The interface between psychiatry and obstetrics: Comprehensive perinatal care. APA Issue Workshop #78

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Abstract

Mental health issues in pregnancy and postpartum are often neglected by obstetricians just as the puerperal period is foreign to psychiatrists. This places women at risk for undiagnosed mental disorder. At Basel University we established a comprehensive care program with close cooperation between obstetricians and psychiatrists.

Johannes Bitzer: The role of the obstetrician in detecting mental disorders in pregnant women. The focus will be on instruments for obstetricians to detect mental disorders. Examples will be discussed: posttraumatic stress disorder (PTSD), affective disorders, personality disorders, wishes for primary caesarian section, etc.

Maria Hofecker: The role of the psychiatrist in early perinatal care. The focus will be on psychiatric treatment, crisis intervention, parenting assessment, and rehabilitation.

Werner Tschan: Psychiatric follow-up care of the patient, the new-born and the partner. The focus will be on outpatient care in the community, treatment of psychiatric disorder, networking, systemic-oriented care involving the family, experiences, and techniques in medium and long-term care.

Psychiatry and birth

Although psychiatrists are involved in almost all parts of the life-circle, their experience and knowledge has been widely neglected by obstetricians. Until the mid 1990s only little research has examined the impact of traumatic events on pregnancy and post-partum outcomes. The traditional risk assessment is based on ”hard facts“, such as laboratory and ultrasonic findings. The emotional reality is in most cases not included into the risk assessment. In accordance with other authors (Rodgers et al. 2003) we propose that a history of sexual traumatization and emotional neglect is associated with pregnancy and post-partum complications. According to results from the affective

neuroscience we have clear evidence that traditional western dualistic metaphysics with the distinction between mental and physical illness is a misleading conception (Panksepp 1998). Often mental illnesses are in general less accepted and often regarded as somehow not quiet real, with an implication of weakness, fault, or loss of reasonable thinking in patients who have those (Sharpe et al. 2001). There is considerable evidence, however, how CSA (child sexual abuse) and neglect affects self-esteem (Fonagy et al. 2002), personal development, and both neuroendocrine and neuroanatomic reactions (Heim et al. 2001, Meany et al. 2003). Attachment Theory provides us with a framework for how the effects of disturbed relationships in case of child abuse and neglect are related to further developments. Finally, the revolutionary new diagnostic approach provided by PTSD and DID (Dissociative Identity Disorder), which was integrated 1980 into the DSM III and later revised in DSM IV (1994), helps to better understand the mediation role of psychological trauma on the individual's development.

Today, the psychological approach to somatic problems uses more of a psychophysiological concept to explain personal imbalances and diseases. The research focuses on characteristic physiological reactions (stimulus-response specifity), and whether different individuals react in characteristic ways to stimuli (individual-response specifity). The influence of the traditional approach of psychosomatic medicine has now decreased. However, it is important to note that much of the early work on somatic disorders was based on patients who were seen after several previous medical referrals, ineffective attempts at treatment, and a variety of potentially conflicting explanations of the problem (Salkovskis 1989). It often leads to a well known outcome: the patient is told after many months or even years of medical investigation that there is no further medical treatment and that the only avenue for further help is through the acceptance of psychological help (Salkovskis). Therefore, patients perceive themselves as having a psychiatric problem arising out of their chronic somatic condition, and also become distressed with the failure of medical treatment. Psychiatric treatment then becomes a "last resort", which is definitely not an ideal precondition for a successful outcome.

