Spousal support and perceived womanhood as determinants of somatic complaints among Igbo women with fertility challenge

Innoeze U. Clara[1*], Eze Innocent Okafor[2], & Echeme O. Joy[3]
[1]Renaissance University Enugu.
[2]Department of Obstetrics and Gynaecology, Nigerian Navy Reference Hospital, Calabar.
[3]Imo State University, Owerri.

*corresponding author: ucheinno84@gmail.com

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ABSTRACT

This study tested the influence of spousal support and perceived womanhood, on somatisation among Igbo women with fertility challenges. The participants consisted of 124 women with infertility, drawn from outpatient Gynaecology Departments of Enugu State University Teaching Hospital, Parklane Enugu, Enugu State and Police General Hospital, Amakohia Owerri, Imo State using purposive sampling technique. Out of the 124 participants, 34 were business women while 90 were civil servants. Their ages ranged from 25-60 years, mean age 36.29, while their marital age ranged from 2-30 years. Four hypotheses were formulated. The study employed four instruments to collect data; Spousal Support Index, Perceived Womanhood Questionnaire, Enugu Somatisation, and Locus of Control scales. Cross sectional survey design was employed for this study and binary logistic regression analysis was used for data analysis. Results showed that lack of spousal support increases somatic complaints among women with fertility challenge, while perceived womanhood does not necessarily increase somatic complaints among Igbo women who are having fertility challenge. This implies that lack of spousal support contributes to high somatic complaints among women with fertility challenge, perceived womanhood does not contribute much to somatisation among women with fertility challenges.

Keywords: Igbo women, Imo, Womanhood, Somatic, Spousal Support, Fertility

INTRODUCTION

Background to the Study

Somatisation or somatic complaint is a term introduced by Wilhelm Stekel (1924). Prior to this, the term is from Greek, "soma" for body. In the middle ages, these disorders were believed to be spiritual disorder of evil and demonic possession. It was equally assumed that it was only peculiar to women until the 17th century. This belief and assumption was long held until, Thomas Sydenham identified through his work that it was a psychological disturbance which could also occur in males, since it was reported more by women (Smith, & Dwamena, 2007, Nduanya, 2018).

It is a disorder that is regarded in our society as not just a defence mechanism, but also a form of communicating psychological distress, which explains why it is described as bodily manifestation of psychic conflict. It is commonly expressed and also considered as the generation of physical symptoms of a psychiatric condition such as anxiety (Woolfolk & Allen, 2006). It is a major category in the DSM V and includes other diagnoses such as somatic symptom disorder, illness anxiety disorder, conversion disorder factitious disorder and a variety of other related conditions (workingfit.co.uk).

Some somatic complaints tend to be peculiar to a particular group of people based on the common stressor that they seem to be experiencing. One of such somatic complaints is known as brain fag syndrome. This is a form of somatisation that was first observed in Nigeria, among students of Igbo and Yoruba origin (mainly medical students). It has been described as a somatisation reaction to studying (Prince, 1960; 1962; 1989, Ebigbo, Elekwachi, & Nweze, 2013). It may constitute a defensive process in which psychological distress is expressed in somatic complaints as earlier mentioned. The brain fag is believed to be as a result of brain fatigue such as, unpleasant feeling in the head, which includes; pain in the head, crawling sensation in the head, visual disturbances, i.e., blurred vision, cognitive disturbance, i.e., inability to grasp the meaning of spoken and written words, (Prince, 1989, Ebigbo, Elekwachi, & Nweze, 2013).

It is also important to note that somatisation has primary and secondary gains that probably make people to somatise. The Primary gain is when a physical complaint distracts an individual from a particular distress. For instance a woman with fertility challenge who complains about heat sensation in the head, has goal frustration, which could mean inability to conceive and enjoy her marriage. Also her complaint of needle-like pinching is interpreted as being in a miserable situation that one could do nothing about, for instance, inability to get solution to her infertility. Crawling sensation both in her belly and all over her body, signifies sexual related problems (Ebigbo, 1986; 2014). With somatisation, a woman with fertility challenge shifts her problem from infertility to physical complaints, which relieves her from the distress of trying to conceive. On the other hand, she also enjoys secondary gain as significant people in her life (husband) tend to give her more attention and care for her as well.

Infertility among couples (married and unmarried) is considered a serious psychosocial and cultural issue among couples desirous of children. It poses a serious concern to couples more especially the married ones, despite their educational, social and cultural background. About 70-80 million couples worldwide are currently infertile. The affliction it brings to its sufferers is not only limited to countries or societies where children are highly valued or considered as integral

part of a family or even the basis for marriage, it is also extended to people in developed societies, where many people do not even consider children as the basis for marriage. Infertility can be considered either primary or secondary. The former has to do with when a woman has never conceived either before or after marriage, while the later has to do with when a woman or a couple still finds it difficult to conceive after one or two children (Van-Balen, 2009).

