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Conference report

Mind/body in sexuality and reproduction*

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It is a common assumption throughout the world that people may be put in one of two categories, male or female, and that members of each group share common attitudes, beliefs and behaviours. However, variations in how male and female behaviour are defined in the different groups may be numerous.

Anthropologist Dr Cecil Helman has tried to set gender in a wider cultural context; he views gender identity arising as a result of the complex combination of a number of influences, including genetic, somatic, psychological and social factors. Social gender is the most flexible aspect of gender identity, showing great variation in different cultural environments. Each culture contributes a set of guidelines, implicit and explicit, acquired from infancy onwards, which tell an individual how to perceive, think, feel and act as either a 'male' or 'female' member of that society. These gender roles are not fixed, but change in response to new environmental influences such as industrialisation or urbanisation. As a result social gender may embrace at times contradictory notions, for example that of 'nurturing madonna' and 'polluting evil' for women in Mediterranean countries. Helman discussed the interaction between the two gender cultures and health care: beliefs and behaviour characteristic of a particular gender culture may contribute to the cause or presentation and recognition of various forms of ill health. In the West, diseases of female social gender more often may be related to alteration of body image with links between diet and physical illness, uncomfortable shoes and orthopaedic problems, and cosmetics and contact dermatitis.

Normal female functions – menstruation, the menopause and childbirth – have also been increasingly medicalised in the West. Sheila Kitzinger has studied childbirth and the role and status of the midwife around the world. In traditional cultures birth is a social event. Normally a group of women will come together and help the delivering mother, creating a celebratory experience. The midwife, employing the special skills each women has, orchestrates the operation. Village midwives in Greece sometimes draw on the image of the opening flower, watching the petals of the 'hand of the mother of God' bloom open up in the heat of the birth chamber as the mother's cervix dilates to release the baby.

Medical investment in human reproduction has been taken furthest in dealing with the infertile couple, who may face a barrage of tests and treatment trials when they seek help. Psychologist Susan Golombok has interviewed couples starting IVF or AID treatment. She found a high level of anxiety among both the men and women, although not depression. This might appear surprising as Dutch researchers reported that 40% of women and 20% of men put their involuntary childlessness as the 'worst thing' that had happened to them. However, couples attending infertility clinics often fear they may be turned down from a treatment programme if they show excessive psychological concerns.

The Warnock report recommends counselling be made available to all infertile couples, but Golombok reported only a third of her sample would accept such input. She is concerned that many couples have unrealistic expectations from their treatment; even after a failed IVF or AID programme, 97% still wanted to participate in any further treatment that might enhance their chances of biological pregnancy. Although such couples were pinning their hopes on medical advances, Susan Golombok believes they must at the same time experience considerable unmet emotional needs.

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