

Sex and the gynaecologist II: Psychosexual O and G

In 1974, I had the unique distinction of writing *Sex and the Gynaecologist*, the first paper about sexuality in the *Australian and New Zealand Journal of Obstetrics and Gynaecology*. After 32 years, I am writing part two. Few articles on the sexual function of our patients have appeared in the interim. I am delighted at this, the first College publication devoted to sexuality. It is timely reminder that new generations of specialist colleagues have been 'spawned' since I made that first impassioned plea for the appropriateness of considering the sexual functioning of our patients.

This happened at the start of vast societal changes in our community regarding sexuality, known later as the 'Sexual Revolution'. (I prefer the more accurate term, 'Sexual Evolution' because not too much has changed and much has since lapsed regarding the training of our medical undergraduates and O and G postgraduates in human sexuality.) Specialist interest groups formed around the world and in Australia in 1973, I became a foundation member of the Australian Society for Psychosomatic O and G (ASPOG), headed by the late Roger Wurm of Adelaide. Years later, Professor Derek Llewellyn-Jones changed the name to the Australian Society of Psychosocial O and G after the sexologists hived off to form their own society. Realistically, the terms psychosexual O and G, psychosomatic O and G and psychosocial O and G cover much the same areas. I lean towards the modern concept of a bio-psychological model.

Being the catalyst for having MCQs on sexuality set in the University of Sydney's O and G final year exams back in the mid-1970s, and then in the MRACOG Part I exam, I doubt that any questions appear in today's exams. In the 1970s, I reasoned with Professor Rodney Shearman that the only way a student will perceive anything in their course as being important is to set questions on that subject.

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Students have so much to learn that if a topic doesn't appear to be examinable, they will dismiss it from their studies as being unimportant. Derek Llewellyn-Jones and I, amongst others, got actual lecture time at the University of Sydney, and I also lectured the medical students at the University of New South Wales.



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However, time went by, medical knowledge expanded dramatically in new, very technical areas, and the teaching of sexuality fell by the wayside again for lack of time.

In no way do I diminish the importance of the wonderful and amazing advances in O and G. I maintain merely that far more women suffer from bio-psychological problems than problems requiring ultrasound, IVF, microsurgery, LEEP, LLETZ or advanced oncology procedures.

My fundamental thesis expounded over 30 years ago is just as valid today. We, as O and Gs, are privileged to be responsible for the management of problems our patients either have or perceive in relation to all the major epochs in their lives. This spans from childhood and pre-adolescence to puberty; birth control; unwanted pregnancies; sexually acquired diseases (SADs); and abnormal cytology through to marriage; infertility; pregnancy and childbirth; prolapse; menopause and post-menopause. This is a privilege unique in medicine – the andrologists only scratch the surface in comparison to us. My thesis then posits: How then can the primary approach to problems in these various areas be with the knife or 'magic bullet'?

This is the domain of psychosomatic and psychosexual O and G. Much which is going on in the woman's life will impact upon her perceived or real problems within our specialty. O and G needs to catch up with the rest of medicine in understanding concepts such as patients exhibiting illness behaviour; abnormal illness behaviour; somatisation and pain behaviour; or doctors exhibiting abnormal treatment behaviour. In other words, the pains our patients complain of before, during or after sexual activity may not need any surgery or drug to fix, merely a display of interest in possible, underlying factors which the specialist takes the time to listen to and interpret.

Psychosexual O and G is a very real component in our work. It is far from a niche market. We don't have to be trained psychotherapists

Disturbing Trends in female sex therapy

a) 'Pink Viagra'

The use of testosterone in its various forms for problems with female libido, sexual arousal and responsiveness is fraught with irreversible complications in inexperienced hands. It is not new since a few of us have been using it judiciously for years in the minority of women who are actually suitable. Viagra, by the way, has been a dead loss for women – but women could have told us that – meaning that, whereas there is demonstrable congestion of the clitoris and its crurae, there is no connection with women's higher centres. They don't perceive that they are aroused. Their brains are the biggest sexual organ of all.

b) The Dyspareunias and Vaginismus

Beware of the researchers now trying to say that the various forms of painful intercourse or vaginismus are not sexual dysfunctions but pain disorders, so that the diagnoses can be shifted from the DSM-IV-TR (Diagnostic and statistical manual of mental disorders [4th ed, text ref]) to the ICD (WHO's Manual of the international statistical classification of diseases, injuries and causes of death). This is absurd and the only reason behind it is that in the post-Clinton era, there is little or no funding for sex research but plenty of funding for pain research.

c) The 'Vaginal Bypass'

This trend disturbs me most of all. I used to joke about obstetric practices with 60 to 80 per cent C/S rates as making the vagina obsolete, calling it a 'vaginal bypass'. However, there is a new form of 'vaginal bypass' which I have seen emerging over the last three to four years – the use of IVF assisted technology to short-circuit the need for sex counselling in treating unconsummated marriages due to vaginismus. Such colleagues have put these women through several IVF cycles at \$5,000-\$10,000 a cycle. I see the unsuccessful ones after three or more unsuccessful attempts.

I looked after a vaginismic female GP recently who, when faced with the two problems: the desire for a child and her unconsummated marriage of six months, plumped for the former to be fixed first. I schooled the couple in the technique of introital ejaculation at ovulation and it worked immediately, saving the woman thousands of dollars. It is always worth a try given those parameters and much appreciated. (Even men who felt Viagra could bypass the need for sex counselling have found that this isn't always the case. In fact, about 45 per cent of American men don't get their repeat prescriptions for Viagra filled.)

to manage these various problems. A positive outcome by merely listening and talking is in itself psychotherapeutic. So, whereas all O and G specialists do not need to become sex therapists, we need special doctors, not all doctors, to manage the types of problems outlined in this special edition of *O&G*. Just remember — without sex, there is no obstetrics or gynaecology.

References

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