Although it appears that women are often seen as culprits or suffer more especially in a male dominated Igbo society, men are also known to suffer and feel the pain of infertility as much as the women. But then, it is worthy to note that in our contemporary African cum Igbo society, male virility is rarely questioned, which makes men with fertility challenges to either shy away from it or shift the blame to their wives or female partners.

In Nigeria, it is estimated that 3-4 million married couples suffer from infertility (Erigbali, Sule, & Eruom, 2008, Hodin, 2017). Unfortunately women are often seen as the culprit in infertility related issues. Most women with fertility challenge in a bid to have children have equally been subjected to all forms of emotional and psychological trauma.

It is also important to note that infertility related complexities and life experiences are highly influenced by the sociocultural context in which the person lives in. Therefore, any comprehensive study on the subject that disregards this context is futile (Gannon, Glover, & Abel, 2004; Greil, Slauson-Blevins & MacQuillan, 2010). In some parts of Nigeria for instance, women who suffer from infertility have been subjected to the worst form of human degradation because they are unable to conceive. In Ekiti State for instance, women with fertility issues are treated as outcastes and when they die, their bodies are buried on the outskirts of the town, where mentally ill people are being buried (Ademola, 1982; Okonofua., 2003).

It has been observed that a man could be sterile or impotent in Igbo culture but on no account is this made public, even by the man's wife. She is encouraged to beget children for her husband through other men, while still being respectful and submissive to him. Even if she decides to leave her husband's house, she is not obligated to leave with those children, especially if her bride price was paid before she had those children. On the other hand, if the woman decides to leave without begetting children for her husband through other men, she does so at her own peril, because it would be said that her husband sent her packing because she is unable to conceive. Marrying another wife who would oblige to the man's suggestions of having children through other men somehow "vindicates" the man. But when infertility becomes the fault of the woman, contrary is the case.

As a clearer illustration, let us consider a similar practice in Nsukka area of Enugu State, South East of Nigeria. Based on account of some elders in Nsukka community, who were interviewed for the purpose of this study and close observation, it is accepted that if a man is sterile (i.e., not being able to impregnate a woman) but potent (i.e. could have erection and as a result maintain normal heterosexual relationship with his wife), this would be brought to the notice of the elders of the immediate family and the woman would be summoned. At this meeting, the eldest male in the family known as "Onyishi", who occupies the ancestral seat of the family, would pour libation to the ancestors and make some incantations, after which the woman is asked to choose from among the kinsmen, someone who would help her beget children for her infertile husband.

The reason for limiting it within the family circle is to ensure that the child carries the blood of the family, whether nuclear or extended.

If there is no capable man (i.e., someone who is willing as well as physically and mentally sound), or if she does not find any man worthy, she would be permitted to go outside the immediate and extended family but only to families that are respected and rid of any form of serious ailment (such as history of epilepsy, madness, suicide or even stealing). Whatever is the case, the man must be known to the elders of that family. The sexual relationship must be strictly for procreation. If the infertile man (husband to the woman), decides that he has got enough children, the woman must cease having sexual relations with the "contracted man" i.e., the man who is helping her to beget children for her husband. It is also important to note here that the woman only meets the "contracted man" when she wants to get pregnant and stops only when she takes in and continues again when she wants to get pregnant.

It is also believed among elders of this community, that if she goes contrary to this traditional contract, the gods of the land would punish her and she could either die or run mad. The man in question, who is helping her to beget children for her husband, also understands this traditional contract very well. He is not only bound by oath not to speak of it, but must never desire the woman outside the tenets of the contract even if his wife does not give birth to a child or children, otherwise, it is believed that if he goes contrary to this, he could die. Situations like this could make a woman feel bad about her infertility challenge and may equally propel her to seek help through any possible means.

A lot of factors have been implicated in somatic complaints among women with fertility issues. Among this litany of factors are; spousal support and perceived womanhood. These factors are more likely to contribute immensely to psychological problems among women with fertility issues in our Igbo culture, for instance Upkong and Orji (2006), carried out a study on mental health of infertile women in Nigeria and their results show that depression and anxiety are more common among women with infertility than their fertile counterparts.

Nevertheless, how spouses of women who are having fertility challenge relate with them is also likely to affect the somatic complaints of such women. The reason for this is that they are not only supposed to be close to their wives but also play a crucial role in trying to figure out how to deal with their inability to have a child or children, which is regarded as spousal support.

