Women and the gynecologist. Difficulties in comprehension

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Summary: In the woman-gynaecologist relationship there is very often extreme difficulty, unease and incomprehension in that the request for help, and consequently the symptoms put forward, does not represent the real need.

It is up to the gynecologist to decode the female code and understand the woman's request, by putting aside his personal point of view and his medical code. Otherwise a vicious circle is created which merely leads to disappointment and frustration on both sides.

The main factors which impede a true and fruitful understanding between the woman and the gynecologist are described.

The difficulty in recognising the real need which lies behind an explicit request in gynaecological consultation is unfortunately all too often the cause of incomprehension and unease.

Unease on the part of the patient, who does not obtain what she wants, unease on the part of the doctor whose intervention is often of no avail.

The enormous difficulty which a woman has in explaining her problem arises out of three main factors:

1) Often she cannot recognise her own problem, probably because it would be too difficult to bear and therefore to put into words.

2) Sometimes on the other hand she is unable to express her intimate difficulties in concrete terms, because she finds them too painful.

3) Very often the educational, social and cultural conditioning to which she has been subjected prevents her from exposing the problem itself.

In most cases all these elements converge, in different proportions and with a varying incidence, to mask the symptoms.

A masking, which is certainly a form of self-defence as regards the true request, but which is also extremely frustrating for the woman even at the moment when she formulates it.

It is obvious that to this frustration in added the preceding one, caused by the problem itself.

A vicious circle is therefore created; one, however, from which the woman feels the need to escape and the gynaecologist represents the means of breakthrough.

The inner world of the woman, the image which she has of herself and of her own body, nevertheless, do not always correspond to (and indeed sometimes conflict with) the image which the gynaecologist has of her and of her needs.

She is in fact experiencing both symbolically and concretely a reality which co-

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mes into being and is elaborated within herself.

The gynaecologist on his part too often tends not to interpret the presentation of the symptom but to take refuge in a strictly clinical point of view.

The difficulty, which nevertheless exists, of decoding the message which is being transmitted, is further hindered by the personal reality of the gynaecologist himself who otherwise is compelled to look into himself.

Very often in these cases ill-formed communication is the root cause of the failure of one's intervention, leading to a sense of frustration.

The balance and the mediation between these two different points of view are the key to the decodification of the real message, to the consequent attainment of a correct answer, above all one related to the deep-seated need in the woman's request.

Gratification at the final result which has been obtained is therefore combined with the personal gratification which each of them feels.

There are various examples in daily practice which confirm the difficulties which exist both for the woman and for the gynaecologist in understanding the real entity of what she is experiencing.

We consider it useful to list the six most frequent groups of symptoms in which there is ambiguity between the real, explicit request and the deeper one, as well as in the difficulty of comprehension for the gynaecologist.

1) Pelvic pain, presented as an organic complaint, by means of a more leisurely anamnesis and personal analysis, often reveals ill-concealed and distressing sexual difficulties.

2) In cases of psychogenic sterility, the desire for a child who does not arrive sometimes becomes obsessive both for the woman and her gynaecologist.

A careful anamnesis and a more profound dialogue will sometimes reveal that the woman is only asking to be absolved from her true desire, which is not to become pregnant.

In proof of this, there are the cases of unsuccessful artificial insemination, or those in which the woman becomes pregnant but has an early spontaneous abortion.

3) In cases of demolitive surgery for benign neoplasia or metrorrhagia, the distracting of attention from the real problem, indicative of a difficulty in accepting it, with the relative request for help, is expressed by an explicit refusal of the surgery itself.

Both in the case of benign tumours and of malignancies a personal fantasy of sexuality, when the latter has been denied or frustrated, is often externalised as victimised or guilt-ridden behaviour.

4) The very frequent cases of vaginismus or dyspareunia show the enormous personal difficulty for the woman in detecting the roots of the problem, whereas on the gynaecologist's part, the often hasty superficial decision to carry out medical therapy or surgery in order to resolve the problem is the cause, not only of its non-resolution, but also of its aggravation of the problem.

5) As far as pregnancy is concerned, the increasingly frequent cases of uterine hypercontractility and premature delivery are not always exclusively of organic origin.

Often it is in the psychic and emotional sphere that one can find the true problem and consequently its correct solution.

6) Last, though not least in importance, the numerous requests for interruption of pregnancy reveal with the passing of time, through anguish at the idea of death, self-destructive fantasies, compensatory children, refusal of sexuality, the real refusal of the interruption of pregnancy and

the personal need for the pregnancy itself to continue.

This list is certainly a restricted one with regard to the multiplicity of problems which are concealed by a request for gynaecological or obstetric intervention.

In our experience, however, these are daily occurrences apart from being, for us, a source of mental training and careful observation.

Therefore, only by bearing in mind what has been put forward up to now can a badly constructed dialogue be more easily transformed into communication, and our ambiguous exchange of information evolve into reciprocal satisfaction, not into personal frustration on both sides.

What we hope, therefore, is that the modern gynaecologist will not blame his failure on the lack of time at his disposal but will succeed in using this to the best advantage, thus placing himself in a position to understand the underlying problem.

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