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A Personality Perspective on Female Infertility: An Analysis through Wartegg Test

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Psychological aspects of Infertility have been analysed more through psychometric methods rather than through projective tests. We examined three samples of infertile women through Wartegg Test: primary organic sterility (20 patients), primary unexplained sterility (20 patients) and consecutive miscarriages patients (21 patients) being in diagnostic phase before starting therapy. They were compared to a sample of thirty healthy women. The quantitative analysis on Wartegg Test scores, by ANOVA and MANOVA, shows significant differences between infertile women and controls regarding to Evocative Character and Formal Quality. These differences confirm the emotional impact of infertility on imaginative life and rational ability to plan. The three patient subgroups appear significantly different. Unexplained sterility subgroup seems more similar to healthy women. The organic aetiology subgroup seems to have less adaptability and integration and the consecutive miscarriages subgroups seems to be affected by strong identity problems. Women affected by organic sterility and consecutive miscarriages showed lower affective stability than others. Regarding to Affective Quality, we didn't find significant differences. Therefore, going on trying to be pregnant seems to happen on an unconscious level and also to be an element to reach psychological affective integration and to overcome depression.

Infertility has been defined by OMS and American Fertility Society as the inability of a couple to bring pregnancy to term after having regular unprotected sexual intercourses for more than a year. A couple is to be considered infertile when one or both members are affected by a chronicle physical pathology that stops them from having a baby (Whitelaw, 1960).

The first example covers couples not able to bring a pregnancy to term: unexplained sterility cases, a relevant percentage so far, up to 28% of the cases (Alaina and Coll,2007), consecutive miscarriages (when a woman can't bring to term at least three or more pregnancies) and organic sterility.

We have known both the resonance of this problem and the psychological reaction to treatment for a long time, and also the consequences on the couple's quality of life.

Infertility is, in fact, a huge problem which affects 8-12% of couple around the world. Even if we know that stress and anxiety highly affect male and female infertility, a connection between physical and mental stress with the couple's inability to conceive is still to demonstrate (Inhorn, 2003).

The first historical studies on infertility also focus on female sterility by an obstetrical and gynaecological point of view, which has a deep impact on woman's mind. First psychodynamic hypotheses were about the unconscious conflict between desiring a baby and woman's resistance in relation to becoming a mother. The contribution by woman psychologists have widened the observation of psychodynamic elements involved on infertility, showing possible connections between conflicting factors linked to woman's condition and her role in family and in society, rather than to the desire of having a baby. The conceptual references of these early theories were psychosomatic theories, where psychological factors are possible aetiology of unexplained infertility cases.

The evolution of biological studies has shown a close relationship between biological and psychological factors. It has also demonstrated that many infertility cases are due to the male partner. As a consequence, this has changed the way of studying infertility, both from a male point of view and placing psychological hypotheses about sterility in a wider and undefined bio-psychosocial model.

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Many researchers agree in identifying stress as main factor of infertility, but it is still not clear which psychological processes are involved. Some situations are more stressful than others, and some people use different coping mechanisms to reduce stress (Stewart and Stotland, 1993).

In reproductive health, knowledge and understanding of relationship between the degree of stress and personal and cultural differences were studied by various researchers. They have also tried to find out which particular psycho-diagnostic tools could be used to find the level of stress and what kind of psychotherapies to be administered besides the traditional ones, e.g. *Hatha yoga*. (Metha and Anand Kumar, 2005).

An interesting research concerning infertility was carried out in Edinburgh. The research focused was on the cultural aspect of infertility and the need of culture, medical and psychological assistance to infertile couples. It shows that both clinics and patients consider assisted reproduction (known as "techno-science western) in India. This study shows how in India assisted reproduction techniques try to unify sacred and secular, human thing and transcendence, tradition and modernity, religion and science in a slow process of biomedical techniques "indigenization" (Bharadwaj, 2006).

Some Austrian researchers (Schmidt et al, 2004) have carried out a study in which they found social and cultural background sometimes represents a relevant factor. In fact, in Europe, a group of emigrant Muslim women affected by polycystic ovary syndrome (PCOS) showed a higher level of psychological distress compared to a group of Austrian sterile women.