This variable is defined as the support a woman who is having infertility challenge gets or rather is supposed to get from her husband. Spousal support has been demonstrated in numerous studies to be one of the keys to successful marital relationship as well as psychological wellbeing. For instance in a study by Holmes, (1993) on spousal support and marital relationship, they asserted that positive spousal support which include physical and emotional information support, suggestion/advice, situation appraisal, teaching, emotional support in the form of relationship, physical affection, confidentiality, sympathy, understanding/empathy, prayer, expressing of concern, reassurance, esteem support in the form of compliment, validation, relief of blame, tangible aid, indirect task , willingness to help anytime positively correlate with marital adjustment. On the other hand, negative form of spousal support such as; complaints about partners' short comings, criticisms, isolation, disagreements/disapproval, has been found to be a great source of conflict and dissatisfaction (Holmes.,1993; Ebenuwa-Okoh & Edu, 2015).

Social support within the marital relationship has been considered to be important for the psychological well-being of both man and woman and can affect their coping behavior with stress (Cohen, Underwood & Gottlieb, 2000; Delongis & Holtzman, 2005, Ebenuwa-Okoh & Edu, 2015).

According to Audu, Ojua, Edem and Aernyi (2013), it is believed that men determine who is infertile in the home and in every circumstance the woman is faulted. As a result of this, infertility can be particularly cruel for the women folk. As a matter of fact, a man in the traditional Igbo society is not considered infertile, even if he is. He could marry a fertile woman, who is encouraged to beget children from other men in his name. Some of these attitudes by the spouse of a woman, who is having fertility challenge, contribute to somatic complaints and psychological distress that the woman goes through in addition to feeling abandoned. As Africans, some of these psychological distresses are manifested in bodily form, which is somatisation.

In addition to spousal support, how the society (Igbo society) views or perceives women with infertility i.e., perceived womanhood, also plays a huge role in their somatic complaints.

This implies how married women, especially those without children are viewed or treated in our Igbo society. It is one of the key variables in this study that will be viewed in relation to somatisation among women with fertility challenges. The culture we find ourselves in sometimes is not very patient and fair with women who are having fertility challenges. It has been observed that the people close to the woman with fertility challenges are often the ones who contribute to her distress and sometimes these people are her in-laws or close relatives. The attitude of in-laws is relatively unfavourable towards the childless woman and in the long-run, they do support her dehumanization because they believe that the childless woman is aiding the termination of their lineage. As such, in-laws encourage the marriage of a second wife in attempt to ensure the continuation of their lineages (Innocent & Onwe, 2015).

Certain behaviour by people in our society about the condition of a woman with fertility issues helps to contribute more to her somatic complaints. For instance, according to Innocent and Onwe (2015), some women who look down on the childless women, most of the time believe that childless women are responsible for their condition. As a result of this, they display unfavorable attitude towards childless women in form of gossip, scornful laughter, downgrading looks, direct/indirect reference to their plight and sometimes open confrontation. There are so many reasons for this wrong perception of women with infertility. Women with fertility challenges are often seen as having led a very promiscuous life in the past, such as committing series of abortion which has affected their reproductive organs, thereby resulting in their inability to conceive children (Tolulope, 2017).

The present study however, is aimed at investigating how spousal support and perceived womanhood in contemporary Igbo society contribute to somatisation among Igbo women with infertility challenge. Reason for limiting this study to Igbo culture is based on the fact that the above mentioned variables to be investigated, are very common in our culture and most women with infertility, often refer to the factors as contributing to their somatic complaints. Hence the researcher decided to see to what extent these two variables determine somatic complaints of Igbo women with fertility challenges.

Objectives

To this extent, the overall objectives of this study therefore include;

1. To determine the influence of spousal support on somatisation among Igbo women with infertility
2. To determine the influence of perceived womanhood on somatisation among Igbo women with Infertility.

Hypotheses

There would be a significant influence of spousal support on somatisation among Igbo women with infertility.

There would be a significant influence of perceived womanhood on somatisation among Igbo women with infertility.

Method

Study setting

This study comprises a total of 125 female participants within the age range of 25-60 years and a mean age of 36 and SD of 6 who are having fertility challenges. They were selected from Enugu and Imo State.

These two states represent a broad spectrum of Igbos of South East Nigeria due to the following reason: Enugu State is a metropolitan city and the capital of old eastern region as well as the former capital of Anambra State. In addition to this, Ebonyi State was also carved out of Enugu State. It also shares boundaries with Anambra, Abia and Ebonyi states. These factors make Enugu State, a state that represents Igbos from different states of the south east, particularly those from Anambra, Ebonyi and even Abia States. Also as a metropolitan city, it represents people from diverse socioeconomic background as well as people from different parts of the country. Imo State is also chosen because it is a metropolitan city and people from different south eastern Nigeria reside there. It has also been observed that many indigenes of Abia State, which is a neighboring state it shares boundary with, equally reside there.

Sampling

The participants were randomly selected from outpatient Gynaecology clinics of Teaching and General Hospitals in Enugu (ESUT Teaching Hospital Parklane) and Imo States (Police General Hospital, Amakohia), South East Nigeria. The reason for this is that, gynaecology outpatient clinics in various teaching and general hospitals, avails one an ample opportunity of seeing women from different socioeconomic backgrounds with fertility issues, who have undergone and are still undergoing treatment. This is contrary to focusing mainly on fertility clinics, where a greater percentage of people who go there, are of higher socioeconomic status due to the high cost of seeking fertility treatment.

