Fertility is Not a Disease

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ABSTRACT

In the past two generations medicine's paradigm has shifted from treating or preventing disease to manipulating normal function, especially in the area of human reproduction, suppressing normal fertility to allow sexual "freedom." This unrecognized paternalism has led to serious consequences such as failure to initiate appropriate treatment for a form of infertility as well as relieving adolescents, (and adults) from the burden of mature, responsible sexual decisions. In so doing, medicine has deprived women, and men, of a powerful maturational component of their gender identity and helped perpetuate irresponsibility and impulsive behavior.

MY COLLEAGUE RETURNED from a workshop session on FOH (functional ovarian hyperandrogenism) also known as PCOD (polycystic disease of the ovary) and said "I'm depressed." After hearing the reason for her feelings, I was not sure if depression or anger would have been more appropriate.

At issue was the treatment of a common ailment, FOH or PCOD, which is found among 5-10% of women, especially young women, and often manifests itself by menstrual irregularity as well as by increased body hair, acne and at times, trunkal obesity. For years gynecologists had prescribed oral contraceptives, which suppress the normal pituitary hormones that govern ovulation and substitute oral contraceptives, which are synthetic estrogen and progestin. When the drug is administered in a cyclic fashion, there are bleeding episodes that are not true menses, but the woman thinks all is well because she is having regular periods.

However, within the last decade the true cause for the development of multiple cysts in the ovary and the changes in the pituitary and ovarian hormones that cause it have become better understood. The causes are not always the same, but the most frequent cause is the

syndrome of insulin resistance. When, after appropriate testing, the diagnosis of insulin insensitivity, also called insulin resistance, is made, the treatment is an oral hypoglycemic agent, a drug used to treat diabetes, usually metformin, which not only corrects the insulin resistance but in doing so reduces the chronically high level of the luteinizing hormone (a hormone of the pituitary gland), allowing it to resume its normal cyclicity. As a result the woman begins, or resumes, normal ovulation.

So, why was my colleague depressed? The workshop leader, also an endocrinologist, was well aware of the causes of PCOD but still advocated oral contraceptives as the proper treatment. On questioning, her justification was that if she prescribed metformin, the girl would ovulate and then she might become pregnant! As if teen pregnancy must be avoided at all costs. The doctor was presuming that the girl either would not or could not make choices about sexual behavior! Yet it is known that untreated insulin resistance results in clinical diabetes mellitus 15 to 20 years down the line. Yet, despite knowing this, not only this specialist in gynecologic endocrinology but far too many other American gynecologists still prescribe oral contraceptives for PCOD in young women. How did we reach the point of considering teen pregnancy as more dangerous than a life time of diabetes?

We need to retrace our steps up the slippery ethical slope. For the past 45 years−-two generations−-women have been taught that procreation not only can but should be separated from sexual behavior. Responsible sexuality was equated with avoiding “unprotected sex.” There was no need to wait for a marital commitment, since family building was precluded by contraception. Various contraceptives, most often the pill, were used until one had “completed one’s family” and then one or the other partner underwent sterilization. The theory, promoted heavily by pharmaceutical manufacturers, was embraced enthusiastically by health-care providers who, in time, “forgot” that women can easily recognize their signs of normal fertility, and hence do not need to suppress their fertility by chemical or mechanical means. But if women were to retain their cyclic fertility, they could not be sexually available at all times! And that might interfere with their social lives, or so the theory went. But is it true? Is fertility only an appendage, or is it an

integral aspect of being male or female?

When a girl has experienced her first menstruation and the boy his first nocturnal emission, their biological capacity for parenthood is present. Its meaning may be dimly perceived, and perhaps not welcomed, but from now on, the boy has the biological capacity to become a father, and the girl a mother. Their bodies may be ready, but what about their minds? Clearly teens have not finished their education; very few could support themselves, let alone a family; and nearly all are dependent on their parents for food, housing, clothing, nurture, and nearly all else. Centuries ago, especially in rural areas, when youths became puberal they married and began to establish their own families Along with urbanization came the need for longer schooling, so that now there is a considerable time interval between biological and emotional and intellectual maturity. Jay Giedd and his group at the National Institutes of Health have shown that the prefrontal cortex, the area of the brain that controls intellectual decision-making, does not mature until 25 to 30 years of age! Until then, decisions are likely to be made in a paleontologically older part of the brain, the amygdala. In other words, decisions may be more likely to be impulsive and emotional than rational. Clearly the culture does not accept this as gospel, for it considers 21 the age of maturity, allows 18 year-olds to vote and enlist in the armed services, and treats any criminal at age 18 as an adult.

Data from the 2003 Youth Risk Behavior Survey show that 52% of youths under the age of 19 are virgins, a considerable increase over the past ten years, when only 42% of youths under 19 years of age still claimed virginity. There is no need to belabor the constant and ubiquitous sexual invitations to which everyone in our culture is subjected in print and in the audio-visual media. Teens who are just becoming used to the hormonal inrush of puberty find it more difficult to cope. The present Administration funds educational programs that emphasize sexual abstinence until marriage and has supported many initiatives to that end. Some exhort teens to “abstain.” Others stress the dangers of sexual encounters, including out-of-wedlock pregnancy (which, parenthetically, girls fear more than the much more common sexually transmitted infections) and diseases, some of which are incurable, and others lethal. Still others stress the emotional and spiritual costs of loss

of virginity in the absence of a balancing commitment. Some programs target parents, who are still the most important factor in supporting premarital chastity, and avoidance of anti-social activity such as membership in gangs, or even entry-level crimes such as shoplifting, and community support groups.

