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Ovarian Stimulation, Body Image and Suffering: A Case Study of a Cameroonian Woman Facing the Assisted Reproductive Technology

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Abstract

Ovarian stimulation, a hormonal treatment technique aimed at collecting several oocytes from women for artificial insemination or *in vitro* fertilization, has not sufficiently interested researchers in the human and social sciences, particularly psychopathologists and clinicians. However, this technique, carried out in a prolonged way, induces psychological suffering in some women because of the considerable weight gain. Excess weight is not culturally allowed in women of certain African ethnic groups in the case of infertility. The aim of this article is to show that excess weight caused by hormonal treatment during medically assisted reproduction provokes an anxiety-depression syndrome which is explained on the one hand, by the non-acceptance of one's body image and on the other hand, by the secrecy of the ART in the infertile African woman. The data of this study were collected from the Hospital Anxiety and Depression scale and from the semi-directive interview; from 4 women aged between 30 and 37 years. The inclusion criteria set up were in favor of those who, after having received hormonal treatment (injections or tablets), had gained considerable weight and complained about their physiology. The content analysis technique in its formal variant led to the conclusion that anxiety-depressive disorders are observed in some obese African women following hormonal treatments in ART. These disorders are explained on the one hand by the self-depreciation reactivated by their infertility and on the other hand by the heavy secrecy to be carried towards their close relations and families on the subject of the ART. Hence the need for psychological follow-up in the various fertility centers concerned.

Keywords

Anxiety-Depression Syndrome, ART, Body Image, Ovarian Stimulation

1. Introduction

Stopped during the natural conception of a child, some candidates to parenthood are sometimes obliged to resort to a medical assistance to procreation. Several techniques are available to them, including ovarian stimulation. This method consists, in women, in facilitating the recovery of several oocytes during a single IVF cycle (Farquhar et al., 2017; Cedrin-Durnerin et al., 2012; Emperaire, 2013; Shapiro & Anderson, 2015) especially since it requires taking into account ovarian aging since fertility decreases by 50% at age 37 (Emperaire, 2013). During this stimulation treatment, hormones are administered to them through daily injections or tablets to induce ovulation in those with anovulation or in women ovulating normally in order to obtain several follicles for intrauterine insemination or *in vitro* fertilization. However, each ovulatory stimulation carries its own risks (Emperaire, 2013), especially since ovarian stimulation depends on both the type of treatment and the dose used.

Similarly, alluding to the discomfort that these hormonal treatments cause in some women; Revelli, Salvagno, Cesano and Piane (2011) explain that it would be safer to use the lowest possible dose of hormones, especially in case of repeated IVF attempts although gonadotropin treatment is not considered oncogenic, or capable of significantly affecting the patient's risk of serious illness. Excess weight would thus be associated with an extension of the duration of stimulation (Hugues, 2008), probably due to an initial hormonal dose unsuited to the weight of the patient. According to this author, the total dose of gonadotropins necessary to obtain follicular development is dependent on the body mass index (BMI). Obesity would be at this level caused by the modification of the menstrual cycle. Some women can therefore register manifestations such as rashes, pain in the lower abdomen, weight gain and many other effects following repeated ovarian stimulation; leading to a poor perception of their body image.

Traditionally speaking, in case of the female infertility, excess weight is not tolerated. This is how the victim is called to submit to certain purification rites in order to drive out the demon that is fattening her to block the conception of a child. In addition, she must consume potions to cleanse her body and uterus. However, in the present case, the victim knows full well what is at the origin of his weight gain but cannot declare anything to his relatives and family.

As medically assisted procreation is still taboo in African customs (Nguekeu, Nguimfack, & Tsala, 2022), ovarian stimulation is in this case kept secret by the woman. She will be victim not only of the stigma linked to her infertility and the shame of social gaze because of her body mass, but also of the inability to justify this abrupt change imposed by hormonal development.

Although obesity affects the success of ART treatment, Brewer & Balen (2010); said treatment may also be the cause of the increase in weight. Faced with this sudden and unpleasant change in body image; that is, the way our body appears to us to ourselves (Schilder, 2017); and the difficulty of explaining it to her relatives, family and in-laws, since she must keep the practice of assisted re-

production secret, the infertile woman who undergoes ovarian stimulation is subject to psychological suffering. This mental difficulty highlights a clinical picture that highlights anxiety-depressive disorders such as frustration, sadness, the feeling of loss of self-esteem in connection with socio-cultural constraints.