Purposive sampling was used to select participants for this study. This is a type of sampling technique where participants for a research are selected based on similar characteristics (Saunders, Lewis & Thornhill, 2012). Participants for this study already have one thing in common, which is infertility. This is the reason, the researcher decided to go directly to Gynaecology units of Teaching and General Hospitals in Enugu and Imo states, where women with fertility challenges can be easily identified for the study.

Instruments

Three instruments were used for this study. The first two which includes; Igbo Perceived Womanhood Questionnaire and Spousal Support Index (SSI), were developed by the researcher, while Enugu Somatisation Scale (ESS) was developed by Ebigbo (1981, 2013). The Igbo Perceived Womanhood Questionnaire (IPWQ) is a 15item questionnaire designed to measure how the society views or treats women with fertility challenges. It is in a 4point likert format, with options ranging from (1) strongly agree, (2) agree, (3) disagree and (4) strongly disagree, which gives respondents the opportunity of describing how they truly perceive the way our Igbo society treats women with fertility challenge. Based on internal consistency employed to test the reliability of this instrument, a Cronbach alpha of 0.94 was obtained, with a norm of 56.5. IPWQ was correlated with Index of Family Relations (IFR) by Hudson (1982) which measures family dysfunction as well as how an individual relates with family members. A validity score of 0.45 was obtained, indicating that there is positive correlation. Scores higher than the mean indicate that a woman with fertility challenge feels that the society views her negatively.

Spousal Support Index (SSI): This is the second instrument used in this study. It is a 14item questionnaire that measures how women perceive how supportive men are to their wives who are having fertility issues. It also measures how women think husbands feel about their wives as a result of their fertility challenges including, whether they feel that their wives are somehow responsible for their infertility situation. Internal consistency reliability was also used to determine the reliability of the instrument and a Cronbach alpha of 0.94 was also obtained. It also has a norm of 52.7. It was correlated with Marital Stress Inventory (MSI) by Omoluabi (1994) and a score of $r = 0.40$ obtained at .01 level of significance. Scores higher than the norm indicate that a woman with fertility challenge does not feel her husband is supportive.

Enugu Somatisation Scale (ESS) is an indigenous psychometric scale designed by Ebigbo (1981, 2013), which measures somatic complaints among Nigerians. It is a 65item questionnaire that is divided into two parts, namely; the head and body sections. Somatic complaints on the head section measures goal frustration while somatic complaints on the body section measures anxiety and depression. This instrument was standardized with 179, psychiatric patients and 349 normal students of the Institute of Management and Technology (IMT) Enugu (Ebigbo, 2013). The norms are the mean scores for the normal and abnormal samples. For normal males, the norms for the head and body sections are as follows; 3.58 and 7.22, while for the females, the norms for the head and body sections are; 4.12 and 7.73.

Research Procedure

The researcher met with some doctors and nurses at the gynaecology department of the respective hospitals, to explain to them the relevance of the research, so that they would be

cooperative during the data collection. Afterwards the researcher met with the participants of the study and explained to them, the relevance of the research. Those who agreed to participate in the research were given a consent form to feel, to ensure that they willingly participated in the research. In addition to this, they were assured of their confidentiality by telling them that their names are not necessarily needed on the questionnaire other than their sincere responses. They were also told that if at any point they wish to withdraw from the research, they were willing to do so.

To further maintain their confidentiality, numbers were used to code the questionnaires, instead of their names.

Ethical Consideration

In order to carry out this study effectively, ethical permission was obtained from ethical committee of Enugu State University Teaching Hospital, Parklane and Police General Hospital Amakohia. Informed consent form was administered to the clients prior to the study, in order to obtain their consent.

Design and Statistics

The design employed in this study is cross sectional survey design. The reason for adopting this research design is due to the fact that comparisons are made on the same subjects. It is the type of design that is employed when a researcher wants to describe the characteristics that exist among a group of people, but not necessarily to determine cause and effect relationships. Hence, it does not involve manipulation of variables. This type of survey design is often used to make inferences about possible relationships or gather data to support further research (Lavrakas, 20 08). Furthermore, it allows a researcher to look at the numerous and prevailing characteristics in a given population as well as to consider the correlations that may exist at a particular point.

The statistics used for this study is binary logistic regression which is an extension of simple linear regression. This is a statistical technique used to predict the relationship between predictors and a predicted variable where the dependent variable is binary (Tolles & Meurer, 2016)

A binary logistic regression analysis was employed to predict the probability that a participant would develop somatic complaints as a result of perceived womanhood and spousal support.