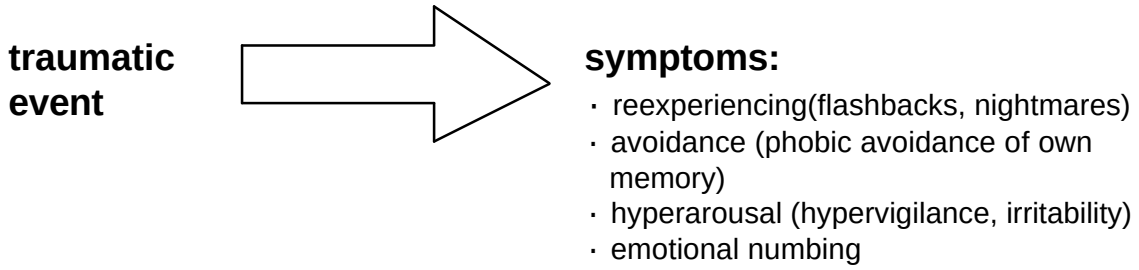
Psychiatrists are involved in child and adolescent treatment, as well as in adult treatment of both male and female patients. Furthermore they are involved in the treatment of martial and family problems, in difficulties of sexual life, in aging and in death. The knowledge we gain from both women and men regarding birth problems enables psychiatry to provide a conceptual framework for obstetricians who want to improve their risk assessment by including emotional aspects. We will focus in our presentation on the impact of psychological trauma (e.g. sexual abuse and emotional neglect) on pregnancy and post-partum outcomes. We will discuss the implications on prenatal care, the risk assessment and the post-natal outcomes including the long term care for both the newborn and the parents.

The identification of women suffering from sexual abuse and emotional neglect is important early in pregnancy. Establishing a risk assessment leads to an increased monitoring of these women, that may help to significantly reduce

pregnancy complication, to identify risk factors, and can also help increase pregnancy outcomes. Without a conceptual framework of both prevalence and implications of CSA and other forms of devastating experiences, the clinical is not able to perform this risk assessment. We also have to consider that some women are sexually abused by professionals while searching help and support. The devastating experiences of PSM (Professional Sexual Misconduct) can lead to phobic reactions towards professionals, and undermines trust in the health care system. In self-reporting questioners 3-4% of gynecologists disclosed a sexual relationship with current or former patients (Wilbers et al. 1992).

Somatic versus mental problems

The are four main avenues which lead to psychological problems related to attachment experiences: (1) sexual violence (2) physical violence (3) emotional violence, and (4) abuse and neglect. The detection of traumatic events in patient histories is in most cases difficult for a variety of reasons. The majority of patients usually do not consider a link between their actual symptoms and the past traumatic experiences, which often happened years, if not decades, ago. Furthermore, feelings of shame, loyalty, and guilt often undermine the ability to openly disclose what had happened to women, further increased by the fear of not being believed or being blamed. The diagnostic procedure always rests with the clinician, therefore, the creation of a trustworthy doctor-patient relationship is the main precondition for disclosing these experiences. The duty to build up and maintain a “secure base” is one the physicians first tasks. The PTSD concept can serve as a comprehensive model, how psychiatrists come to their diagnoses: is there a relation between the current symptoms and past traumatic and threatening experiences, which leads to a functional impairment? This approach is illustrated by the following figure:



Aside from the exposure to one or more traumatic events, the diagnosis requires a characteristic response, such as intense fear, helplessness, or horror, and the symptoms must lead to a significant distress or functional impairment. There was reluctance among health professionals to acknowledge that PTSD can also occur following childbirth, and women have not been offered appropriate treatment (Lyons 1998). Kitzinger (1992, quoted in Lyons) proposed that there are similarities between traumatic obstetric experiences and the experience of sexual assault. In childbirth, as in rape, a woman may be stripped, forcibly exposed, her legs splayed and tethered, and her sexual organs put on display to all comers. The woman is no longer of control of her

own body and of her intimacy. This may trigger horrifying past experiences such as sexual abuse histories.

However, in most cases of severe and repeated trauma during childhood, the psychological response is different from this simplified pathogenic model as suggested by the PTSD-concept. When complex traumatic experiences such as chronic sexual child abuse (by own father or less common by own mother) occur, the outcome is more characterized by DID, personality disorder, depression, psychosis, substance abuse, and somatic problems such as eating disorder, chronic pain disorder, fibromyalgia, chronic urogential problems, etc. The link to severe trauma in all these diagnostic entities is based on rather new results - mainly stimulated by research following the implementation of PTSD and DID since 1980. The vast majority of these studies were published after 1995.