Researchers (Macklon, Stouffer, Giudice, & Fauser, 2006; Kyrou, Kolibianakis, Venetis, Papanikoulaou, Bontis, & Tarlatzis, 2009; Vaiarelli, Cimadomo, Trabucco et al., 2018) have highlighted the advantages and disadvantages of ovarian stimulation in the woman during the ART process but have not sufficiently taken into account the suffering that weight gain could induce in the infertile woman vis-à-vis her partner (who finds her overweight and unpleasant); of her family and in-laws (who rebel against her for not having children and are unaware of the cause of her unusual weight) and of herself (prone to self-deprecation, self-deprecation and failure of loyalty to all).

1.1. Excess Weight, Infertility and Psychological Suffering

Overweight encourages the victim to go to war with his own body, his physiology. This battle that is born becomes heavy in his consciousness and leads to an obstacle in the harmonious evolution with this same consciousness. We will therefore note the difficulty in accepting one's body, the changes in daily habits (food and clothing), marked by feelings of sadness, lack of self-knowledge, frustration and above all the need to feel loved as before. All these negative emotions have an influence on the couple relationship; even if the partners are aware of the origin of the problem which is accentuated by the fertility treatment.

It should be mentioned that in the present case, the pain of being overweight is all the more increased in the victim when it is associated with that of his infertility. Not only does she feel diminished in the eyes of others because of her inability to give birth, but also the treatment inflicted on her increases her suffering. She faces a double mourning; namely that of her body image and the absence of a baby. The body transformed by this constraint is painfully experienced and felt. Physical and/or psychological pain thus reactivates many questions directed towards one's partner. She will feel diminished, devalued; powerless in the face of the setbacks of her spouse who fights body and soul to give himself value within his community; by indulging either in polygamy, infidelity or in the worst case, divorce for the benefit of the one who will give him the desired child (Nguekeu, Mbangmou et al., 2022).

Faced with self-devaluation and lack of self-confidence, the woman, very anxious, will adopt a "police" posture to carry out investigations into the various movements of her spouse. The attitude of doubt will come to the fore and he will be suspected of being unfaithful. His jealousy will be rekindled by an unfounded fear of losing his companion; this is how she will be overwhelmed by a feeling of dread, especially if her spouse has had a child from a previous relationship.

The experience of the unwanted change in body image will be all the more difficult if the woman cannot confide in her loved ones about the PMA. Not

being able to confide, due to a withdrawal into oneself, will also lead to psychopathological disorders such as paranoia: she will feel constantly under threat and persecuted by strangers or even her relatives. This is how she will be able to interpret the words, gestures and behavior of people in an erroneous way; because she says: everyone makes fun of me because I don't give birth and I'm very fat.

Nevertheless, this excessive weight gain will remain secret, especially since it is not common in Cameroon to declare its follow-up in PMA. This is also a taunt mobile; camouflaged by the idea of a child made in the hospital; and who says born of PMA, implies "abnormal child". The secret thus maintained with his companion will not be easy to bear, especially since he is enlisted with guilt, remorse and perpetual questioning. These will focus on his youthful behavior, among other things: dating, taking contraceptive pills, abortions, mystical-religious persecutions; in short, anything that could be the cause of her infertility. This will reflect his failure of loyalty to his couple, his family, in-laws and his entire community (Nguimfack, Newson, & Nguekeu, 2016).

This article highlights the anxiety-depressive behavior observed in African women who, due to the ovarian stimulation imposed by the treatment of infertility, are overweight; what induces in her a psychic suffering in connection with her culture of belonging.

1.2. Excess Weight, Infertility and Interpsychic Conflict

Being overweight was considered a sign of wealth, well-being and comfort among the African population until very recently; the beauty of the African woman was measured by her curves (Puoane, Fourie, Shapiro, Rosling, Tshaka et al., 2005). African women, the stronger ones seemed to be culturally more acceptable because they represented a symbol of health, sexual dignity, attractiveness and even increased functional capacity than the thin woman (Renzaho, 2004; Venter et al., 2009). Culture thus, affecting body image and perceptions of body size from an early age and in many African countries.

