The Social Sciences 11 (9): 2176-2179, 2016
ISSN: 1818-5800

Comparison of Personality Disorder in Infertile and Fertile Women

Sorour Moshavvegh
School of Human Science, University of Mohaghegh Ardabili, Ardabil, Iran

Abstract: Infertility is an important stressor in life and it is difficult to accept that. Many couples with recurrent and painful course of treatment are faced with a process without progress. Finally, infertile couples feel powerless to reach the goal that leads to psychological problems and emotional stressful experiences. The aim of this study was to compare personality disorders in fertile and infertile women referred to infertility clinics of Ahvaz. This is a cross-sectional comparative study. The 30 infertile women in infertility treatment clinics were selected by simple random sampling. The 30 fertile women were matched with the infertile women of sample 8 in terms of age, education, socioeconomic status. The required information were collected by the test Millon III with a demographic questionnaire. In this study, multivariate analysis of variance was considered as the significant level to analyze the data ($p<0.05$). The results showed that there is a significant correlation between infertile women and fertile women in the clinical patterns (avoidant, depressed, dependent, masochism, paranoid significant difference in clinical symptoms of anxiety, somatoform, depression, post-traumatic stress, major depression ($p <0.05$). According to the prevalence of psychiatric disorders in infertile women, it is needed to serious attention of specialists in the field of psychological treatments for this group of patients, especially supportive psychotherapy and psychological therapies should be considered in the context of infertility treatment.

Key words: Personality disorders, infertility, fertile, prevalence, psychotherapy

INTRODUCTION

Psychologically, having a child is a ceremonial passage into adult life. Having a child is a fundamental part of gender identity and the main purpose of marriage. Studies have shown that after a year of marriage, the pressure on couples to have a baby grows and reaches a maximum in the third and fourth year (Porter and Christopher, 1984). Research has shown that in Muslim countries, social pressures to have children shortly after marriage increases (Husain, 2000). In this regard, 12-16% of women cannot become pregnant normally and are experiencing infertility. Infertility is defined as failure in pregnancy after one year of regular unprotected intercourse. A study at the Institute for International Health in Belgium, France and the Netherlands has shown that women know infertility in the fourth list of 12 critical events after the death of mother, father and betrayed husband.

Infertility is one bitter experience, comparable to a death in the first-degree relatives that follows a grief reaction (Boyarasky and Boyarasky, 1983). In this regard, women who have been trained especially for mothers are the most affected. Studies have shown that stressful experience of infertility can lead to a wide range of psychological damage including the destruction of self-esteem, increased levels of stress, anxiety, depression, feelings of inferiority and inadequacy, inaction productivity sex, marital problems (Boyarasky and Boyarasky, 1983).

Almost 32% of women in the early stages of infertility treatment are at risk of mental health problems. Comparing the prevalence of psychiatric disorders in infertile women compared with fertile women shows that the prevalence of psychiatric disorders in infertile women than in fertile women with these disorders were statistically significant (Nourbala *et al*., 2008). A class of psychiatric disorders composed of personality disorders.

Personality disorder is a (inclusive) effective pattern, durable and uncompromising attitude of inner experience and external behavior that is certainly different from cultural expectations of the individual and leads to distress or impairment. Limited range of experiences and responses of patients with this disorder may lead to psychological, social or occupational problems. The disorder usually begins in adolescence or adulthood (or at least it is detectable at this age), though in some cases the disorder starts in childhood.

Personality disorder, distress and problems that caused by it affect a person's life but there are different types in terms of collapse. However, whether disorders are mild or severe affects all aspects of a person's life. Treatment of the disorder is the most difficult types of

treatment for psychological disorders. It is estimated that the prevalence of personality disorders among adults is 4-15% (Zimmerman, 1994).