Cultural factors can even influence public health regulations regarding prevention of infertility. Egypt, with 40 operational centres for IVF (In Vitro Fertilisation) techniques, has been the centre of an interesting study that demonstrates how new reproductive technologies produce the most effective solution to infertility problem, with a high percentage of resolved cases. This research highlights the importance of promoting a primary prevention about the infections which are responsible for organic infertility in developing countries. Therefore, it does not encourage to assisted reproduction techniques, which are too expensive and difficult to implement.

however, the used techniques seem to affect the emotions of infertile couple during pregnancy. A study found out significant differences regarding both emotional responses towards pregnancy and personality dimensions. Women in this group showed higher muscular tension and higher level of anxiety towards loosing their child compared to the control group. Men in this group showed a higher level of somatic anxiety, indirect aggressiveness, sense of guilty and more separation anxiety towards loosing their child, compared to men belonging to control group (Hjelmstedt et al, 2003).

Even if we concentrate on psychological reactions to infertility, the women are more emotionally involved and more suffering, though she is not the only one affected by sterility. Within the range of this study (Dhaliwal, 2004), it has been found a "female partner tendency" to show anxiety and depression during infertility treatment, both in female and in male infertility.

The main objective of another study was to analyse the ability of different genders to build specific mechanism to cope with an IVF treatment. Using a questionnaire to find out socio-demographic data, it allowed us to know adaptation response and perceived tensions both in men and in women. This research also showed that women presented a higher control and defence from others regarding the pain they felt as compared to men. Above all they showed a higher level of "brooding" regarding their inadequacy not to succeed in conceiving (Pottinger et al, 2006).

Schmidt et al (2003) highlighted the way women give more importance to the assistance they received inside the clinic before, during and after IVF treatment. In fact, women presented a higher level of satisfaction regarding medical services offered at the clinic and felt positive towards the treatments finalized to pregnancy. Belonging to a lower social class is an additional factor for satisfaction.

Female infertility both organic and unexplained linked to psychological and psychiatric factors, was studied in different cultures. An interesting research found, in a group of 50 Turkish women, through a battery of quantitative tests (Beck Depression Inventory, Spielberg Stait-Trait Inventory, Rosenberg self-esteem scale and Symptom Checklist), how infertile women showed a higher level of anxiety and depression compared to the control group (Guz et al, 2003).

A group of Japanese researchers carried out a study in which they underlined the relationship between anxiety and depression level and, on the other side, thought processes and emotions linked to infertility in a group of infertile women. The Hospital Anxiety and Depression Scale (HADS) was administered to see the attitude of women towards their own infertility. The factorial analysis puts in evidence how anxiety and depression are strictly and positively correlated to lack of support from their husbands and stress. These conclusions show the importance of building a psychological support in order to reduce anxiety and depression levels (Matsubayashi et al, 2004).

Khademi et al, (2005) administered Beck Depression Inventory on a group of 251 women who asked for an assisted reproduction treatment, before and after the treatment, found that higher scores related to treatment failure and lower scores was related to treatment positive outcome. In another interesting study (Jedrzejczak et al, 2004) Beck Scale was submitted to a group of women in order to find depression levels and to show how Beck scale mean scores were higher for infertile women compared to control group.

In relation to consecutive miscarriages, a less occurring event (recurrent miscarriage affects between 0.5 and 3 % of couples, Habayeb and Konje, 2005), a study carried out by Klock (1997) put in evidence how 32% of women affected by multiple miscarriages could be defined depressed. These women also reported higher anxiety levels. They felt like they couldn't protect their own baby, amplifying endured psychological stress. Mourning reactions to child loss and possible mourning negation allow to think that this infertile woman group present peculiar psychological features (Daini, 1997).

Taking into account these aspects of female infertility, this study aimed to find out the correlations between female infertility, consecutive miscarriages and specific personality traits projective through Wartegg test.

Methods:

Participants and Procedures:

A sample of 61 urban Italian female patients affected by infertility, were diagnosed and treated at Policlinico Gemelli Hospital from 2003 to 2006 was selected for the study. According to gynaecological examinations, patients were divided into three groups: group A (N=21) consisting of women with consecutive miscarriages (ranging from 2 to 14 at various gestational age) and with no living babies (mean age 30.81 ± 1.18 years); group B (N=20) consisting of women with organic sterility (mean age 28.50 ±1.48 years); group C (N=20) including women with unexplained sterility for more than two years according to diagnostic checks (mean age 28.40 ±. 1.16).