Gradually, the nutritional patterns of the African population have jointly changed with the adoption of the Western way of life (Venter, Walsh, Slabber, & Bester, 2009) where the slender woman is the most appreciated since she is refined. Most modern African women tend to copy this Western model, which they believe contributes to well-being; delays aging; therefore being overweight becomes synonymous with negligence, poor diet; non-support of the body.

In Africa, although curves were once appreciated in women, the popular imagination has always emphasized that it is not normal for an infertile woman to be overweight; not only is this not socially accepted but it creates a kind of stigma in her. She is considered to be the cause of her infertility because fat in the body is said to prevent conception. She is accused of having filled her uterus with bad fat, which not only prevents male penetration but also fertilization.

It should also be noted that cultural factors will thus have a great influence on

the overweight infertile woman insofar as the way one perceives one's body also depends on the culture (Thompson, van den Berg, Roehrig, Guarda, & Heinberg, 2004).

1.3. Excess Weight, Infertility and African Culture

Cultural factors have a very great impact on the ideal that each individual would like to achieve. Speaking of culture, psychoanalysts have noted that the individual psyche is based and organized on it and that any small group has a psychic apparatus. This joins the reflection of Kaës (1993) when he describes the psychic organizers of restricted groups in relation to their socio-cultural organizers; to show that culture is a container within which not only the individual psyche can be built, but also that of the restricted group. It is also necessary to recognize that at the base of any group, there is the culture which provides the models of regrouping which serve as organizers of this one throughout its operation (Arpin, 2006).

The cultural frameworks of the individual, the restricted group and the family (Aulagnier, 1975), have their origins in the set of statements defining the reality of the world, which is the raison d'être of the cultural group and even the origin of its models.

In Africa, although weight gain is considered to be a modality of wealth and plumpness, this is not totally accepted in the infertile woman who will rather be taxed as a witch who has eaten all her children in the womb or even, who gives birth to his totem in the bush. All of this causes personal grief; frustration; anguish; marital stress and many others; thus leading the woman into a withdrawal and a loss of self-esteem since no one supports her in her distress. In this case, secrecy is maintained vis-à-vis the PMA not only because the practice is still taboo, but also because the victim suspects an evil hand that could hinder its success. It thus avoids the failure that occurred in the case of natural conception. In case of infertility in Africa; most of the time, the accusations are multi-oriented; on the one hand, it is the victim who blames the entourage, feeling persecuted and on the other hand, his people make him feel guilty.

This is how witchcraft connotes the anxiety of destruction of the total person and the coherent set of defenses allowing after the fact to fix this anxiety on a specific object (Sow, 1978). In Africa, witchcraft is a social moral problem that reflects a conflict between the witch and the bewitched; but said conflict will only be examined by a traditional practitioner since the bewitched person does not know the sorcerer, his executioner; the latter has no distinctive sign that could differentiate him from a non-witch. For this, each member of the community, each man, each woman and each child potentially possesses the power of sorcery since he is capable, because of hatred or even jealousy, to feel for others the feelings of destruction of the other. This is what justifies the relentlessness of the infertile woman towards her relatives; and by extension the secrecy in his practice of PMA.

Moreover, it should be noted that some women, although seeking pregnancy

through assisted reproduction (and all the related constraints) to make up for their lack of children, are also concerned about their body image for various reasons; which induces most of the time psychological disturbances (anxio-depressive behaviors) observed in the latter.

2. Method

The data in this article were collected during the doctoral research course in a fertility clinic in the city of Douala, Cameroon. The data were collected during the sessions of ovarian stimulation injections by the women, with the aim of eliciting the harvest of several oocytes for the treatment of their childlessness.

This research is qualitative in nature and respects the principles of clinical psychology. The choice of case studies is made on purpose; moreover, it is the best tool for understanding the functioning of the human being in its uniqueness and totality; this gives us the opportunity to understand each of our participants in depth.

2.1. Participants

The interviews were conducted with 4 infertile women whose ages ranged from 30 to 37. They had undergone several ovarian stimulations for IVF for some and ICSI for others. Ladies A, C and F are on their second attempt at ART and Mrs. H on her third attempt. All of them complain that the repetitive injections have contributed to a considerable increase in their weight, apart from discomfort and skin rashes. It should be pointed out that we have no evidence to prove the change in weight from before hormone treatment. Only their testimonies and complaints were taken into account during the interview.

