski does not differentiate between organic infertility and infertility of psychological origin, as highlighted in a book she co-authored with M. Lintzer, stating that infertility is a symptom in itself, whether or not it is based on a medical explanation. Infertility expresses suffering arising from internal conflict. If the individual can articulate this conflict, which they themselves are unaware of, through a therapeutic relationship, the symptom of infertility may disappear. Bydlowski interprets infertility through the studies and cases she has worked on as follows:

a. In the first case:

Infertility is interpreted as the failure to fulfill the phantasm of the incestuous relationship, specifically the intimate relationship with the father of the child, as Freud referred to in "the return of the repressed."

b. In the second case:

Infertility arises from the phantasm of virginal procreation (parthenogenesis), where the woman desires a child for her mother. This child does not materialize because the woman receives a prohibition from her mother, who, in some cases, only had one child herself and refuses to allow her daughter to become a mother in turn. If the mother has already died, her death can solidify this prohibition, leading women to develop phantasms of control and domination over their bodies.

c. In the third case:

Women cannot bear children due to the fear of repeating their mother's dramatic fate. Here, we find women whose mothers experienced traumatic events after childbirth, where the mother explicitly links this dramatic fate to the birth of the child itself.

All the aforementioned researchers emphasize the role of the mother, even in cases of primary infertility. Thus, infertility appears as a symptom of prior suffering. The researchers conclude that suffering does not arise from infertility, but infertility arises from suffering (Rogergiers, 1994, p. 98).

Bydlowski proposes a hypothesis that voluntary temporary infertility (through contraception) increases due to the fear of pre-existing permanent infertility. She describes how the image of the mother for an adolescent girl (who is not yet in a position to conceive) differs from the image a child holds of their mother. To the

adolescent, the mother appears to despise the father and monopolize the capacity for reproduction. This perception of the mother can persist until the daughter's first motherhood, which marks the end of female adolescence. During this phase, identifications shift, and the woman rediscovers the nurturing image of her mother from early childhood. Infertile women find themselves trapped in this adolescent view of their mothers, where identification with the mother becomes impossible without acknowledging her weaknesses and flaws.

In this regard, it is worth noting that every motherhood requires four elements:

- The relationship with the original mother.
 - The desire for phallic fulfillment.
 - The incestuous desire.
 - The Love of a Man Present in Current Life
- if any element is lacking in a woman's life, the transition to motherhood will encounter obstacles.

The child is often paralleled with phallic desire, while the pre-Oedipal relationship with the mother is neglected, despite its essential role in female reproduction, as noted by Bydlowski. This original mother, influenced by mourning, represents a narcissistic myth of fertility. For pregnancy to be assimilated, there must be an acknowledgment of similarity with the mother. This requires revisiting pre-Oedipal anxiety and the image of a mother who is weak enough for the child to be born to repay a debt of life. Conversely, women who miscarry symbolically reject their mothers. Infertile women remain fixed in an adolescent position, unable to conceptualize a weak mother to whom the child is offered as reparation, a child they can no longer conceive.

Infertility aims to avoid relinquishing the image of the mother, which imposes on these women a sense of unbearable gratitude. Often, motherhood becomes possible for these women only after the death of their mothers or fathers, through mourning that reveals the fragility of the mother, previously perceived as dominant. Sometimes, the desire for a child conceals issues of poverty or inadequate sexual lives that they cannot express. The request for a child allows them to give new meaning to their lives. Some couples have a symbiotic relationship where one is the twin of the other, leaving no room for a child (Bydlowski, 1997).

In a similar vein, Cahen (1985) suggests that when examining infertile couples individually, each partner may appear fertile, but together they become infertile. She hypothesizes that the intervention of a child threatens their fragile balance. For these individuals, the couple represents a protection of their unique unity, where marital life compensates for the original unity with the mother a state of solitude, the security of the child in the womb, and the symbiosis that fulfills the child's desires after birth. Among infertile couples, there is always an unconscious symbiotic fusion, where the partners lose their individual identities to become one entity represented by the couple. A third party, such as a child, becomes impossible because it would endanger their unity, leaving no room for a third person. The impossibility of reproduction is more impactful if the relationship with the parents is incestuous.