They were compared to a control group of 30 women with no infertility problems and matched with age and socio-economic status (mean age 30.03 ± 0.78). They were chosen randomly, among women who had a day hospital gynaecological check. The majority of them were married (70%) with children (ranging from 1 to 3), while the others didn't try to be pregnant. All participants performed clinical interview and the Wartegg test as a part of a psycho-diagnostic assessment treatment. Test on sample group was performed before planning further attempts to be pregnant. The test was scored by one of the Authors.

Measures:

The Wartegg is a graphic, projective, semi-structured test, composed by a module containing eight panels, numbered from one to eight. They are arranged in two horizontal parallel series of four panels and separated from a wide black margin. The subject's task is the graphic realization of any mental content that uses, as starting point, the graphic-signs already present in the various pictures, based on subject's spontaneous choice of the sequence, and giving a sense to them. The diagnostic value of each panel is the actual state of identity (panel 1), vitality and sensibility (panel 2), ability to direct own psychic resources toward aims and objectives (panel 3), relation to rules and authority (panel 4), directionality of aggressive dynamics (panel 5), relation to reality and rationality (panel 6), relation to femininity and sexual energy (panel 7), social relations and wish to protection (panel 8).

The graphic realization of the Wartegg makes it really a projective test. In fact, the graphic -signs takes shape as semi-structured stimuli on which subject "is tending to project specific contents and personality dynamics and they are, therefore, revealers of its organization" (Rapaport, 1977). The Jungian psychoanalytic matrix, from which it comes from, enables the choice of stimuli which recall unconscious meaning widely shared by all cultures.

This test is suitable to be distributed to individuals and groups. Also it describes thoroughly, the personality organization of the examined subject, thanks to the new method of Crisi (1998), and the innovation and informatics support purposely devised.

The 91 Wartegg tests, in this study was codified and analysed following Crisi (1998) method. It was analysed considering the three principal dimensions proposed by Crisi(1998): the Evocative Character (EC), the Affective Quality (AQ) and the Formal Quality (FQ). It was also taken into account the statistics frequency by which contents frequently made and named "vulgar" are presented (V%). Moreover, their more or less positive meaning depends on the value obtained by this contents during the formal quality evaluation (V+%). In this research, the comparison between Affective Quality and Formal Quality and nominated "Stabilization Affective Index" was also analysed (A/F). In addition, other two particular phenomenon more frequently found in the Wartegg were studied: the deletion or blackening of the stimulus-sign, called "Anxiety Index" (I.A.) and the overtook margin called "Impulsivity Index" (I.I.). The "Interior Intension Index" is deduced from the last two indicators (I.T.I).

The Evocative character: Wartegg (1957) talked about the archetypal function of the 8 stimulus-signs chosen by him. With this definition he meant the intrinsic and universal capacity/power of signs, also based on specific Gestalt rules, to evoke unconscious experiences for everybody to take part of. Therefore, the EC gives us information on how the subject reacts to the stimulus-signs of the test, both from a purely perceptive-gestalt and associative point of view. If the subject catches the hints of the stimulus-sign and make related graphic realizations is given the score 1. When the solutions only partially integrate the evocative character is given the score 0.5. When the pictures completely fail is given the score 0.

The Affective quality: is only and exclusively an evaluation based on emotional connotation that characterizes each subject's picture. The AQ tells us about subject's emotional tone, its ability to get into relation with its affective and instinctual dynamics and to show them outside. Even in this case, each picture gets a score 1, 0.5 or 0, depending on subject's draws positive, neutral or negative emotional contents.

The Formal Quality: evaluates the ability to express the most important features that make picture "peculiar and recognizable to our eyes" (Crisi, 1998). This ability can be considered closely connected to subject's cognitive level, because it is based on the ability to recognize the whole through a part. According to FQ criteria also, score 1 is assigned when picture significance is obvious and immediately

recognizable by the examiner. Score 0.5 is assigned when this significance is suitable to various possibilities of reading, and 0 when picture is totally unclear, unrecognisable and arbitrary.

On the basis of more used scores, vulgar answers are divided into vulgar answer properly gave (= V; the score 1 is assigned), and semi vulgar (= v; score 0,5 is assigned). The discovered value (V%) measures any thought stereotype and critical capacity absence in depressed, formal and conformist people. The vulgar answer percentage with positive formal quality (V+%) evaluates subject's adaptation process to the reality and common thought not only in a quantitative way, which is V%, but also qualitative.