We used some criteria while selecting the participants of this research. These are the inclusion and exclusion criteria.

2.1.1. Inclusion Criteria

During this research, we considered the following criteria:

- To be an infertile woman in consultation in the ART service;
- To have undergone hormonal treatment;
- Complains of weight increase after taking hormonal treatment;
- To be in a regular relationship;
- To have given informed consent to participate in the research.

2.1.2. Exclusion Criteria

Any woman who did not meet the above inclusion criteria was excluded from the scope of this research. However, according to the information notice, any participant was free to withdraw from the research at any time.

2.2. Semi-Structured Interviews

The semi-structured interviews were conducted consecutively with the HADS scale. These tools seemed to be effective in understanding the psychological

functioning of these participants. The semi-directive research interview made it possible to explore more or less specific aspects of the participants' psychological functioning in relation to the research objective, which was to understand how excess weight caused by hormonal treatment during ART can provoke an anxiety-depression syndrome in the victim woman. In total, 8 interviews were conducted individually; two per case, with an average duration of 35 minutes each.

2.3. Passing the HAD Scale

Before beginning the interviews, the participants took a few minutes to complete a standardized self-report questionnaire. This was the Hospital Anxiety and Depression Scale (HADs) developed by Zigmond and Snaith (1983). In its current use, this scale is used to diagnose the anxiety-depression syndrome in patients. This scale has 14 items rated from 0 to 3. Seven questions relate to anxiety (total A) and seven others to the depressive dimension (total D), thus making it possible to obtain two scores (maximum score for each score = 21). To detect anxiety and depression symptoms, the interpretation of the instrument can be proposed for each of the scores (A and D): —7 or less: no symptoms—8 to 10: doubtful symptoms—11 and more: definite symptoms.

2.4. Data Analysis

For the data analysis, content analysis in its formal variant was used since it is basically qualitative and takes into account the analysis of expressions, enunciation, co-occurrences and the form of the participant's speech.

3. Results

The results will be presented in **Table 1** and **Table 2** dealing respectively with the expected scores after the HADs scale and the collection of the different semi-directive interviews of the participants.

3.1. Results of the Individual Semi-Directive Interviews of Each Woman

The collection of the semi-directive interview is presented in the form of cognitions, affects and behaviors in order to facilitate the visualization of the data related to the experience of the suffering induced by excess weight after hormonal induction

Table 1. Hospital anxiety depression scale results.

	Anxiety Score (A)	Depression Score (D)	Conclusion
Mrs A	12	10	All those ladies present A symptomatology with an anxiety depressive tendency
Mrs C	14	9	
Mrs F	11	12	
Mrs H	12	12	

in infertile women. Cognitions here imply a set of knowledge, i.e. all the information received by the participant about his or her body image and infertility situation; affects show the affective state, painful or pleasant, vague or qualified, presenting itself as a massive discharge or as a general tone (Laplanche & Pontalis, 1967).

Table 2. Collection of the different semi-directive interviews with the participants.