Cahen (1985) also describes couples for whom a third party is necessary to avoid conflict or to function better, as caring for this third party requires the couple to

collaborate. In such cases, we find children who are perpetual thieves, unable to heal because their parents need them to confront their pathological relationship. In infertile couples, infertility can take on the role of a third party as a psychosomatic symptom of the couple. It brings the couple closer and gives them a purpose to continue. The couple does not consider themselves responsible, and clinging to the past leads to a potential crisis.

The psychological causes of infertility vary among researchers. Guérin (1988), in her clinical cases and analytical approach, agrees with Tort that the origin of infertility lies in the early relationship with the mother. The mother can lead to infertility in her daughter, and the common factor among these mothers is that they view their daughters' bodies as erotic objects, establishing destructive fantasies toward the mother. Although the daughter always seeks maternal love, the only solution for her is to repress her desires and complexes toward fertility, projecting them onto her husband, who confronts a terrifying maternal image and the anxiety of separation, equivalent to the desire for the phallus. Based on the equations of child-desires-being-enjoying-creating, which are desires forbidden by the mother, it is not the desire for the phallus that prevents a woman from having a child but what this desire conceals in the daughter's relationship with her mother.

Through the mother's hatred of the daughter and the daughter's hatred of the mother, the daughter develops self-hatred, particularly toward her body, which she refuses to identify with her mother's body through motherhood. It becomes impossible for her to carry a child in this hostile body. As long as there is a rejecting mother in the origin, the woman's body inherently rejects a child.

9. The Psychosomatic Approach to Explaining Psychogenic Infertility

Feder observes the psychosomatic orientation of infertility and emphasizes her resistance to generalizing the psychosomatic explanation of organic disorders, including infertility. She links the psychosomatic symptom to its unconscious meaning and highlights the difficulty of situating infertility between the somatic and the analytical. According to Marty, the psychosomatic symptom carries no meaning; it is not a symbolic expression of a fantasy, as in conversion hysteria. Feder notes that cases of unresolved mourning are often found in the childhood histories of infertile women.

In light of the complexity of the body's manifestations between psychosomatic symptoms and hysteria, Feder suggests establishing a theoretical comparison. This approach posits a hypothesis of overlapping psychological determinisms, drawing from the works of McDougall (1978) on the concept of psychosomatic hysteria, which illustrates a type of somatization that simultaneously exhibits hysterical and psychosomatic features.

Symptoms such as infertility, which have a psychological origin, are, according to McDougall, linked to the repression of id impulses and resemble conversion hysteria, which translates the defenses resulting from the superego's strong repression. In contrast, true psychosomatic conditions do not fulfill genuine defensive functions. While hysterical communication is situated within the oedipal complex, cases of psychosomatic hysteria rather reveal fears of symbiotic (fusionnels) desires, leading us to consider certain cases of psychosis. However, due to the assimilation of neurotic or psychotic defenses, it is the body that is directly affected to repair the narcissistic image of the client, who is influenced by the primitive maternal relationship.

Lombard (1991) proposed a hypothesis related to narcissism. When primary narcissism transitions to secondary narcissism, a necessary part always retains its primary quality. It is worth noting that primary narcissism is non-objective, as it exists before object relations. However, with the intervention of a third party, infertile women suffer from self-stimulation, depression, and identification issues. In their discourse, they describe themselves as undesirable. Lombard observed that the same phenomenon prevails in male infertility, where the transition from primary to secondary narcissism occurs indirectly. This hypothesis provides an explanation for the occurrence of pregnancy in infertile women after adoption. According to Lombard, the adopted child becomes a source of narcissism that facilitates the fluid transition from primary to secondary narcissism in the couple.

