"NOTHING VENTURE, NOTHING GAIN" *

Case History

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I first met Mrs E. T. at one of Dr M.'s afternoon clinics specially set aside for long cases. She is a housewife, aged 30 who has been married for 7 years.

History of Present Illness

About 4 years ago, Mrs E. T. noticed that when she became emotionally upset, an annoying tremor affected her hands. Over the past year, it has become worse and is now so incapacitating that she is unable to drink tea in company when the tremor occurs with feelings of fear and tension.

This unpleasant fear also affects her when she is in a crowd and she has on occasions abandoned waiting for a bus because of the inner anxiety and tension that overcome her. She however does not feel that people are trying to harm her in any way. She complains of attacks of lightheadedness and giddiness, and flushing of her face. Quite often, she has difficulty in getting off to sleep.

After 7 years of childless marriage, she is anxious to have a child. Dr M. has referred her for specialist investigation of her infertility and she has received extensive treatment without any success. Her menstrual cycle is one of 28 days with bleeding for 4 days. There have never been any abortions.

Some of the women in her neighbourhood have been taunting her about her infertility. This upsets her and makes her symptoms worse.

Mrs E. T.'s husband is not one of Dr M.'s patients, but he has been investigated for infertility and found to be normal.

She has now given up hope of having a child of her own and would like to adopt one.

Past Illnesses: Age 7 years—diphtheria. 13 years—pneumonia. 14 years—rheumatic "trouble".

Gynaecological investigations and treatment: In 1954, (8 months married) she was found to have a cervical erosion and a retroverted

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uterus. In 1955 she was in hospital. Her erosion had healed and her uterus was anteverted, but a right benign ovarian cyst was found and removed leaving the ovary intact. A small left ovarian cyst was not removed. Her Fallopian tubes were patent. In 1956 curettage showed normal ovulation to be taking place. In 1958 her request for artificial insemination with husband's semen (A.I.H.) was refused by a gynaecologist on the grounds that there was no mechanical defect. In 1959, she was readmitted to have a Gilliam sling operation to correct retroversion. In 1960 a second gynaecologist refused to give A.I.H., but she and her husband were thoroughly instructed on sexual technique and she was given a chart to record her temperature.

Family and Social History

Mrs E. T. was the first girl in a family of seven children. Family relationships in her early days were strained. When 7½ years old, she was evacuated to a neighbouring district away from her parents at the start of the second World War. At the end of the war, she returned to find her parents had divorced and her father had custody of the children. Her paternal grandmother took care of her for a short time, then she and her sister spent 2 years with their father who had remarried. The girls next moved over with their mother who had also remarried.

She hated school and her school record was poor. After leaving school at 14, she was employed for 5 years as an office girl in a wire works. This was followed by six changes of job over the next 4 years until she married at 23.

Her sister had also married and had two children. Mrs E. T. helped to care for these children and the younger boy even called her " Mummy". On several occasions, when her sister was away she managed them on her own. It was a tremendous loss to her when this family migrated last year to Australia.

When married, Mrs E. T.'s husband was employed in a brewery and they lived for the first 2 years with her mother. The next 2 years were spent in a house provided by the brewery, but then her husband changed his job to work as a bricklayer, as conditions in the brewery became unsuitable. They had to relinquish their house and return to her mother's to spend 3 more years.

Last October, she discussed her housing problems with Dr M. who then wrote to the medical officer of health requesting rehousing. The housing authorities were notified and the family was given priority with the result that in January they obtained a house in a new housing scheme. This is a first floor flat in a council tenement. It has two bedrooms, sitting room, kitchen, bath, and toilet

with hot and cold water.

Mrs E. T. receives £10 per week for housekeeping from her husband. Neither she nor her husband smoke or drink. They spend their leisure hours watching television, going for walks with their dog, and planning for the day they have a child.

Mrs E. T.'s personality is different to her mother's; she is a shy, reserved, and motherly individual while her mother is a forceful, demanding, and talkative person. Mrs E. T. appears to be fond of her mother and says she loves her father as well. She describes her husband as a homely, quiet, and loving person, who is also looking forward to having a family. He has a simple, pleasant personality and although unambitious is a steady worker.

On Examination

I examined Mrs E. T. in November 1961 with Dr M. She spoke with a soft, anxious voice but I was most struck by the involuntary nodding of her head and coarse tremor present in her hands. Her gait is normal but she has genu valgum.

Her thyroid is not palpable and there is no exophthalmos.

She is unable to do simple mental arithmetic but there is no evidence of true mental subnormality.

Her weight is 11 st. 8 lb. and her height is 5′ 1″.

Nervous System: Cranial nerves show no abnormalities. Upper and lower limbs have good muscle tone and power; no cog-wheel movements. No loss in cutaneous sensation. All tendon jerks brisk and equal. Normal planter response.