Anamnestic data of participants	Collections of the semi-structured interview		
	Cognitions	Affects	Behaviours
Mrs A, 30 years old, after 5 years of life without children, returned with her husband for a second attempt at ART, after the failure of the first. She has a problem with her fallopian tubes and has undergone the fertility protocol in order to produce several oocytes for IVF. She is already complaining of considerable weight gain since her first hormone treatment	Usually, Mrs. A's weight does not exceed 65 kg. Since she started taking hormones, she finds herself at 70 kg; which raises questions among his colleagues and relatives who think, for the most part, that his excess weight is linked to eating behavior. "*My colleagues and friends have been asking me for a while why this sudden change in weight when I am not pregnant; some say to themselves that I consume more delicacies*"	-Eating behavior disorder "I am afraid of gaining more pounds when I eat; which makes me lose my appetite in front of my favorite dishes" -The feeling of loss of self-esteem "*I sometimes think that I have lost everything, since I no longer have my good front line and I no longer have children*" *-The feeling of being useless "we no longer go to nightclubs to dance as before, I feel like I am no longer of much use to my husband; I don't even know if he still loves me.*"	-The practice of purges "*I did the purges to lose weight but I had the impression that it didn't work because you had to take foods that promote conception like avocados at the same time.*" -Taking parsley "*I was asked to drink parsley but taking it regularly made me dizzy.*" -The practice of sports exercises; "*I used to play sports but over time I got discouraged*"; -The restriction of contact with the in-laws "*I prefer not to have contact with my in-laws since they do not find it normal that I gain weight when I cannot conceive*"
Mrs. C. is 35 years old. After 7 years of life as a couple without children, they undertook PMA. They are currently on their second attempt having failed in the first. Mrs. C is concerned, after all the hassles associated with this procedure, with her constantly changing body image. She complains of weight gain linked to fertility hormones. This situation seems rather devalued to her in-laws who do not understand the reasons for this sudden change when there is no pregnancy. She nevertheless agreed to speak with us.	Mrs. C must above all keep secret the reason for her weight gain since the practice of PMA is still taboo in her social environment. "*It's very hard to bear the mockery coming from the in-laws who believe that I eat money, I get fat without being able to give their son a child. If only they could imagine what was happening. The secret is kept between their son and me. I carry the heavy burden. They must not know what is going on. Our entire wish is that this ends in a good result.*"	-The feeling of guilt "*Sometimes I wonder if I didn't make the wrong choice, maybe if I were married to another man, everything would be different; I won't be going through all this.*" -The feeling of being too ugly "*I no longer see myself as sexy in my outfits; which irritates me every time I have to go shopping, since I have to increase the size of my clothes and suddenly I look like a ball*" -The fear of abandonment by her spouse "*my husband used to appreciate my small body and my style; but since we have been following this treatment, he no longer says anything about the change and I ask myself questions*"	-The practice of weight-loss diet; "*When I research how to lose weight, we recommend eating healthy, however certain foods that promote conception are also fattening, a bit like eggs and dairy products*" -Modification of clothes "*I am always changing the measurements of my clothes which no longer fit on me*" -Complete cessation of sugary products "*I no longer consume sweet products since the weight gain started*" -Limit at the output level "*I prefer not to be with friends since I don't feel comfortable with my new physique*"

Continued

Mrs F is 33 years old, having lived together for 8 years without children, her husband and she adopted the ART which ended in failure. They came back for their second try but the woman languishes in a strong feeling of worthlessness because of her weight load which worries her family and her in-laws but she cannot reveal the secret of the ART	Mrs F has had to refuse visitors for quite a while since her unusual weight no longer allows her to do the usual exercises "*I don't want people to visit me anymore since I will have to cook for them and give them time to discuss current affairs, my weight tires me out and I spend most of my time on weekends in bed, I no longer work as before, in short I mean, I sleep more*"	-Low self-esteem; "*taking hormones makes me gain weight but I can't tell people, It disturbs me a lot when people ask me questions*". -*Feeling of displeasing people*, "*I suffer enormously because I no longer feel like myself, I have the impression that I disgust people*" -Anxiety and depression "*I feel tired all the time, I can't take initiatives personally*"	Taking slimming potions but no convincing result "*When I noticed that I was gaining weight I immediately started weight-loss products, but over time I realized that it was a waste of time*" -Withdrawn "*Most of the time I stay in the background so as not to have to give explanations about weight gain or advice on how to lose it*"
Mrs. H. is 37 years old, she has not always been able to give a child to her spouse after 10 years of living together. She is on her third attempt at conception via PMA with repeated failure; unfortunately the hormonal treatment, which influences his weight, increases the level of anxiety already present due to infertility	Mrs. H. felt rather disturbed by her mother-in-law's disappointment; "*my mother-in-law who had equated my weight gain with pregnancy was very disappointed when I let her know that I was not pregnant, I really hurt when I talked to her. She was sure there was something but over time she took the trouble to ask me the question because she couldn't see the belly coming out. My answer disappointed her so much*"	-Dissatisfaction with his appearance; "*I don't feel satisfied with my physical appearance, it's as if everyone is rejecting me*"; -Frequent disruption "*I have to stop eating my favorite foods because of my overweight*" -*Low self-esteem*, "*I sometimes wonder what I'm good for with my husband, I have lost my beauty and I am without a baby, I wonder if he still loves me*" -Feeling of shame; "*I'm ashamed to be with friends*"	-Reduction of meals but overweight due to hormonal pills; "*I eat less than before but the fact that I am always on treatment does not change anything*" No visits to relatives and in-laws; "*People have been asking me for a while now why I'm gaining so much weight, it bothers me so much and prevents me from going to people's homes*" -The regular practice of sports exercises "*I had to stop playing sports because it made me look ridiculous, especially when I was alone, I had this impression that people were talking about me and I was ashamed most of the time*"