Regarding modern theories, numerous studies begin with Châtel, who views the problem of infertility in relation to modern artificial reproductive technologies. These techniques, in fact, distinguish between gender and reproduction, compensating for the unconscious desire for a child, which is fulfilled when pregnancy does not occur spontaneously. In an article published in 1990, Châtel argued that the desire for a child is not direct but rather a reinforcement of the unconscious desire for every woman. Thus, the unconscious dimension of the desire for a child becomes self-evident, while human reproduction is considered a psychosomatic phenomenon. Fertilization is not merely physical because the language of somatization related to fertilization precedes its content, given the conflicting symbols active in the unconscious desire. Fertilization is thus a symbolic encounter (Châtel, 1998, p. 113).

On the other hand, the desire for a child is formulated as a request to fulfill a need, the result of which is infertility. Thus, the desire for a child, which was once the outcome of a sexually charged symbolic encounter, has become, for doctors, merely the effect of unknown substances.

In the analytic approach, infertility is seen as resulting from the mother's failure to grant her daughter permission to bear children. Several factors lead to repression, and Châtel ultimately emphasized that hypotheses in the field of psychologically rooted infertility are not deeply explored, and each case is not unique but stems from different causes.

Among modern theories, Pagier argues that psychologically rooted infertility cannot be confined to the absence of an organic form. In reality, psychological conflicts can lead to organic problems. Infertility may have an organic starting point, but the suffering can revive childhood issues, where the woman is unable to have children and blames her mother. This results in organic symptoms that support depression. Pagier noted that infertility revisits Freud's theory of femininity but remains skeptical about the desire for a child, which is seen as a manifestation of the desire for the phallus. Pagier leans more toward the hypothesis of the rejection of femininity.

9-1: Interpretation of Infertility According to Pragier

Pragier presented several interpretations, dividing them into a set of ideas as follows:

A.	Incestuous	Desires
Infertility results from the repression of the desire to have a child from the father. The infertile woman is positioned within the oedipal triad between the beloved father and the rival mother. This leads to an oedipal fixation and an inability to resolve the complex, as well as the impossibility of identifying with the reproductive mother due to		

issues of autonomy from the mother and a weak paternal image. Pragier discussed an oedipal relational conflict involving the repression of the desire for a child from the father.

B. the Desire for a Child as a Desire for the Phallus

This hypothesis is found in Freud's theory of femininity. After identifying with the father, motherhood emerges as a desire for narcissistic repair and the repression of femininity. The vagina remains in a regressive state, and the desire to be a male child leads to the creation of an imaginary child as a substitute for the paternal phallus. Pregnancy is seen as a theft of the phallus. The desire for a child encompasses all other desires (Andr , 2009).

C. the Impossible Child

Infertility following grief or trauma is interpreted as the presence of a child taking the place of the lost individual. This belief stems from an inability to properly process grief, and in some cases, infertility may be voluntary, resulting from guilt associated with identification.

D. Self-Destruction

this is the most commonly suggested explanation by researchers in the field of psychologically induced infertility. It is seen as a form of self-rejection, although the American school of thought has contested this idea.

E. Impossible Motherhood

The mother is the first object of love and identification, serving as a reference for the girl's identity. The girl must always confront and resolve her oedipal complex and ensure her mother's love (Resire, 2002, p. 155).

9.2 Interpretation of Psychologically Induced Infertility Based on Identifications

Infertility arises from the impossibility of identifying with the mother, which can repress the Oedipus complex. This idea was developed by Groddeck (1998), who wrote, "Women who hate their mothers do not have children." Deutsch (1949) also noted that infertility results from aggression due to a lack of autonomy from the mother.

Pragier emphasized the ego's victory over sexual impulses and the preservation of the self. She also highlighted that the issue is particularly prevalent in women with fragile narcissism, as these women perceive their husbands as maternal substitutes.

In her 2001 work, Pragier addressed unexplained medical infertility through the lens of mother-daughter separation. Infertile women often remain deeply invested in their mothers as the sole object of emotional investment. Most of the clients she worked with had been extremely close to their mothers during childhood, investing heavily in them as extensions of themselves. Pragier described the mothers of infertile women as possessive, unwilling to accept their daughters' independence. These mothers strive to remain the sole object of love and the primary focus of their daughters' lives, refusing to acknowledge them as women.