Cardiovascular System: Pulse rate—92 per min.; regular in time and force. Blood pressure—120/80 mm. Hg. Heart sounds—I & II present; no murmurs.

Respiratory and Alimentary Systems: No abnormalities found.

Genito-Urinary System: Hymen broken. Vagina tense on speculum examination; cervix not seen.

Investigations: Blood: Hb. 90 per cent = 12.6 G. per 100 ml. W.B.C. 7,000 per c.mm., 60 per cent polymorphs. Urine: No abnormalities. Chest x-ray was normal in mass radiography campaign in June 1961.

Diagnosis: Chronic anxiety state.

Treatment: Immediate: Phenobarbitone, 30 mg. t.i.d. Long term: Recommend her to an adoption society as suitable for adopting a child.

Discussion

Dr M. has devoted much attention to Mrs E. T. for the past 12

years that he has been her doctor. Her present illness presents no difficulty in diagnosis.

The possibilities of Parkinson's disease, disseminated sclerosis or thyrotoxicosis are eliminated by the absence of physical signs. Her features are those of an anxiety state.

The start of her illness dates back to her unstable childhood. The separation from her parents and their divorce must have been a severe psychological blow and this occurred in her formative years when such distress can be very harmful. Her previous family doctor noted that she was of a nervous disposition and he recorded such disorders as "gastritis" and "nervous diarrhoea." The changing home environment with varied parental care could give her no feeling of security. She and her sister formed a strong emotional bond and this was carried on after their marriages. The care and affection she showed for her sister's children helped her to develop maternal responsibilities and made her desirous of having her own. The failure to have any even after extensive treatment made her very distressed. Her anxiety symptoms became prominent after the departure of her sister's family. The fact that taunts from her neighbours make these symptoms worse shows the importance of infertility as a factor in their causation.

The management is a more difficult problem. Psychotherapy is of little value due to her limited intelligence. Drugs such as meprobamate, avomine, drinamyl, and fentazin have been tried but none had any lasting effect. Phenobarbitone has now been given but the long term care is more important. Dr M. made sure that the marriage was consummated. Gynaecological treatment has been unsuccessful and A.I.H. has been twice refused. The question of adoption now has to be considered.

A social worker at the adoption society which I visited, disclosed the requirements for adoption to me.

The important ones include:

1. The couple should have a stable marriage.
2. Both parents should wish to adopt the child but not with the hope of improving an unstable marriage.
3. There should be a steady source of income.
4. The couple should be infertile.
5. The home should be suitable.
6. There must be no illness in either partner which might cause sudden death.

The primary concern is for the child and the society investigates all factors which might affect its welfare. In placing the child, it tries to match very closely the biological parents with the parents for adoption, taking into account such factors as personality,

background, social status and religion.

To allow Mrs E. T. to have a child, knowing her background, is an undoubted risk. There is the chance that the presence of a child removes the factor causing infertility and permits her to become fertile, as has been known to happen.

Dr M. had to consider very carefully before making his decision. His responsibility was to his patient but he could not neglect the child's welfare. Should she not be given a child, he might be faced with no improvement in her condition and it might deteriorate in fact. A barren woman is scorned in her social group. Could an adopted child take the place of one of her own and so allow her to be accepted again? Not all infertile women develop anxiety states. Can her anxiety state be relieved by giving her a child? If this child were brought up incorrectly and became a juvenile delinquent, more social problems would be created.

The decision was not an easy one to make. But, viewing all the favourable factors—the care she had shown for her sister's children, the stability shown in her first job, and her stable happy marriage, Dr M. decided that she was suitable for adopting a child. On his recommendation, the adoption society is considering her application.

Mrs E. T.'s faith in scientific medicine has perhaps been undermined but nevertheless, a firm family-doctor-patient relationship has been built up. She discusses her problems freely with Dr M., and his understanding of them will be invaluable in her future management.

I visited her unexpectedly one afternoon, four months after I had first met her, and was pleasantly surprised to find how tidy, clean and homely her house was. She was a more relaxed and calmer person as she showed me around. Relations with her neighbours were better she said. The neighbourhood was full of children at play and she mentioned how she and her husband were looking forward to the day when they would have theirs. I left feeling that a child brought up by them would be loved and well cared for.

Summary

A case of chronic anxiety state is presented occurring in a housewife, aged 30 and married for 7 years.

Infertility with an unstable childhood are thought to be the main causative factors. Extensive infertility investigations and treatment have not made her fertile. She now wishes to adopt a child. The question of her suitability for this is discussed. Her family doctor has decided in favour of adoption as he is of the opinion that this will solve her social problems and improve her anxiety state.