3.2. Analysis of the Results of the HADs and the Semi-Structured Interviews

3.2.1. Analysis of HADs Results

At the end of the HADs scale, Mrs. A. obtained a score of 12 on the anxiety pole and 10 on the depression pole; this gives her an average of 11. Mrs. C obtained an average of 11.5; Mrs. F, an average of 11.5; while Mrs. H obtained an average of 12. As prescribed by the authors who designed this scale, an average of between 11 and more refers to a certainty of anxiety-depressive symptoms. Consequently, all these four participants who complained about their overweight are victims of psychological suffering. Mrs. A totals the lowest score, equal to 11; this could be explained by the fact that she is younger not only in age but also having done less time in marriage. The highest score (12) obtained by Mrs. H could be explained by her seniority in this practice. Aged 37, she has not always

been able to give a child to her spouse and is on her third attempt to conceive via PMA without success; unfortunately the hormone treatment, which influences her weight, increases the level of anxiety already present due to infertility in the latter.

3.2.2. Joint Analysis of Semi-Structured Interviews

The joint analysis of the participants' speeches must focus on the cognitive and affective elements and on their behavior.

The cognitive elements, it should be remembered, are responsible for thoughts and psychic elaborations related to the information received on excessive weight gain in an infertile Cameroonian woman. Take the case of Mrs. A, she has gained 5 kg over her usual weight since taking fertility hormones. His indignation rests on the inquisition of his colleagues and friends vis-à-vis his new physiology; worse still, she is not pregnant as some might think; and feels hit by intrusions that she would eat more; she testifies as follows: "My colleagues and friends have been asking me for a while why this sudden change in weight when I am not pregnant; some say to themselves that I consume more delicacies". In this regard Schilder (2017) will say that the image of the human body is the image of our body that we form in our mind; how our own body appears to us. The difficulty presented by Mrs. C is noticeable at the level of the secret which is difficult to keep; she cannot tell anyone who will listen that she is undergoing treatment for the purpose of assisted procreation, since the practice is not yet rooted in Cameroonian customs; she admits it, explaining that "It is very hard to bear the mockery coming from the in-laws who believe that I am eating money, I am gaining weight without being able to give their son a child. If only they could imagine what was happening. The secret is kept between their son and me. I carry the heavy burden. They must not know what is going on. Our entire wish is that this ends in a good result. The eyes are unfortunately fixed on her, her spouse being free from any mockery. It should be noted that in case of couple infertility in Africa, the woman is first incriminated before any suggestion. And this is justified in the words of Sow (1978) when he says that in procreation, the woman holds the greatest responsibility since she is the shelter, the home of the spawning egg. Immersed in her attitude of withdrawal into herself, Mrs. F is obliged to refuse visitors since her unusual weight no longer allows her to do the usual exercises "*I no longer want people to visit me since I will have to cook for them and give them time to discuss current affairs*; *my weight tires me out and I spend most of my time on weekends in bed*; *I no longer work as before*; *in short I mean*; *I don't sleep anymore"*; there is a refusal of self-acceptance, Mrs. F does not assume the commitment she has given herself to submit to the constraints of PMA to save her couple or even behind her refusal to receive visitors is concealed the secret about assisted reproduction therapy. Following what Dolto (1984) underlines about the image of the body, Mrs. F has a difficulty of symbolization; it fails to transform its representations and locks itself in the imagination. As for Mrs. H, she is rather overwhelmed by the failure of loyalty to her

mother-in-law: *"my mother-in-law who had equated my weight gain with pregnancy was very disappointed when I let her know that I was not pregnant*; *I really hurt when I talked to her. She was sure there was something but over time she took the trouble to ask me the question because she couldn't see the belly coming out. My answer disappointed her so much*"; she clearly expresses her pain in the face of the disappointment that the latter experienced.