Result

Table 1: Summary of Descriptive Statistics for the Predictor variables (perceived womanhood, spousal support)

Continuous Variable	Mean	Standard Deviation	Min.	Max.
Perceived Womanhood	45.46	7.15	30	58
Spousal Support	44.43	7.48	30	59

As seen in Table 1, the scores on perceived womanhood ranged from 30 to 58 (M = 45.46, SD = 7.15). On the other hand, it is shown that spousal support scores ranged from 30 to 59 (M = 44.43, SD = 7.48). The results of the binary logistic regression analyses are presented in Table 2.

Table 2: Logistic Regression Analyses for spousal support and Perceived Womanhood on Somatisation

	B	**Std Error**	**Wald Statistic**	**Df**	**Sig**	**Od ds Ratio Exp(B)**	**95% Confidence Interval for Exp(B)**	
							Lower	**Upper**
Perceived Womanhood	-120	.038	9.968	1	.002*	.887	.824	.956
Spousal Support	.096	.037	6.900	1	.009*	1.101	1.025	1.182

*Note: N = 124, **p < .001, **p < .01, $^{N.S.}$ = Not Significant*

The table shows results of logistic regression analysis to investigate the influence of spousal support and perceived womanhood in somatic complaints among women with infertility. The predictor variable which is spousal support has a significant influence on somatic complaints among women with fertility challenge at p<01 level of significance. It is also indicated in the table that the odds for reporting somatic complaints are 1.10 higher for participants with high spousal support score.

The table above shows that there is negative correlation between perceived womanhood and somatic complaints among married women with fertility challenge at P< .01 level of significance. Based on this outcome, the second alternate hypothesis which states that there would be a significant relationship between perceived womanhood and somatic complaints among married women with fertility challenge is also accepted. The table also shows that the odds for somatic complaints are .83 lower for participants who have higher perceived womanhood scores than those with lower perceived womanhood scores. This indicates that the higher score a woman with fertility challenge obtains from Igbo perceived womanhood questionnaire, the less report for somatic complaints and vice versa.

Discussion

Spousal support was found to have a positive correlation with somatisation among Igbo women with fertility challenge. In the opinion of the researcher, it is not surprising therefore that women with fertility challenges in our culture, who lack spousal support somatise a lot. The reason is not far from the fact that when it comes to the issue of infertility in our culture, women are seen as the culprits and this invariably makes the man to develop a sense of apathy towards her, because he feels that he is not responsible for it. As a result of this, some men tend to withdraw love and support from their wives, which in turn make their wives to feel lonely and greatly distressed about their fertility situation. Fear of Displacement or divorce could equally contribute to somatic complaints among infertile women. In a society that places high value of children, it is not uncommon to see men whose wives are suffering from infertility, divorce their wives or even go for a second wife, even in a Christian dominated society like the Igbo society. This practice makes a woman with infertility challenge to feel unease and uncomfortable because "onweghi oche" meaning that she doesn't have a "seat" in her marital home. Furthermore, the lack of spousal support makes the burden of finding solution to infertility challenge an excruciating one as the woman in question does not have the financial and emotional support of the significant person in her life, which is her husband.

High correlation between spousal support and somatic complaints among women with fertility challenge is also attributable to fear. This could be fear of rejection and abandonment. When a woman with infertility feels that she would be rejected by her husband or in-laws in our Igbo society, she feels greatly distressed because it is believed and usually said in local Igbo Parlance that "Ugwu nwanyi bu di ya" meaning that the pride of a woman is her husband. If she senses that she would lose her marriage or husband as a result of her infertility situation, she is likely to somatise a lot.

The second variable in this study, which is perceived womanhood, has a negative correlation with somatisation among Igbo women with fertility challenge. This outcome shows that high score on the perceived womanhood index indicates low somatic complaints. This supports the study on Japanese women with infertility by Akizuki and Kai (2008) where negative social perception were reported by women with fertility challenge, but no psychological distress was reported. The negative relationship between perceived womanhood and somatic complaints among married women with fertility challenge could be as a result of Enlightenment. Currently people are becoming more aware of different forms of assisted reproductive techniques, ranging from In vitro Fertilisation (IVF) to Natural Procreative Technology (Naprotech). Some couples with this kind of challenge, tend to be more open to adoption, so long they can afford it, unlike among ignorant people where adoption is still seen as a taboo.

More so, some women with fertility challenge, seem to adopt an indigenous kind of cognition of refusing to accept their infertile condition. This cognition is described by the Meseron therapy of cognitive behavioural theory as the "I refuse" thinking pattern. According to Awaritefe and Ofovwe (2007), "Meseron therapy is a psychological treatment approach of African origin that consists of a direct and holistic counter-attack on undesirable conditions. It derives from an African custom of rejecting the negative while accepting the positive circumstances of life". As such, it is not unusual to hear women with fertility challenge use certain terms like, "infertility is not my portion, I refuse to be barren or it is well" even when they know that all is not well.