For over twenty years, the Title XX programs of the HHS Office of Population Affairs were designed to reduce teen pregnancy by contraception or abstinence. Thankfully the federal government does not support abortion, although there are sufficient privately funded groups that target single expectant women preferentially. Planned Parenthood Federation of America is the largest single abortion provider in the U.S. It stands to lose a lot of revenue if the market for contraception were to disappear. The latter is also true of many obstetrician/gynecologists and family practitioners, as the annual well-woman visit is chiefly for contraception and its adjunct, the Papanicolao smear to detect malignancy of the female reproductive tract. The pap smear is most useful to detect changes in the cervical epithelium. Nearly all cervical cancers are preceded by infection with the human papilloma virus (HPV), mostly types 16 and 18. If premarital chastity were maintained along with marital fidelity, the annual well-woman visits would become far less necessary, and we would be able to concentrate on prevention of other health-threatening areas such as obesity, hypertension, breast- cancer detection and substance abuse rather than focusing mainly on the consequences of sexual promiscuity of the woman or her partner.

And yet, the truth that couples can manage their fertility by means of natural family planning (NFP) is generally derided by the professions, even though the effectiveness of NFP has been proven beyond doubt. Providers of contraception either profess (culpable) ignorance or assume either that the practice of NFP will be too hard and thus unacceptable, or that one or the other partner will not remain faithful. This mindset is unfortunately prevalent among providers of health care not only to adult but also to adolescent patients. After all, if one can prevent the physical consequences of sexual intercourse, why wait until one is an adult and in a committed relationship called marriage? Society initiated marriage only to assure support for children, no?

So, how can one persuade teenagers who have heard all these

messages for years to delay sexual gratification? Already the "abstinence message" is negative. Imagine being told that one needs to learn something which one has done since birth! One needs to *do* something to enter into a sexual act, not *not do* something, as the word abstinence education implies. There is a powerful ally in the body's own truth. For example, when we began to explain the fertility cycle and its chief prospective marker, the cervical mucus that reflects the rising estrogen level of the developing follicle, and its importance for supporting sperm viability in the woman's body, the behavior of our teen mothers changed. They looked at themselves differently and acquired more self confidence. As a result they were no longer pressured to have intercourse when they did not desire it.

Even chaste teens showed progress toward emotional maturity and self-direction upon learning to understand the fertility patterns and their meaning. In our program, called Teen STAR® (*S*exuality *T*eaching in the context of *A*dult *R*esponsibility), we have seen undergirding of primary and secondary abstinence consistently not only in the U.S. but all over. Program outcome results from the Chilean Teen STAR program are typical[1]:

	Study subjects	*Controls*	*Significance*
N males	251	195	
N females	147	147	
% transitions (virgin – non-virgin)			
Males	8.8	17.6	p =<0.004
Females	3.4	12.4	p= <0.001
Discontinuation of intercourse*rate increase			
	20%	9%	p=<0.03

[1] P. Vigil, R. Riquelme, R. Rivadeneira, H. Klaus , "Effect of Teen STAR, an Abstinence-only Education Program, on Adolescent Sexual Behavior" in *Journal of Pediatric and Adolescent Gynecolology* 18 (2005): 211

Resumption of intercourse			
	0	11%	p=<0.04

* No intercourse within the last three months of the program

Our international evaluation of "Changes in Sexual Knowledge, Attitudes and Behavior among Polish, Chilean, and American Teen STAR program participants, 2002-2004" delved more deeply into the changes of the above parameters.[2] The behavioral impact was similar to the other Chilean cohort and showed superior outcomes when fertility charting was universally practiced and its implications were monitored and discussed in the (mandated) individual meetings. There was a reduction in the use of pornography, while heavy petting appeared to increase in one country from pre-test to post-test, perhaps because as the teens began to learn correct terminology, they learned the proper name for their previously begun practices. ["no, never oral sex, but we do B. J's"]. Protective factors against initiating sexual activity were also analyzed and, not surprisingly, included parents who were opposed to premarital sex, despite the fact that all groups rated their teachers as the best source of information about love and sexuality. This can be explained by the need for teens to separate from parents and even devalue parents' knowledge in the process of forming their own personality. Other protective factors were a negative attitude toward abortion, understanding that no family planning method is 100% effective for prevention of pregnancy and STD's, and non-use of tobacco, alcohol and drugs in the last month.

While the Giedd group's work is thought-provoking, we cannot wait until everyone reaches age 25 before helping them to avoid the

[2] S. Grzelak, P. Vigi, E. Heyne, H. Klaus, "Changes in Sexual Knowledge, Attitudes, and Behavior among Polish, Chilean, and American Teen STAR Program Participants, 2002-2004," presented at Medical Institute for Sexual Health (Washington, D.C. May 27, 2005).

consequences of sexual behavior. Whether teens' choices to engage in sexual intercourse are rational, sub-rational, emotional, impulsive or none-of-the-above, the effects can be devastating.

When we harness the power of the body's own truth, teens understand themselves differently and behave differently. They move away from peer pressure, begin to make their own decisions, and accept responsibility for them. In psychological parlance they move from middle to late adolescence. They come to understand and value their sexuality and fertility in such a way that they will (hopefully) not make use of this faculty until they can express it fully, not partially.

Pope John Paul II discussed many aspects of bodilyness in his *Theology of the Body*, but our culture takes the opposite tack as it views the body as an object to be manipulated in a thousand ways. But, as even the Boston Women's Cooperative recognized, our bodies are ourselves. Where we diverge from their conclusion is in refusing to manipulate fertility out of a sexual relationship to obtain momentary gratification, while of necessity sacrificing the total, faithful, mutual self-giving that signifies the marriage act and that alone may allow the couple to go beyond themselves to incarnate their love in a child.