As for the emotional elements, we note sadness, the feeling of guilt, the feeling of failure of loyalty, the loss of self-esteem, the fear of abandonment by the spouse, anxiety; disappointment among the participants. At Mrs. A, there is anxiety in eating behavior because she says "*I am afraid of gaining more pounds when I eat*; *which makes me lose my appetite in front of my favorite dishes"*; she refrains from eating at the risk of aggravating her weight which is already difficult to accept. The fact of feeling very fat generates in the latter a feeling of loss of self-esteem; its former line fails it; Added to this she has no children and she admits it in these terms: "*I sometimes think that I have lost everything*, *since I no longer have my good front line and I don't I don't have any more children*". She has lost the habit of having fun because her situation of infertility and her body image make her uncomfortable and create in her the feeling of being useless "*we don't go to nightclubs dancing like before*, *I the impression of no longer being of much use to my husband*; *I don't even know if he still loves me.*" Mrs. C rather experiences a feeling of guilt when she does her introspection; she feels responsible and blames herself for having perhaps failed in the choice of partner; one has the impression that this feeling exhausts him and interferes with his daily life; she says: *"Sometimes I wonder if I didn't make the wrong choice*; *maybe if I were married to another man*, *everything would be different*; *I will not be going through all this"*. However, she is conscious and sad to see this change taking place in her physiology and creating dissatisfaction in her; she mentions: *"I no longer see myself as sexy in my outfits*; *which irritates me every time I have to go shopping*, *since I have to increase the size of my clothes and suddenly I look like a ball*". Feeling ugly makes her think about a possible divorce; she is afraid of being abandoned by her partner who no longer admires her as usual: "*my husband used to appreciate my small body and my style*; *but since we have been following this treatment*, *he no longer says anything about the change and I ask myself questions*". In Mrs. F, we rather notice a drop in self-esteem; the truth is hard to tell even when asked "*taking hormones makes me gain weight but I can't tell people*; *it disturbs me enormously when people question me"*; the fact of not wanting to tell people refers to the refusal to assume and value oneself; this is why Mrs. has this feeling of displeasing the people around her because she no longer believes in her own virtues: "*I suffer enormously because I no longer feel myself*; *I feel like I'm disgusting to people."* Consequently, she lives in anxiety and manifests depressive states all the time: "*I feel tired all the time*; *I can't manage to take initiatives personally"*. Like Mrs. C and Mrs. F, dissatisfaction with her appearance is also experienced by Mrs. H; be-

cause she points out: "*I don't feel satisfied with my physical appearance*; *it's as if everyone is rejecting me"*; which explains the fact that she is constantly disturbed and also suffers from an eating disorder "*I am forced to stop eating my favorite foods because of my overweigh*t". In addition to regressing in terms of self-esteem: "*I sometimes wonder what I am good for with my husband*; *I have lost my beauty and I am without a baby*; *I wonder if he still loves me*"; she feels a kind of shame when she thinks of finding herself in the company of her peers; because she says: "*I am ashamed to find myself with friends".*

As far as behavior is concerned, several behaviors were recorded in all these ladies; among others: The practice of purges; the consumption of weight-loss products; the practice of sports exercises; restriction of visits and leisure; changing the style of dress; control of substances to be ingested; whether Mrs. A, C, F or H, each of them declares having taken products to regain her line: "*I carried out the purges to lose weight but I had the impression that it was not working because 'it was necessary at the same time to take food favoring conception such as avocado"* points out Mrs. A; *"I was asked to drink parsley but taking it regularly made me dizzy*"; point of view of Mrs. F: "*When I noticed that I was gaining weight I immediately started weight-loss products*, *but over time I realized that it was a waste of time*"; Mrs. C declares: "*I no longer consume sugary products since the weight gain started*". Similarly, each of them puts into practice sports exercises: "*I used to do sports but over time I got discouraged*"; almost all have restrictions on visits: Mrs. A says: "*I prefer not to have contact with my in-laws since they do not think it normal that I gain weight when I am not conceiving*"; it's the same for Mrs. F: "*I prefer not to be with friends since I don't feel comfortable with my new physique"*; Mrs. H supports the same argument: No visits to relatives and in-laws; "*People have been asking me for a while now why I'm gaining so much weight*; *it bothers me so much and prevents me from going to people's homes".* The clothing aspect was also underlined: "*I am constantly changing the measurements of my clothes which no longer fit on me*".