On the other hand, infertile women are often depressed, as their mothers failed to fulfill their emotional needs. Infertility thus becomes an outcome of generational frustration. The father is not recognized as a third party because the mother never established him as an object of desire. The mother's desire keeps the daughter tied to her, leading to narcissistic wounds and identification issues.

In reality, the infertile woman suffers from this dependency by denying her desire for it, as she remains in a childlike state. She attempts to alleviate her anxiety by maintaining a symbiotic relationship with the primary object (the mother) from whom she has never separated. Alternatively, she may try to reward her mother by giving her a child. However, when fears related to this child arise, the symbolic castration fails, leaving room for regressive separation anxiety that prevents the transition to autonomy. The mother is identified with, but this identification remains untranslated into independence.

Infertility in women is experienced as a dependency that negates their desire for dependence even more, as they remain tied, like a small child, to the primary object from which they have never truly separated. They attempt to alleviate their anxiety by coexisting with this primary object or by trying to reward their mother by giving her a child. However, with the emergence of fears related to this child, the symbolism of castration fails, leaving room for a regressive anxiety of separation that prevents the transition to autonomy. The mother is internalized, but in the absence of the father's desire, the Oedipal movement cannot occur, and the relationship remains stagnant. This makes it difficult for the woman to love other men, and she remains fixated in a maternal image. The Oedipal conflict is not due to infertility but to the absence of the Oedipal movement, which is the core issue. The father is not erotically invested, and Pragier considers infertility, regardless of its cause, as meaningful, as this bodily inhibition points to a problem of independence from the mother.

However, the close relationship with the mother remains denied. The infertile woman strives to live a normal life, burying her depression deep within herself. The awaited child here serves as a form of liberation from the image of the primitive mother. Pragier interprets infertility based on theories concerning: the causality of infertility, infertility and conversion, and infertility and somatization.

9-3 Psychological Interpretation of Infertility from a Hysterical Perspective

Infertility is noted for its unique place among various somatization cases. It is a symptom that resolves a conflict, meaning the child in question is not conceived. Infertility thus acts as a conversion symptom, expressing a compromise between desire and repression.

McDougall explains that the body translates infertility as an inhibition of the id's drives through the containment of excitation. The absence of the oedipal conflict reveals the symptom as a resistance against castration anxiety.

Jerdryuides (2001) highlights the unconscious mechanisms at play in infertility through clinical cases, suggesting that the absence of a child conceals another deficiency in infertile women, stemming from a painful relationship with the primary mother during the oral stages, which was inadequately satisfying. These women struggle to internalize the role of a good mother while continuing to seek satisfaction from their own mothers.

Bohelber (2001) traces psychologically rooted infertility back to the myth of the feminine image in Euripides, where, despite the pain it causes, infertile women exhibit a fantasy formed from early sexual fantasies, repressed memories of traumatic early object relations, and persistent somatic fantasies.

For the infertile woman, separating from her parents to join a sexual partner (husband) equates to the risk of losing herself and her internal objects. She cannot detach from her

parents, who demand complete submission to resolve this conflict, either by uniting with the maternal object or the paternal object.

These women are unconsciously convinced that a sexual relationship poses the danger of dependency on the partner and the potential for frustration by him. Faced with this potential frustration, they respond by withdrawing into themselves, thus inhibiting their femininity and rendering their bodies cold and infertile.

Their feminine bodies are perceived as sources of uncontrollable somatic or aggressive drives. These women experienced trauma in their early object relations with depressed mothers who were unable to help them integrate their primitive fantasies. They believe they are the cause of their mothers' depression and that they destroyed them with their aggressive drives. On the other hand, the body appears as the property of the mother because they internalize their dead mothers.

Infertile women are all convinced that only one party can emerge unscathed from pregnancy and childbirth: either the child and the mother, or the self and the object.

