minutes). A singleton pregnancy was the most desirable type of pregnancy for both patients and their partners (71 versus 73%). Despite similar counseling time, patients consistently and significantly overestimated the risks of prematurity for twins (median 20 versus 10%, $P<0.001$) and triplets (40 versus 22.5%, $P=0.001$) as well as the risks of preeclampsia for twins (20 versus 15%, $P=0.005$) and triplets (30 versus 23%, $P=0.012$). Patients were also more likely to overestimate the risks of death for 2500 gram infants (5 versus 3%, $P<0.0001$) and 1500 gram infants (25 versus 10%, $P<0.0001$). When presented with clinical scenarios with multiple suboptimal outcomes (preterm delivery, preeclampsia and clinical depression), patients were twice as likely to consider it desirable or highly desirable compared with their partners ($P<0.03$).

Conclusions: Patients and their partners appear to receive adequate counseling from their physician and mental health providers. While patients significantly overestimate the risks associated with multiple gestation compared with their partners, both estimates are well above actual risk. Patients are much more likely to consider a suboptimal scenario desirable than their counterparts.

P-303

Why Leave a Donor Insemination Program Before Conceiving? [1,2]J. E. Scheib, [1]A. C. Steele, [1]P. R. Shaver, [2]M. Riordan. [1]Department of Psychology, University of California, Davis, CA and [2]The Sperm Bank of California, Berkeley, CA.

Objective: Success rates with donor insemination (DI) are high compared to other forms of assisted reproduction (e.g., IVF) and the financial costs relatively low. Nonetheless, a significant proportion of recipients leave prior to conceiving. This study identified factors related to leaving a DI program prior to conceiving.

Design: Anonymous telephone interviews were conducted with a representative sample of recipients who had used the sperm bank between 1995–97 and undergone at least one cycle attempt.

Materials and Methods: The sub-sample of recipients ($n=49$) who left prior to conceiving, answered open-ended questions about why they left, completed standardized measures of social support and relationships, and provided demographic information. The overall response rate was 80.2%. Data were analyzed using Chi-square, Fisher's exact, and t tests.

Results: The most common reasons for leaving were health and fertility problems (reported by 33% of respondents), pursuing other reproductive options (33%), experiencing logistic problems (35%), and feeling that DI was too emotionally difficult (27%). Other reasons included financial limitations (20%), personal changes (12%), and hitting personal deadlines (8%). Because lesbians comprised 59% of our sample (similar to the whole sample (64%)), we analyzed whether sexual orientation was related to responses. It was—lesbians were more likely to report logistic problems (e.g., time constraints, shipping problems, limited choice of donors) and that they were pursuing other reproductive options (e.g., IVF, fresh sperm through a known donor). Heterosexual women more often reported leaving because of a personal change (started a relationship, changed careers). We also compared reasons given by respondents who stopped all attempts to conceive (47%) to those of respondents who continued elsewhere (53%). Women who stopped completely were more likely to report leaving because of health and fertility problems, hitting personal deadlines, and DI being too difficult emotionally. They were also significantly older when using DI ($M=40.9$) than those who continued elsewhere ($M=36.2$), and scored lower on measures of satisfaction with social support. Women who continued elsewhere were more likely to report experiencing logistic problems and pursuing other reproductive options that they felt would increase their chance of conceiving.

Conclusion: Women who leave DI programs fall into two categories—those who stop trying to conceive altogether and those who go on to other programs and reproductive options. Their reasons for leaving suggest that, although DI is the simplest form of assisted reproduction, recipients still face significant emotional and logistic difficulties that can hinder their attempts to conceive. Programs that provide psychological and logistic support may help women meet these challenges and increase the probability that recipients conceive prior to leaving DI programs.

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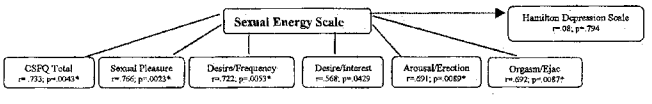
P-304

Sexual Energy Scale (SES): A Valid Assessment of Sexual Dysfunction in a Clinical Setting. J. K. Warnock[1], A. H. Clayton[2], W. R. Yates[1], J. C. Bundren[1]. [1]University of Oklahoma Health Sciences Center, Tulsa, [2]University of Virginia, Charlottesville, VA.

Background: Sexual dysfunction (SD) is gaining increased attention as a public health concern. Laymann et al (1999) documented a 43% prevalence of SD in women and a 33% prevalence of SD in men. Progress in the research and treatment of SD is hampered by the lack of practical and valid psychometric instruments. The Sexual Energy Scale (SES) provides a simple, easy and objective means of assessing the patient's lost familiar experience of sexual desire and vital/sensual energy. The SES also measures changes in sexual function following an intervention. The scale is a visual analog model in which the patient rates their current sexual energy level on a scale of 1 to 10.

Materials and Methods: To determine concurrent validity, the Changes in Sexual Functioning Questionnaire (CSFQ) and the SES were completed by a series of psychiatric patients ($N=17$) who presented for treatment of medication induced SD. The CSFQ is a 32 item structured interview designed to measure illness and medicated-related changes in sexual functioning with reliable and valid psychometric properties. Correlation coefficients were calculated for SES and the CSFQ total and subscales. In addition, the patients were readministered both the SES and the CSFQ 1 month after treatment for their sexual dysfunction. Correlation coefficients between the change score for the SES and the change scores for CSFQ total and subscale scores were also obtained.

Results: Figure 1 shows the correlation coefficients between the SES and the CSFQ and subscales. The change scores on the SES correlated significantly with change scores on the following CSFQ scales: SES & CSFQ global score $r=.679$; $p=.01$; SES & Desire/Freq $r=.647$; $p=.01$; SES & Desire/Interest $r=.66$; $p=.01$; SES and Arousal $r=.625$; $p=.02$.



Conclusions: The SES indicates good concurrent validity with the CSFQ. Discriminate validity is supported by the low correlation between the SES and the Hamilton Depression Scale. The SES can be used by clinicians as an easy valid tool in the assessment of SD.

P-305

Patient Perception and Awareness Regarding Diagnosis and Treatment of Polycystic Ovary Syndrome (PCOS) as Measured by Confidential Self-Reports. [1]E. S. Sills, [1]M. Perloe, [2,4]D. P. Levy, [3]M. G. Genton, [4]G. L. Schattman, [1]M. J. Tucker. [1]Georgia Reproductive Specialists, Atlanta, GA; [2]Service de Gynécologie, Hotel Dieu, Paris, France; [3]Department of Mathematics, Massachusetts Institute of Technology, Cambridge, Massachusetts; [4]Center for Reproductive Medicine & Infertility, Weill Medical College of Cornell University, New York, NY.

Objective: To evaluate self-reported perception, awareness, selected demographic and clinical parameters regarding PCOS among gynecology patients.

Design: Anonymous, confidential questionnaire.

Materials and Methods: Using a computer-based evaluation instrument, a 15-item questionnaire addressed the following parameters by internet-accessed questionnaire: patient age, time since (and reason for) last gynecology office visit, gravida status, and history of prior ovulation induction. Additionally, respondents were asked this question: "If your PCOS could be safely and effectively helped by something else besides fertility drugs or birth control pills, would that interest you?" Incomplete questionnaires were not entered, and responses were electronically tabulated to block duplicate submissions from the same individual.

Results: A total of 657 women participated in this study. The majority of patients (63%) reported their age as between 26–34 y; mean BMI was 30.4