4. Discussion

The results of this research show, like that of (Hugues, 2008), that practiced repeatedly and without control, ovarian stimulation becomes harmful to body mass; however, weight management often reflects significant suffering associated with the difficulty of cohabiting with a body deemed unacceptable (Saffer, 2015) and this results in sometimes excessive diets or caloric restrictions. In the past, everyone would like to conform to social demands, to please and to feel loved in order to live in harmony with each other. In his theorization, Dolto (1984) already underlined that the unconscious image of the body is first of all a representation of the being in development, which is elaborated in humanizing speech, before being an expression. She takes the example of a crippled child, whose singularity has been expressed, thus indexing his experience to move from one symbolic stage to another to develop healthily, while what is not ex-

pressed can create an impossibility of move from one stage of symbolic development to another.

In this case, the emotional story of an overweight infertile woman due to ovarian stimulation is all the more complex because it cannot be expressed. There is a difficulty of symbolization insofar as the secret is present there. She will find herself confronted with a sort of ambivalence, especially since she wishes at the same time to give a child to society through this assisted reproduction treatment (which imposes a foreign body on her) and at the same time, she cannot bear this new pattern of which she is a victim. Recently, Schilder (2017) said of the body image that it is a three-dimensional image that everyone has of themselves; and which can also be called "body image". This author explains that apart from the sensation that this concept embodies, there is also the imagination; so it refers not only to mental images, but also to the representations we have of ourselves.

The results of this research corroborate with these reflections of Dolto (1984) and Schilder (2017) insofar as the infertile woman confronted with hormonal treatment which impacts her physical appearance is also mentally affected, which generates in her a syndrome anxiety-depression observed through withdrawal, loss of self-esteem and multifaceted frustrations. The cultural constraints in this case are not the least in the anxious experience of the infertile Cameroonian woman struggling with her body image; especially since with Sow (1978), the African should conform to the demands of society. He says: "*the evolution of the African person—personality, from birth to death, represents a continual passage from the cosmic to the social, from nature to culture, from exteriority to interiority, from the informed to the formed, from the 'empty' to the 'full', from the non-recognized to the recognized, from the non-signifier to the signifier, from non-being to being*" (p 116). It is in this that his body image may correspond to the meaning he gives to himself and to the representation he makes of his personality. This self-image in women refers to the fact that "*women, agents of life, are respected as procreators*" (Sow, 1978: p. 118); he thinks that the child who is born, on the one hand, is an insurance for the future, the permanence of the group; and on the other hand, is the living symbol of the links and continuity that exist between men, spirits, the Ancestor and God; it is to this that great importance is attached to birth and the conditions in which it takes place. This explains the reasons for the secrecy maintained around PMA among Africans.

The high scores on the HADs scale can also be explained on the cultural aspect of the experience of these participants by the fact that "*for the African living according to the traditions, progress consists above all in the realization by a given generation, steps that others have taken before her. It is always the present generation that is at the forefront of progress*" (Sow, 1978: p. 117). However, according to this study, no progress was noted in our participants; this is the reason why we note a kind of guilt in their respective speeches such as: "*I sometimes wonder if I had not made the wrong choice, maybe if I were married to another man, everything would be different; I won't be going through any of this,*" says Mrs. C.

5. Conclusion

The results of this study, although they cannot be generalized, reveal that the infertile woman who has undergone repeated ovarian stimulation (in the process of ART), is subject to an anxio-depressive syndrome which is observed through multifaceted suffering. At first glance, she faces stigma related to her infertility situation; Then, she does not accept her new body which already exposes her to physical and psychological discomfort; finally, she is indebted to her couple, her family and her in-laws, by extension her culture of belonging. To remedy possible situations, the fertility centers concerned should have within them mental health professionals who are quick to develop their expertise in order to enable everyone to make efforts to reconcile tradition and modernity in the concern to obtain a psychic balance.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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