How common traumatic experiences such as sexual abuse are, is a matter of how the sexual abuse is defined. If someone uses a narrowly defined approach or includes non-contact experiences such as exhibitionistic behavior, leads to a great variation of research findings (see next paragraph). The recently published World Report on Violence and Health by the WHO (2002) estimates that about 20% of all women worldwide, and up to 10% of all men, suffer sexual violence as children or adolescents. Russel (1983, 1986) reported in a study that 38% women in the sample had suffered sexual abuse involving physical contact, whereas the figure was 54% when experiences involving non-contact were included. Therefore we agree with Rodgers et al. (2003): “Given the high prevalence of sexual trauma, it is likely that a substantial proportion of pregnant women have been victims of sexual trauma at some point in their lives.”

Detrimental past experiences can lead to avoiding pregnancy or to fear of childbirth. Several authors showed that there are women who need to deliver by caesarean section because of their previous negative experiences of childbirth (Ryding 1993). Current research suggests that it is not possible to determine whether a traumatic event or experience will trigger a post-traumatic response for a given individual (Lyons 1998). Flashbacks may be triggered by pain, touch, not being in control, lack of privacy, and/or unprofessional behavior. According to Foy (1992) PTSD following childbirth can be caused by:

- women’s personality
- social support
- socio-economic group
- antenatal preparation
- subsequent expectations
- difficult pregnancy
- obstetric interventions
- worse experience of childbirth than expected
- memories of previous childbirth traumas
- miscarriage
- death of a child

- memories of sexual abuse or assault may be triggered by childbirth

The fear of losing a baby seems to be the most powerful trigger for PTSD symptoms after pregnancy and childbirth.

The bodily experience of birth can be a trigger for abuse memory

There is an ongoing discussion whether repressed memories really do exist or not. From a practitioner's perspective there is overwhelming evidence that these phenomena are based on real experiences. This view has become the basis of today's DID conception (Sinason 2002). A widely cited study on this question is that by Briere and Conte (1993), who found among 450 adults with sexual abuse histories, that 59% had lost their memories for the abuse over a certain amount of time. The authors concluded that amnesia for abuse was a common phenomenon. Other studies showed lower incidences of repressed memories (see e.g. in Loftus et al. 1994). As part of a larger project on the association between reports of traumatic life events and clinical diagnoses, Loftus et al. investigated 105 women (in out-patient treatment for substance abuse) about memories of childhood sexual abuse (n=57/105, 54% reported sexual abuse) and 19% of the women claimed that they had repressed memories. The authors of the study published some interesting facts:

Frequency of types of childhood sexual abuse (Loftus et al. 1994) (n=105)		
At least one item	57	54%
Did anyone show you their private parts?	41	39%
Did anyone masturbate in front of you?	19	18%
Did anyone ever touch your body in a sexual way?	41	39%
Did anyone try to have you touch in a sexual way?	31	30%
Did anyone rub their private parts against your body?	37	35%
Did anyone attempt to have sex with you?	44	42%
Did anyone have intercourse with you?	32	31%
Did anyone ever put their penis in your mouth?	12	11%
Did anyone ever put their penis in your butt?	5	5%
Did anyone ever take pictures of you?	9	9%
Did you have any other sexual contact?	8	8%
Frequency of abuse (n=55)		
once	19	35%
several times	27	49%
many times	9	16%
relationship of abuser to victim (n=55)		
parent	5	9%
stepparent	8	15%
sibling	5	9%
other relative	21	38%
friend of the family	27	49%
any family member	30	55%
stranger	21	38%

Keeping in mind the epidemiological findings it is not surprisingly therefore, that in some cases the experience of birth can be the first trigger in the adult life of the experience of penetration as a child and the associated pain. A prepartal assessing of these women will reveal no information about a specific psychosomatic risk for birth. The same difficulties arise when you claim to detect substance abuse, which is often a co-morbid phenomenon in patients

with sexual abuse histories. For a variety of reasons many victims of child sexual abuse will not disclose what had happened to them - this may explain the underestimation of the problem of sexual violence as a risk factor for birth complications.