The index of affective stabilization (A/F) describes in which way affectivity and rationality are related. It notices the presence or the absence of any emotional stabilization, of an affective balance, of self-control and a maturity reached by the subject. In general, relevant prevalence of affective aspects can be considered in close relationship with Jungian extrovert type, while clear-cut prevalence of formal aspects with the introvert type (Crisi, 1998).

The Interior Intension Index represents a "not specific signal of psychological discomfort". It describes the inadequacy degree and/or emotional tension present in subject". The Impulsivity Index evaluates impulsiveness, acting-out and therefore subject's ability to check sexual and aggressive energy. The Anxiety Index shows anxiety, insecurity and indecision occurrence. All these three indexes (I.T.I.; I.I.; I.A.) vary from 0 to 1.

Statistical Analyses:

First, age differences effect on Wartegg variables was calculated. The effect of "group" variable was analysed by MANOVA, for Wartegg parameters, and the post hoc differences between group means were obtained by Multiple Comparisons. Non parametric dependent variables (as order of Panels in answers) were analysed by Chi square Test. Statistical elaboration was performed with SPSS11.0 program.

Results:

Regarding to Test performance times, the ANOVA shows a trend of B and C groups to have longer Test performance times compared to other groups even if this trend is not completely significant (F: 2.35, $p<.08$). This data is a defensive attitude index.

Regarding to Panels sequence order, while 76% of control group executed Panel 1 first, only 50% of two sterility groups made the same choice. Finally, this choice is present only in 24% of subjects affected by recurrent spontaneous abortions. This difference is noteworthy on a statistical level (Chi square =13.36; $p<.004$). Instead there are no clear significant differences among groups about choosing last picture.

Multivariate Analysis on key variables of Test correction (CE; QA and Q.F) shows significant differences between research groups (F: 3.218 $p<.001$). In particular, significant differences were noticed in Evocative Character (p .006) and Formal Quality (p .0001) means, while no significant differences were noticed in Affective Quality among groups. Recurrent spontaneous abortions group, instead, showed only a trend to have lower means as compared to organic sterility and control groups.

Table 1 show differences related to Evocative Character in experimental group. Recurrent Spontaneous Abortions (RSA) sample has significantly lower means related to control and unexplained sterility groups. In particular, the post hoc analysis shows significant differences regarding Panel 1 control group compared to control and organic sterility groups. There are significant differences also concerning Panel 4 compared to unexplained sterility group and Panel 5 compared to controls. The

organic sterility group shows lower means compared to unexplained sterility and control groups that can be attributed to Panel 4,5,6,7.

Table 1

MANOVA Diagnosis (Recurrent Spontaneous Abortions, Organic Sterility, Unexplained Sterility and Controls) for Evocative Character scores in eight Panels

Wilk's Lambda	R S A Group A (N=21)	Organic Sterility Group B (N=20)	Unexplained Sterility Group C (N=20)	Control Group D (N=30)	F 3.218 (P<.001)	LSD Post-Hoc Test
	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)		
Panel 1	0.78 (0.4)	0.95 (0.1)	0.87 (0.3)	0.94 (0.1)	2.15	A<B* A<D*
Panel 2	0.40 (0.4)	0.52 (0.4)	0.37 (0.4)	0.43 (0.4)	0.44	
Panel 3	0.57 (0.3)	0.52 (0.3)	0.65 (0.3)	0.69 (0.3)	1.45	
Panel 4	0.42 (0.4)	0.42 (0.4)	0.67 (0.4)	0.62 (0.4)	2.52	A<C* B<C*
Panel 5	0.50 (0.4)	0.45 (0.4)	0.65 (0.3)	0.71 (0.3)	2.74	B<D* D>A*
Panel 6	0.88 (0.3)	0.85 (0.3)	0.95 (0.1)	0.98 (0.1)	1.79	B<D*
Panel 7	0.52 (0.4)	0.40 (0.4)	0.65 (0.3)	0.67 (0.3)	2.82	B<C* B<D*
Panel 8	0.81 (0.3)	0.77 (0.3)	0.77 (0.3)	0.81 (0.2)	0.10	

* : p<.05 ;

Table 2 shows results related to Formal Quality. Even in this case, RSA group presents lower scores. In particular, differences in unexplained sterility and in control group are very significant. These results are above all ascribed to relevant differences related to Panel 4. Organic sterility group instead, presents significantly lower scores compared to unexplained sterility and control groups. Therefore, the unexplained sterility group is more similar to healthy controls concerning Formal Quality.