Implication of the study

The high correlation between poor spousal support and somatisation among married Igbo women with fertility challenge, illustrates that in a male dominated Igbo society, most men do not show or give their wives who are having fertility challenge the necessary support needed to cope with their infertility challenges. This implies that there may be need for men to be more empathic and see the infertility situation of their wives as part of their problem, as doing so can go a long way to reduce the distress that married women with fertility challenge face.

The study has brought to limelight, some of the factors that contribute to somatic complaints among married Igbo women with fertility challenge. It which shows that there is no significant relationship between perceived womanhood and somatisation among married subfertile women, which implies that women with fertility challenge are learning to rise above dwelling on irrelevant issues from non-family members and even family members, that could worsen their infertility situation and instead are trying to focus on solutions to their problems, which is very commendable.

More so, knowing the extent of somatic complaints that women battling with infertility face will enable psychologists, to understand the nature of psychological problems that women battling with infertility are going through, so that they will know how best to assist them to cope with their situation. This study will further help gynaecologists who these women often report to, to understand the reason and nature of the psychological (somatisation) problems that women with infertility present alongside infertility issues, and refer them to relevant professionals that would treat these underlying problems while they are undergoing fertility treatment.

Finally, this study will enable government to develop policies that will subsidize fertility treatment so that poor couples, who ordinarily cannot benefit from fertility treatment due to its high cost, can so. This research will further provide insight to our legislators to develop policies that will protect infertile women, particularly those whose husbands are dead.

Recommendation

Based on the outcome of this research, it is recommended that fertility clinics as well as gynaecology units of teaching hospitals should employ the services of a clinical or counseling psychologist to organize marriage/family therapy for married women who come to seek treatment for their infertility. This will in addition to the medical treatment that they go to seek in hospitals enable their spouses and relatives to understand what they are actually going through as a result of their challenge with conception.

It is also recommended that couples who are having fertility challenge should also meet a clinical psychologist or a marriage counselor while undergoing fertility treatment, to enable them deal with the psychological implication of infertility as a couple. This will not only help them to be empathic of each other but will also help to strengthen their marriage.

Finally, the researcher recommends that government should subsidize the high cost of fertility treatment so that poor couples who are experiencing infertility can also benefit from the treatment.

Conclusion

This study shows the roles spousal support and perceived womanhood collectively play in somatisation among married women with fertility challenge. Although there has been some studies on the role of some of the variables in determining psychological problems among women with fertility challenge, none at least to the knowledge of the researcher has been able to look at the roles the above mentioned variables collectively play in determining somatisation among women with fertility challenge in South east region of Nigeria.

This study also suggested strategies which if implemented could help to improve the psychological problems that women with infertility face within themselves, in their respective families and the society at large.

References

Adebayo, O., & Oluwaseyi, A. (2018): Labour Pain Perception Experiences of Nigerian Mothers. *Pan African Medical Journal*, *30*, 288. doi:10.11604/30.288.16672.

Adejumo, A.O., & Bukola, A. (2017). Patterns of Spiritual Help Seeking Behaviour among Women with Secondary infertility in Ibadan Nigeria. *Journal of Psychology and Behavioural Sciences, 5*(2), 2374-2399. Doi: 1015640/jpbs.

Ademola, A. (1982). Changes in the patterns of marriage and divorce in a Yoruba town. *Rural Africana, 14*, 16.

Assessed in the strange situation and at home, Hillsdale, N.J.: Lawrence Erlbaum.

Akizuki, Y., & Kai, I., (2008). Infertile Japanese Women's Perception of positive and negative interactions within their social networks. *Human Reproduction*; *23*(12), 2737-2743.

American Psychiatric Association. DSM-IV: *Diagnostic and statistical manual of mental disorders*. American Psychiatric Association, Washington DC. 1994.

Anvar, M., Mohammed, M.D., Meshkibaf, H., & Kokaba, R. (2006). Study of Psychiatric Disturbance in Infertile Women. *International Journal of Reproductive BioMedicine*, *4*(2), 73-75.

Audu, D.T., Ojua, T.A., Edem, C., & Aernyi, R.T., (2013). Infertility and Gender Difference in Reaction among Couple and Family and Community Treatment: a Study of Patients attending N.K.S.T Hospital Mkar in Benue State, Nigeria. *European Scientific Journal, 9*(32), 1857-7881.

Awaritefe, A., & Ofovwe, C.E., (2007). Meseron Therapy: An African Approach to Psychological Treatment. *IFE PsychologIA*, *15*(2), 71-81.

Brennan, D., Peterson, N., Newton, C.R., Rosen, K.H., & Schulman, R.S. (2006). Coping Processes of Couples Experiencing Infertility. *Family Relations, 55*, 277-239.