The personality disorders is the most important social and medical problems. Psychiatrists, mental health specialists, sociologists, public health officials, politicians, business owners, charitable business-owners, community leaders and news analysts have not concerned it. Prevalence of ADHD in the general population is estimated to be between 11 and 23% that the figure is alarming, it means that a person of our friends and neighbors, regardless of socioeconomic status or where they live is suffering from personality disorders. These people can suffer chronic problems in work, love, friendship. Personality disorders are Axis 2 disorders that contrary to most of the clinical syndrome Axis 1 clinical syndrome usually have a specific recovery period. These disorders do not change in terms of severity of the disease or improve it over time. A person with personality disorder is also affected mental disorders (axis 1) (Flich *et al*., 1993).

About half of all psychiatric patients suffer from personality disorder and the disorder usually associated with disorders of Axis 1. Personality factors, interfering with his response to treatment with renal syndrome Axis 1 get worse incompetent individual patient's situation. In addition, personality disorder is the underlying risk factor for many other psychiatric disorders (Sadock *et al*., 2009). Considering that the majority of women who face infertility crisis are in the course of their adult life, and this period is the beginning of personality disorders. It is likely that these people suffer personality disorders (clinical patterns). There are four hypotheses in this study:

- There are significant differences in clinical patterns of fertile and infertile women
- There are significant differences in severe personality pathology of fertile and infertile women
- There are significant differences in clinical syndrome of fertile and infertile women
- There are significant differences in severe clinical symptoms of infertile and fertile women

MATERIALS AND METHODS

This was case-control study (after an event). Population is all fertile and infertile women referred to gynecology and infertility clinics in Ahwaz in the period July 2009 to November 2009 for the treatment of infertility, pregnancy and contraception services related to the care. Among these, 30 women infertile and 30 fertile women were selected by simple sampling (available). After the connection is established, the purpose of the study was expressed for women and if they like, they were participated in the survey. Data gathered by Millon III test and a questionnaire is made to assess demographic characteristics.

Millon Clinical Test 3, this test is a self-report scale with 175 items Yes / No that evaluates 14 character pattern and 110 clinical symptoms that is used for adults 18 years and older. This test has been made based on the model of psychopathology million (1969/1983). It has been revisedtwice since its release. M. C. M. I. is one of the most widely used psychological tests which have been translated into several languages and in Iran has been normalized twice. Khwaja Mugahi has normalized the second revision of this test in Tehran, Sharifi has normalized the third revision in Isfahan. M. C. M. I. I-3 is M. C. I. which has been revised was introduced in August 1994 in the America Psychological Association meeting. More than 50% of my statements of M. C. I. I-3 has been changed, the length of scales dropped and two new scales (scale of depressive personality disorder and post-traumatic stress disorder scale) are added to the test scales.

Also, the grading system has been changed and weight of test items has been changed from three points to two points scale. In this system, the statements with the main trait of a disorder weighted 2 and the statements with the second traits weighted 1. While, the base rate score of 85 or higher indicates the most prominent disturbance, the base rate score of 75 or higher indicates the existence and properties of a disorder. The base rate score of 65 or higher describes the personal character that raw score is 50% of the population.

RESULTS

In the case of reliability of M. C. M. I. I-3, there are five data sets that are re-examining in this study from 5 days to 6 months, for the personality disorder scales, average correlation from 0.58-0.93 (depressed) is obtained by an average of 0.78. In the scale of the clinical syndrome disorder, average correlation from 0.44 (PTSD) to 0.95 (MDD) is obtained with an average of 0.80 .

Reliability of the scale in M. C. M. I.-3 normalization study was reported at an interval of 5-14 days from the 0.82 (scale-aliasing) to 0.96 (somatoform) with average 0.90 for all scales. In Iran, several studies were performed about M. C. M. I. In Sharifi's study and test-retest correlation raw scores have been reported the first run in the range of 0.82 (delusional disorder) to 0.98 (schizoid personality disorder). The reliability of the test is

calculated by internal consistency alpha coefficient scale and scope vary from 0.85 (alcohol dependence) to 0.97 (post-traumatic stress disorder).