Table 2

MANOVA Diagnosis (Recurrent Spontaneous Abortions, Organic sterility, Unexplained Sterility and Controls) for Formal Quality scores in eight Panels

Wilk's Lambda	R S A Group A (N=21)	Organic Sterility Group B (N=20)	Unexplained Sterility Group C (N=20)	Control Group D (N=30)	F 3.218 (P<.001)	LSD Post-Hoc Test
	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)		
Panel 1	0.66 (0.4)	0.67 (0.4)	0.81 (0.3)	0.71 (0.2)	0.86	
Panel 2	0.59 (0.4)	0.58 (0.4)	0.76 (0.4)	0.80 (0.3)	2.14	B<D*
Panel 3	0.28 (0.4)	0.36 (0.4)	0.37 (0.3)	0.50 (0.4)	1.44	
Panel 4	0.25 (0.3)	0.58 (0.3)	0.74 (0.3)	0.66 (0.3)	7.37	A<B ** A<C *** A<D ***
Panel 5	0.4 (0.4)	0.50 (0.3)	0.66 (0.3)	0.55 (0.3)	1.80	A<C *
Panel 6	0.81 (0.3)	0.61 (0.4)	0.76 (0.3)	0.75 (0.3)	1.24	
Panel 7	0.56 (0.4)	0.64 (0.4)	0.63 (0.3)	0.75 (0.3)	1.03	
Panel 8	0.66 (0.4)	0.67 (0.4)	0.71 (0.3)	0.80 (0.3)	0.87	

* : p<.05 ; ** : p<.01 ; *** : p<.001

The results of Interior Intension, Anxiety and Impulsivity Indexes are reported in Table 3. Concerning Interior Intension, there are relevant differences among groups. This index appears significantly higher in unexplained sterility group compared to the other two experimental groups. Anxiety Index instead is similarly higher in unexplained sterility group compared to the other two groups, even if it is not in a pathological range. There are no significant differences compared to controls.

Table 3

MANOVA Diagnosis (Recurrent Spontaneous Abortions, Organic Sterility, Unexplained Sterility and Controls) for Anxiety and Impulsivity Indexes

Wilk's Lambda	R S A Group A (N=21)	Organic Sterility Group B (N=20)	Unexplained Sterility Group C (N=20)	Control Group D (N=30)	F 3.218 (P<.001)	LSD Post-Hoc Test
	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)		
Interior Tension Index	0.22 (0.3)	0.24 (0.2)	0.39 (0.2)	0.27 (0.3)	2.11	A<C B<C
Anxiety Index	0.01 (0.04)	0.04 (0.1)	0.14 (0.2)	0.07 (0.1)	3.27*	A<C B<C
Impulsivity Index	0.22 (0.2)	0.21 (0.2)	0.26 (0.2)	0.20 (0.2)	0.36	

* : p<.05

Table 4 shows results related to ratio Affectivity/Form. In this case, consecutive miscarriages group shows significantly higher means than unexplained sterility and control group. Organic sterility group instead, shows higher means compared to unexplained sterility group. As regards variable F (Form), these results are attributed to very significant differences among groups. With reference to subject's Vulgar contents answers (V% e V+ %), significant differences were not found among samples.

Table 4

MANOVA Diagnosis (Recurrent Spontaneous Abortions, Organic Sterility, Unexplained Sterility and Controls)

Wilk's Lambda	R S A Group A (N=21)	Organic Sterility Group B (N=20)	Unexplained Sterility Group C (N=20)	Control Group D (N=30)	F 3.218 (P<.001)	LSD Post-Hoc Test
	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)		
A Affectivity	2.33 (0.8)	2.72 (0.6)	2.60 (0.9)	2.64 (0.8)	0.88	
F Formal	1.52 (0.9)	1.97 (0.9)	2.57 (0.9)	2.45 (0.7)	7.46***	A<C A<D B<C B<D
A/F	0.81 (1.0)	0.75 (1.0)	0.02 (1.2)	0.19 (1.0)	2.96*	A>C A>D B>C

* : p<.05; *** : p<.001

Discussion:

Our findings confirm that infertility problem involves female personality deeply, with a range of features correlated to infertility type taken into account. This study regarded the causal connection and the presence of previous pregnancies loss considering all that variables that make infertility a complex and articulate problem. Women affected by primary sterility and who haven't lost their child, appear less problematic than women whose infertility is linked to a sense of mourning for not having pregnancy to term.