Cohen, S, & Wills, T.A (1985). Stress, social support, and the buffering hypothesis. *Psychological bulletin, 98*(2), 310.

Cohen, R.D., Kauhanen, J., Kaplan, G.A., & Salonen, J.T. (1994). Alexithymia may Influence the Diagnosis of Coronary Heart Disease. *Psychosomatic Medicine. 56*(3), 237-244.

Cohen, S, Underwood, L. G., & Gottlieb, B. (2000). *Social support measurement and intervention: A guide for Health and social Scientists*. New York: Oxford University Press.

Delongis, A. & Holtzman, S. (2005). Coping in Context: The Role of Stress, Social Support and Personality in Coping. *Journal of Personality, 73*, 1633-1656 doiw.1111/1487-8494.2005.00361.x.

Ebenuwa-Okoh, & Edu, E., (2015). Relationship between Spousal Support and Marital Satisfaction among married Female workers in Consolidated Banks in Warri Metropolis. *Journal of Emerging Trends in Educational Research and Policy Studies, 6*(6), 423-438.

Ebigbo, P. O. (1982). Development of a culture-specific screening scale. *Culture, Medicine and Psychiatry, 6*, 29–43.

Ebigbo, P. O. (1986). The mind, the body and society: An African perspective. Advances: *Journal of the Institute for the Advancement of Health, 4*, 45–57.

Ebigbo, P. O. (1995). Harmony restoration therapy: An African contribution to psychotherapy. *Paper presented at the annual meeting of the Royal College of Psychiatrists,* Riviera Centre Torquay, UK.

Ebigbo, P. O. (1996). Somatic complaints of Nigerians. *Journal of Psychology in Africa*, *1*, 28–49.

Ebigbo, P. O., & Anyaegbuna, B. (1989). *The problem of student involvement in the mermaid cult: A variety of belief in reincarnation (Ogba-Nje) in Nigerian secondary school.* In Karl Peltzer.

Ebigbo, P.O., (1988) (Eds.) *Clinical Psychology in Africa* pg. 425–434. Enugu, Nigeria: Chuka.

Ebigbo, P. O., Elekwachi, C. L., Eze, J. E., Nweze, F. C., & Innocent, U. C. (2013). Development of harmony restoration measurement scale. Paper presented at the Annual Benchmark Conference of Psychology (A.B.C.) *Ife Psychologia*, Ile-Ife, Nigeria.

Ebigbo, P. O., & Ihezue, U. H. (1981). "Ogbe-Nje" phenomenon and its meaning for

psychotherapy in Nigeria. *Psychosomatische Medizin und Psychoanalyse, 27*, 84–91.

Ebigbo, P. O., & Ihezue, U. H. (1981). Some psychodynamic observations on the symptom of heat in the head. *African Journal of Psychiatry, 7*, 25–30.

Ebigbo, P.O., Janakiramaiah, N., & Kumaraswamy, N. (1989). Somatization in cross-cultural perspective. In K. Peltzer, & P. O. Ebigbo (Eds.) *Clinical Psychology in Africa* pg. 233–250. Enugu, Nigeria: Working Group for African Psychology.

Eram, U. (2017). Knowledge, Attitude and Myths on Infertility: A Review Article. *International Journal of Research and Management*. *4*(2)

Erica, F., Fromm, K., Ronald, F., & Shor. (2009). *Hypnosis*: developments in Research and new perspectives.

Erigbali, P., Sule, J.O., & Eruom, L., (2008). Prevalence of Infertility in Women in Southwestern Nigerian Community. *African Journal of Biomedical Research, 11*(2), 225-227.

Gannon, K., Glover, L., & Able P. (2004). *Social Science Medicine, 59*(6), 1169-75.

Greil, A.L., Slauson-Blevins, K., McQuillan, J., (2010). The experience of Infertility: A review of Recent Literature. *Sociol Health Ill. 32*(1), 140-62. Doi:10.1111/l.1467-9566.2009.01213.x.

Holmes, J. (1993). John Bowlby & Attachment Theory. Makers of modern psychotherapy. London: Routledge. p. 69. ISBN 978-0-415-07729-3.

Hudson, W. W. (1982). Index of family relations. *The clinical measurement package: a field manual*. Chicago: Dorsey Press.

Innocent, U. & Onwe, N. (2015). The plight of Infertile Women in Nigeria. *Journal of Policy and Development Studies, 9*(3), 40-47.

Kroenke, K., Spitzer, R.L., Hahn, S.R., Linzer. M., Williams, J.B., & Brody. D., (1997). Multi somatoform disorder: An alternative to undifferentiated somatoform disorder for the somatizing patient in primary care. *Archives of General Psychiatry, 54*(4), 352-8.

Lavrakas, P.J., (2008). In: Encyclopedia of Survey Research Methods. Doi: https://dx.doi.org/10.4135/9781412963947.n120

Maj M. (2005). Psychiatric comorbidity: An Artifact of current diagnostic systems. *British Journal Psychiatry, 186* (3), 182-4.