The diagnostic validity of M. C. M. I-3 scales is estimated very well. For example, the positive predictive scales is variable from 0.58 (Histrionic personality disorder) to 0.83 (delusional disorder) and the negative predictive is variable from 0.93 (negatively oriented personality disorder) to 0.99 (anxiety disorder). Total prediction, the positive predictive and negative predictive and all M. C. M. I-3 were very well in the first and second diagnosis. The ability to diagnosis is the highestin sadistic personality scale with maximum power (0.98) and negatively oriented scale with minimal power (0.92) is at the end.

The delusional disorder scale with the highest positive prediction (0.83) is at the top and the histrionic scale with the power of prediction (57.7) is the lowest. In terms of the negative predictive, anxiety disorder (0.99) is at the top and the negative oriented scale is located at the end. In this study, multivariate analysis of variance (MANOVA) was used for statistical analysis. To perform this analysis, ENTER method was considered that the criterion for inclusion of variables is the value of $p<0.05$, above tests were conducted in SPSS statistical software version 16.

DISCUSSION

Age range of fertile women was 23-42 years with an average 31.6 and age range of infertile women was 25-45 years with an average 2-18. The duration of marriage in fertile women was 2-18 with an average of 8 years. The duration of marriage in infertile women was 2-25 with an average of 6 years and the duration of infertility was 2-18 with an average of 6.1. In examining clinical patterns of infertile women, there is a significant difference in avoidance patterns, depressed, dependent, self-destructive of infertile women at the level of $p<0.05$. Average score and the cut of point in infertile women is higher than in fertile women. There was no significant difference between the two groups in schizoid personality patterns, histrionic, narcissistic, antisocial, other abuse, obsessive, negative oriented.

Study of severe personality damage in the two groups showed no significant differences in the pattern of paranoid with fertile women ($p<0.05$), there was no significant difference between the two groups in borderline and schizotypal pattern. This finding is consistent with research of Wischmann *et al.* (2009) and Noorbala *et al.* (2008).

There is a significant difference in clinical syndrome of infertile women in syndrome anxiety disorders, somatoform, depression, post-traumatic stress with fertile women at the level of $p<0.05$. There was no significant difference between two groups in the manic syndrome, alcohol dependence and drug dependence. Increasing anxiety, somatic complaints, depression was consistent with the studies of Bagheri Yazdi (1996). There was no significant difference between two groups in severe clinical symptoms in Major Depressive Symptoms ($p<0.05$). This finding is consistent with the studies of Sargolzaei (2001); Behdani (2004) and Neilf *et al.* (2005).

As it was said, infertility is a crisis and a stressful event in the lives of most women. Infertility undermines women's personal and social competencies, sense of mother and wife values. The mentioned threats and uncertainties that are created due to infertility cause part of distress, cognitive and mental health disorders among infertile women.

Psychological disorders that the infertile women may be exacerbated by treatment and medical tests. Physical and emotional conflict and severe medical tests for infertile women are generally worrisome and inconvenient. They are accompanied with signs of grief, denial, anger, anxiety, depression and impaired self-esteem and body image (Abbey *et al.*, 1992). While these tests for fertile women are generally pleasant and strengthen the feeling of a mother and wife, personal competence and confidence.

In the position of infertility, women feel more responsibility for their infertility (Abbey *et al.*, 1992; Denilok, 1997) and husbands know the wives responsible for infertility, even when her husband is the cause of infertility. Blame to the woman by her husband and herself can affect mental health.

Grief reactions are common among infertile wives, andgrief seems necessary to resolve the crisis. In any case the normal reaction of some spouses become pathological grief and is consistent with the DSM.IV definition of depression. The outcome of treatment for infertile women to experience failure in treatment cause stress. Depression, anxiety and anger are the most common response to treatment.

Most of studies about the infertile women's experiences in social network have shown that the infertile women have experienced the negative social interactions, as it is reported that they are emotionless or they are supported by family and friends. In addition, this study shows that non-supported social interactions are associated with psychological distress in the infertile women (Lerreno *et al.*, 2007). Nearly half of infertile women understand the stressors what they say to others outside the family.