Any type of organic sterility group presents a lower adaptability and ability to build social relationship. This group has a trend not to understand the evocative nature of panels regarding female and aggressive themes and relation to authority.

In these dimensions, these women show differences compared to unexplained sterility and control groups. This organic sterility group is similar to consecutive miscarriages group but differs from it for a stronger sense of identity (Panel 1). The Formal qualitative analysis on same patients suggests a difficulty to make an adequate reality and to have a good self control. The significant difference of Panel 2 compared to control group suggests a poor integration regarding emotional themes. The sterility condition leads to sense of inferiority in women. In fact, although organic sterility underlines a body inability, it allows the elaboration of woman's potential sense of guilt. In fact, in this case Interior Tension, Anxiety and Impulsivity Indexes are on average.

The unexplained sterility group shows psychological features more similar to control group. In fact, there aren't significant differences among these groups. Therefore, the absence of sterility allows maintaining a fairly good emotional, cognitive and relational equilibrium. This condition is probably associated to a hope of a natural or non medical resolution of sterility. But, the definition of a woman's own identity appears potentially rigid and with internal tension (scores are higher than average, in both Evocative Character and Formal Quality – Panel 1). However, this group appears to have more anxiety compared to the other two groups of sterile women, but not in pathological terms. Concerning unexplained sterility, some authors (Bydlowski, 2003) underline the secondary gain of the illness. In our study we hypothesize that this secondary gain is not related to partner or family attention but to a more acceptable personal psychological equilibrium. This equilibrium could come to a crisis both because of a child's existence and the diagnosis of definite sterility.

Spontaneous consecutive miscarriages group shows a remarkable psychological effect on female personality, even if the hope to have a child has not been dropped. It follows a compromised identity regarding her inner world that is not able to make up for adequate rational defences. Relationship with the normative sphere also appears problematical (Panel 4). Women affected by recurrent spontaneous abortions show extremely significant differences as compared to all other groups. This makes to think that miscarriage experiences are correlated not only to disappointment regarding a pregnancy expectation, which is encouraged by the ability of conceiving, but also to an extremely strong unconscious conflict characterized by an irrational sense of guilt. Although anxiety and internal tension indexes are not so high, the relationship unsettling between affectivity and rationality makes us think about a subject's immaturity and poor ability to control its reactions and to plan its activities. In this group, the psychological burden due to infertility seems to reflect on woman's emotional and cognitive equilibrium completely, maybe due to the attachment relationship towards the child during pregnancy. A woman can experience this relationship since the early months of pregnancy and it can modify her narcissistic equilibrium. Therefore the spontaneous miscarriage can be suffered by a woman as a traumatic event and it can be a reason for her to come to a crisis.

It is remarkable that the absence of significant differences regarding the affective quality among all infertile women and control groups. This would make us think about an absence of depressing feelings in a psychodynamic sense, contrary to findings based on psychometric tests. An interpretative hypothesis could refer to the situation in which tests have been performed. This could be related to a new examinations phase regarding a potential pregnancy attempt. Consecutive miscarriages group has shown lower scores as compared to other samples but the difference was not found statistically significant. For this and the other infertile women groups, a new attempt for pregnancy could represent a balancing element for affectivity.

A significant tendency to Alexythimia, has been recently reported in organic and unexplained infertility groups, through Self Report Instruments (Lamas and Coll, 2006). The study used a graphic and Wartegg projective test and found that the poor communicative ability is an exterior defence rather than a shortage of emotions or affective feelings.

The extension on sample dimensions could allow us to differentiate further variables which can intervene in modifying the psychological framework of infertility, for example the presence of different organic causes, linked to a greater or minor recovery expectation. However the variables analysed in this study allow differentiating various psychological profiles in female infertility.

Conclusions:

The demand of psychological service to infertile couples and especially to woman is recognized both by researchers adhering to a psychodynamic point of view and by those more critical towards it. (Wischmann, 2003). Studying this problem through projective tests allows us to highlight less clear perspectives from a symptomatological point of view and to outline various personality profiles. This can help us making a custom-made treatment for patients.

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