Malhotra, S., Singh, S., & Mohan, A. (2005). Somatoform and dissociative disorders in children and adolescents: A comparative study. *Journal of Behaviour Medicine, 36*(5), 454–465. doi: 10.1007/s10865-012-9440-2 PMCID: PMC3726557

Nduanya, U.C. (2018). *Predominantly Somatic Symptoms: Pattern and Correlates among non-psychotics general outpatients of a tertiary hospital in Nigeria.* (unpublished research work).

Nwokocha, A.R.C., Chinawa, J.M., Onukwuli, V., Ubesie, A., Ndukuba, A., Chinawa, A.T., Arfiwada, E., & Uwaezuoke, S. (2017). Somatisation Disorders among Adolescents in the Southeast Nigerua. A neglected Issue. *International Journal of Mental Health, 11*, 57. Doi:10.1186/s/3033-017-0161-3.

Obimakhinde, A.M., Ladipo, M.M., & Irabor, A.E. (2015). Familial and Socioeconomic Correlates of Somatisation Disorder. *African Journal of Primary Health Care and Family Medicine,* 7(1), 746-. Doi:10.4102/phc/m.v7i/746.

Okafor, C.J., Owoidoho, U. & Ekpe, E.E. (2017). Preliminary Study of Somatic Complaints as Psychiatric Symptoms based on cluster Analysis of symptoms in Modified Enugu Somatisation Scale. *British Journal of Medicine & Medical research, 20*(11), 1-4

Okonofua, F.E., (2003). Infertility in Sub-Saharan Africa. In: Okonofua, F.E., Odunsi, O.A., editors. Contemporary Obstetrics and Gynaecology for Developing Countries. Benin City: *Women's Health Action Research Center*; 128-25.

Omoluabi, P.F. (1994). *Adapted manual for MSI.* Lagos: PPC Consultant Nigeria.

Prince, R. (1960). The "brain fag" syndrome in Nigerian students. *British Journal of Psychiatry, 106,* 559–570.

Prince, R. (1962). Functional symptoms associated with study in Nigerian students. *West African Medical Journal, 11,* 198–206.

Prince, R. (1989). The brain fag syndrome. In K. Peltzer, & P. O. Ebigbo (Eds.) *Clinical psychology in Africa;* 276–296. Enugu, Nigeria: Working Group for African Psychology.

Smith, G.R., Monson, R.A., & Ray, D.C. (1986). Patients with multiple unexplained symptoms. Their characteristics, functional health, and health care utilization. *Archives of Internal Medicine, 146,* 6972.

Spitzer, R. L., Williams, J. B., Kroenke, K., Linzer, M., Verloin deGruy, F, & Hahn, S.R., (1994). Utility of a new procedure for diagnosing mental disorders in primary care: the PRIME-MD 1000 study. *Journal of American Medical Association, 272*(22), 1749-56.

Tabong, P.T. & Adongo, P.B. (2013). Understanding the social meaning of infertility and childbearing: a qualitative study of the perception of childbearing and childlessness in Northern Ghana. *PLoS One*. 2013;8(1):e54429 . doi: 10.1371/journal.pone.0054429. Epub 2013 Jan 16.

Tolles, J., & Meurer, W. (2016). Logistic Regression Relating Patient Characteristics to Outcomes. *Journal of the American Medical Association.* 316(5). 533-4. Doi: 10.1001/jama.2016.7653. ISSN 0098-7484.OCLC6823603312. PMID 27483067.

Tolulope, M.O. (2017). The Socio-Cultural Perception and Implication of Childlessness among Men and Women in an Urban Area, Southwestern. Journal of Social Science. *21*(3), 205-209. https://doi.org/10.1080/09718923.2009.11892772.

Upkong, E.O., & Orji, A., (2006). Mental Health of Infertile Women in Nigeria. *Turkish Journal of Psychiatry, 17*(4).

Van-Balen, F., & Bos, H.M., (2009). The Social and Cultural Consequences of being Childless in Poor-resource Areas. *Facts, Views and Vision in ObGyn, 1*(2), 106-121. PMCID: PMC4251270. PMID: 25478076

Van-Balen, F., & Trimboskemper, T.C. (1993). Long Term Infertile couples: A study on their wellbeing. *Journal of Psychosomatic Obstetrics and Gynaecology. 14*,53-60.

Woolfolk, R. L., & Allen, L.A. (2006). Treating Somatization: the Concept and its Clinical Application. *American Journal of Psychiatry. 145*(11), 1358–68. doi:10.1176/ajp.145.11.1358. PMID 3056044.

World Health Organisation. (1993). *International classification of mental and behavioural disorders: diagnostic criteria for research, ICD-10.* World Health Organization; 1993.