Losinger emphasizes that this unconscious feminine fantasy is always present in every woman, though less visibly. Confronting the dark side of their motherhood is essential for women to develop their own maternal behavior and derive narcissistic and libidinal satisfaction, all of which result from the growth of the woman's personality. According to psychoanalysis, a woman's personality develops through the evolution of her relationship with the object, which is determined by three meanings.

The first meaning is the object of the drive as a support and factor for satisfaction, while the second meaning concerns the person from whom satisfaction is expected.

Freud states that the object of the drive is that through which or by means of which the drive achieves its aim (Freud, 1977).

Psychoanalysis holds that the investment of interpersonal relationships operates through unconscious dynamics and fantasies in which people are internal objects recorded based on personal history (Perron, 1994, p. 71).

Since the beginning of psychological life, the ego is capable of self-gratification of its desires, a phenomenon known as narcissism. During this phase, the ego aligns with what is desired and does not require the external world, operating under the dominance of the pleasure principle (Freud, 1915, p. 38).

This narcissistic stage represents the initial phase of life, where the child exists in a state of sexual undifferentiation from the external world. Later, Freud addressed the distinction between the internal and external worlds, marking the transition from primary narcissism to the objective stage. Initially, there is no differentiation between the internal and external realms; the child gradually develops this distinction through external intervention, as they are unable to manage the emotional charges resulting from internal biological imbalances due to their immaturity.

The emergence of the objective stage is associated with what Spitz termed "eighth-month anxiety," which serves as an indicator of the development of a secondary organization related to the structural adjustment of the psychic apparatus. Here, the ego becomes distinct from the id and the external world.

For most psychoanalysts, the relationship with the object is built upon the care and attention provided by the mother. The repeated experience of satisfying the child's needs gradually leads to the discovery of the object, which is perceived as the source of gratification, fostering an attachment to the mother.

Failure to achieve satisfaction can disrupt the sense of continuity of existence, leading to maladjustment, threat, and fragmentation (Perron, 1985, p. 62). The core issue here revolves around the interplay between the imaginary and perceptual domains, with the body serving as the mediator in a dialectical process aimed at resolving conflicts and contradictions (Sami-Ali, 1974, p. 67).

It appears that the child's primary identifications are crucial in shaping the individual's personality, and the quality of these early identifications determines the level of subsequent structures. Regardless of the differing perspectives and mechanisms involved, the stage of recognizing the mother as a distinct individual remains the pivotal moment in organizing development and differentiating the ego from the external world, as well as the ego from the id. The emergence of ambivalence is one of the fundamental manifestations of this process.

The transition from one stage to another becomes clearer through the relinquishment of one erogenous zone in favor of another. This surrender is often repressed and forgotten, as development is influenced by intersections, shifts, and cumulative movements that manifest later. Past experiences shape the individual's history and the functional organization of their personality (Widlocher, 1973, p. 24).

Sexual life is not limited to adulthood but evolves through childhood stages. The phases of libidinal development lay the groundwork for the activities of later stages. The mother is considered the child's first love object, and Freud asserts that these feelings persist through infantile sexuality, translating into active or specific desires and emotions (Freud, 1977, p. 157).

Unlike the boy, the girl must undergo a change in the object of love to achieve femininity-transitioning from a maternal fixation to an attachment to the father—as well as a shift from the male to the female genital organ to reach the stage of infantile sexuality, where drives are unified under the primacy of the genital zone. The absence of the penis in the girl is interpreted by her as a result of castration.

Freud emphasizes the bisexuality inherent in individuals, though this duality is more pronounced in women. The sexual life of women is generally divided into two phases: the first has a masculine character, while the second is distinctly feminine. Thus, the development of a woman involves a transition from one phase to another (Freud, 1977, p. 251).