According to the mentioned factors, it is well known negative social communication is a stressful factor that is expected to have negative effects on emotional health of women infertile and this leads to further isolation.To make social connections with others less stressful and more supportive, it is essential to be clear that infertile women understand positive or negative issues in social interactions (Akizuki and Kai, 2008). Totally, these factors can make a significant difference between fertile and infertile women in various mental health indicators.

CONCLUSION

According to the results of this study that shows a high prevalence of psychiatric and personality disorders in infertile women compared with fertile women, the experts should be aware of the importance of psychological factors in this group of patients and cures for infertility and they should identify these people. They must consider psychological counseling therapy, supportive psychotherapy, especially in the context of infertility treatments, this leads to a reduction in psychiatric symptoms, increase of mental health and pregnancy rates in infertile women. So, it is appropriate that counseling and psychology place should be considered that can facilitate the healing process and follow-up.

REFERENCES

Abbey, A., F.M. Andrews and L.J. Halman, 1992. Infertility and subjective well-being: The mediating roles of self-esteem internal control and interpersonal conflict. J. Marriage Family, 54: 408-417.

Akizuki, Y. and I. Kai, 2008. Infertile Japanese womens perception of positive and negative social interactions within their social networks. Hum. Reprod., 23: 2737-2743.

Bagheri, Y.A., C. Blhry and D. Shahmohammadi, 1996. Prevalence of mental disorders among patients referred to Yazd Infertility Center gets. J. Behav., 1: 32-41.

Behdani, P., 2008. Evaluation of anxiety and mood disorders in women referring to Mashhad Montaserieh clinic. J. Midwifery Womens Infertil., 3: 23-15.

Boyarasky, R. and S. Boyarasky, 1983. Psychogenic factor in male infertility. J. Med. Aspect Hum. Sexuality, 17: 86-89.

Carreno, M.J., C.F. Morales, B.C. Sanchez, A.C. Henales and H.J. Espindola, 2007. An explanation of depression and anxiety symptoms in sterile women. Ginecologia Obstetricia de Mex., 75: 133-141.

Flick, S.N., P.P.R. Byrne, D.S. Cowley, M.M. Shores and D.L. Dunner, 1993. DSM-III-R personality disorders in a mood and anxiety disorders clinic: Prevalence comorbidity and clinical correlates. J. Affective Disord., 27: 71-79.

Husain, F.A., 2000. Reproductive issues from the Islamic perspective. Hum. Fertile., 3: 124-128.

Neil, W.C., A. Ahmadi and M. Abedi, 2005. Attitude towards infertility and its relation to depression and anxiety in infertile couples. J. Reprod. Infertil., 5: 552-546.

Noorbala, A., F. Ramezandadeh, N. Abedi and M. Naghizadeh, 2008. Psychiatric disorders personality Vtyphay fertile and infertile women. J. Reprod. Infertil., 8: 350-360.

Porter, N.L. and F.S. Christopher, 1984. Infertility: Towards an awareness of a need among family life practitioners. Family Relat., 33: 309-315.

Sadock, B.J., V.A. Sadock and P. Ruiz, 2009. Kaplan and Sadock's Comprehensive Textbook of Psychiatry. 9th Edn., Lippincott Williams and Wilkins, Baltimore, USA., ISBN-13: 978-0781768993, Pages: 4884.

Sargolzaei, D., 2001. Mental disorders and female sexual referred to infertility center in Mashhad. J. Reprod. Infertil., 1: 40-48.

Wischmann, T., H. Scherg, T. Strowitzki and R. Verres, 2009. Psychosocial characteristics of women and men attending infertility counselling. Hum. Reprod., 24: 378-385.

Zimmerman, M., 1994. Diagnosing personality disorders: A review of issues and research methods. Arch. Gen. Psychiatry, 51: 225-245.