This stage culminates in the formation of intense feelings toward the mother, as sexual activity reaches its peak during this period, leading the girl to set a sexual goal that can only be recognized later. The girl's detachment from her mother is a significant step in her developmental trajectory. It is observed that, in distancing herself from her mother, the girl relinquishes the acquisition of the correct genital organ, perceiving it as inadequately provided and failing to meet all her needs. Initially, she consults her mother but is subsequently deprived of sexual activity (Revault, 1991, p. 75).

As a result of these processes, resentment toward the mother emerges, stemming from the earlier stages. This resentment finds reinforcement in the Oedipus complex, where jealousy of the mother over the father becomes prominent.

All these reasons are sufficient to justify this aggressiveness, some of which stem from a crisis inherent in the nature of infantile sexuality, and others as a rationalization of emotion and the girl's detachment from the mother. In most cases, this is interpreted as an expression of masculinity in the girl and a transition to the theme of love for the father.

With the girl's discovery that she is not the only one deprived of the male organ, as she initially believed, she becomes aware of other female beings similar to her, including her mother. From that moment onward, it becomes possible to distance herself from aggressive feelings or, in other cases, to channel them.

With the alleviation of castration anxiety, the superego begins to form by dismantling the infantile genital organization. These transformations appear to result from external interventions and upbringing that threaten the loss of love. The girl's Oedipus complex tends to be more stereotypical, pushing her beyond replacing the mother and adopting a feminine position toward the father. However, she cannot endure the loss of the phallus without attempting compensation. Her Oedipal complex reaches its peak in the long-repressed desire to receive a child as a gift from the father—to bring forth a child from her father. This is considered a slow relinquishment of the Oedipus complex, as the desire remains unfulfilled. The dual desires of possessing the phallus and having a child from the father continue to operate at the unconscious level, which may contribute to the emergence of psychological infertility in the future (Revault 1991).

D'Allonnes presents a perspective on female sexuality and the girl's development based on the initial ambivalence toward the mother and the resulting sense of guilt. This guilt intensifies the desire for the father, leading to a partial renunciation of him. However, this renunciation is not complete. In reality, the resentment the girl feels toward her mother generates guilt, compounded by her desire to be close to her father, which can only occur against her mother. This further intensifies her guilt, ultimately leading her to relinquish the father in favor of the mother to alleviate this guilt (Revault, 1991, p. 90).

Here, the importance of the relationship with the father becomes evident. A father who is physically or emotionally absent, or who is weak, leaves a significant imprint on his daughter's relationship with him and the development of her femininity. He is incapable of providing her with a sense of value as a woman in the future or reinforcing her confidence in her femininity in the eyes of another man. This leaves her dependent on her mother's influence. The girl constructs herself in opposition to the maternal experience. The specificity of the feminine position is a product of the mother's seduction in the pre-Oedipal phase and the active engagement of the oedipal desire in favor of the mother. This constitutes the core of the feminine complex, where difficulties related to guilt and the desires inherent in this triangular dynamic arise. The issue of identification with the mother explains the emergence of infertility at a later stage (Revault, 1991).

The history of a woman's life leaves relational traces with both the father and the mother. Among these traces is the imaginary child that the young girl desires to become

a mother like her own and to fulfill her desire through her father. This imaginary child arises from the oedipal conflict and the love the girl harbors for her father.

The investment in the imaginary child stems from the emotions perceived during this phase. This fantasy is, in part, meant to compensate for weaknesses in her narcissism and to console her in her solitude within the parental couple. The imaginary child is born from the oedipal conflict and the unspoken love for the father, which is kept secret from the mother. It is a secret child preserved in an active fantasy, always thought of but never disclosed. This imaginary child allows the girl to envision a sexual relationship with the father (Revault, 1991, p. 260).

The deeper fantasy is the possibility of having a child—symbolizing the possession of the mother's capability. It is not about having a real child but rather about possessing the capacity to do so and fully identifying with the mother. This explains why some women or couples live without children, provided they are assured of the possibility of having them when desired. This also explains the trauma of infertility, as infertility does not eliminate the child itself but rather the ability to conceive a real child.

From the above, it is evident that understanding femininity plays a significant role in explaining infertility by referring to the unconscious and the processes that mark the starting point of sexual duality and the Oedipal relationship. This is achieved through identification, fantasy, and female sexuality based on levels of fixation. The girl is always directed toward waiting: first for the phallus, then for feminine attributes, then for menstruation, and finally for a child, and so on. This waiting is beyond her control and is often linked to experiences of object loss, where fixation occurs. The girl cannot become a woman except by rejecting the maternal femininity of her mother. The change of object first occurs on the mother's body, which transitions from the mother to the woman. Separation from the mother means thinking of herself as a woman (Revault, 1991).

10. Psychotherapy of Infertility in Women

In cases of psychological infertility in women, where medical causes remain unidentified, the focus shifts to modifying psychological functioning by addressing early psychological traumas, unconscious conflicts, distorted thoughts, and cognitive schemas. Additionally, reducing psychological stress, which can adversely affect fertility, is emphasized. Therefore, we propose a range of psychological treatments aimed at alleviating the psychological challenges faced by women experiencing infertility. The psychotherapist is granted the freedom to choose the therapeutic approach based on their theoretical orientation and professional expertise in psychological treatment.

10-1 Psychodynamic Therapy

This therapy, inspired by psychoanalysis, aims to uncover deep-rooted causes such as childhood psychological traumas and unconscious desires related to reproduction. The goal is to bring unconscious material into conscious awareness, thereby understanding the psychological roots of infertility (Luborsky, 1996).

10-2 Ericksonian Hypnotherapy

This therapy facilitates complete relaxation and reduces resistance in women

experiencing infertility. It helps them overcome fears, release unconscious repressed emotions, and address the pain associated with infertility (Dumont, 2024).

10-3 Cognitive Behavioral Therapy (CBT)

CBT aims to modify negative thoughts about infertility or reproduction, thereby alleviating stress and removing inhibitory thoughts about pregnancy. It also works to restructure negative cognitive schemas related to pregnancy and childbirth (Bal & Uçar, 2023).

10-4 Acceptance and Commitment Therapy (ACT)

ACT trains women to accept painful emotions associated with infertility and commit to embracing their personal reality rather than avoiding it. This approach enhances awareness and understanding of their condition, reducing the stress that impacts fertility (Monestès, J.-L., 2011).

10-5 Mindfulness-Based Therapy

This therapy aims to increase women's awareness and focus on their daily lives in a balanced way. It emphasizes that infertility is not inherently problematic and encourages women to enjoy their lives while maintaining hope for future reproduction (Kabat-Zinn, 2012).

10-6 Couple or Family Therapy

This approach seeks to maintain a balanced relationship between partners to prevent increased stress and tension, which can negatively affect the relationship and, consequently, fertility (Miguel & Line, 2013).

10-7 Bioenergetic Therapy

A form of psychosomatic therapy, bioenergetics encourages women to release repressed and suppressed emotions related to the rejection of reproduction. It addresses emotional blockages that have negative representations and indirectly affect pregnancy and childbirth (Lowen, 2015).

It is important to note that numerous psychological treatments can be utilized in cases of female infertility, and multiple therapeutic techniques may be employed simultaneously, such as humanistic support therapies. However, the final decision rests with the psychotherapist, based on their theoretical approach, professional orientation, and clinical expertise.

Conclusion

Infertility in women, as previously discussed, stems from both organic and psychological factors. Within the framework of psychosomatic unity, it is essential to adopt a dual approach that integrates both medical and psychological care. While focusing solely on the medical aspect and prescribing medications, despite the absence of any physiological deficiencies in either partner, may not address the root causes of infertility. Upon identifying the psychological factors that adversely affect conception and reproduction, it becomes imperative to foster a culture of dual medical-psychological care. On the psychological front, it is crucial for women to undergo psychological therapy to eliminate all factors that hinder the process of conception. Additionally, it is vital to ensure a suitable quality of life for partners, creating favorable conditions and enabling the husband to avoid all psychological stressors emanating from the social environment.

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