Accordingly with Lyons (1998), great caution should be exercised in the prompting of disclosure of sexual abuse during pregnancy. Reasons for this caution include:

- Most women are emotionally vulnerable during pregnancy. Their reactions to disclosing sexual abuse histories may be intensified. The mother-child relationship can be negatively affected.
- Women with sexual abuse histories have higher rates of depression, self-harm and suicidal attempts.
- If a woman discloses memories of abuse to professionals, it is possible that the mother will associate the memory of the disclosure with that particular professional. If the same person, especially a midwife, should then assist at the woman's delivery, her presence may actually increase the chance of experiencing flashbacks.

If a pregnant woman refuses to talk about her devastating experiences, professionals should accept this, unless the woman clearly indicates, that she needs help related to this issue. The more the affected woman feels under control, the better the results. Referring her to a psychiatrist against her free consent will lead to detrimental experiences in most cases.

Several authors have studied the impact of domestic and sexual violence during pregnancy itself. According to epidemiological findings, pregnancy is a high-risk period during which violence may begin or escalate. Rates up to 20% of all pregnant women experiencing violent acts have been reported (Cokkinides et al. 1999, Hedin et al. 2000, McFarlane et al. 1996). Violence during pregnancy is associated with adverse maternal conditions, which may also have a direct or indirect influence on the fetus. An influence is documented with:

- self induced or attempted abortions
- spontaneous miscarriages
- divorce and separation during pregnancy
- secondary psychological problems like alcohol and drug abuse
- maternal antenatal hospitalization
- labor and delivery complications
- higher rates of cesarean delivery
- preterm birth
- low birth weight
- postnatal complications

In the aftermath of pregancy and birth, some other problems arise. Holding the newborn baby in her arms, a woman with a history of sexual abuse can suddenly gain a shocking awareness of her own vulnerability, when she was sexually abused as a child, either by a male or a female Even more hidden and

disturbing are sexual abuses by females (Hislop 2001). It is estimated, that in about 20% of all sexual abuse cases the perpetrator is female. Lamott and Pfaefflin have reported about the characteristics of 37 women who killed their own children. All of them had suffered from severe trauma in their own childhood (sexual abuse 33%, death of a parent or another important person 62%). Using the AAI (Adult Attachment Interview) they showed in 31% a secure attachment pattern, and in 69% an unsecure attachment (dismissing 31%, enmashed-preoccupied 38%). Recent data suggest that the effects of severe trauma on neural network provide a common diathesis for PTSD and psychotic disorders (Seedat et al. 2003). Again, there is no research available about a possible link between sexual abuse and postpartum complications such as postpartum depression and psychosis. We suggest further research about the association between sexual trauma and pregnancy and postpartum outcomes.

A German research group has recently published their data from a prospective study investigating the association between traumatic experiences and premenstrual dysphoric disorder (PMDD). In contrast to some previous clinical studies among sexually abused women, the now available data suggest a causal effect of traumatic events on PMDD (Wittchen et al. 2003). At the moment, the implications of this data on risk assessment of birth problems are unclear, but they will certainly stimulate more research about the specific effects for PMDD as well as for pregnancy outcomes.

Preparing for parenthood

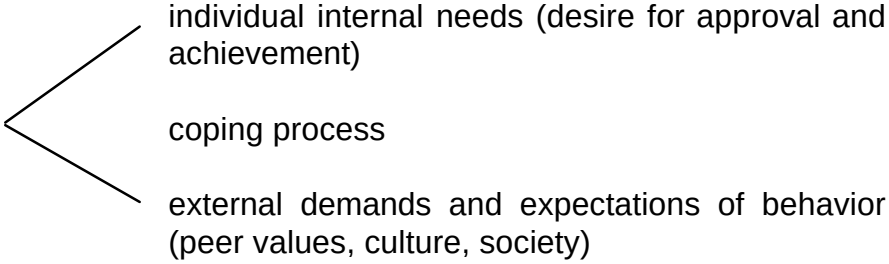
The number of men present during their partner's labor has increased to nearly 100% today. Decades ago, the medical professionals rejected fathers' presence for a variety of reasons. What has become evident in the meantime is that women who have their partners present while attending birth will suffer less pain, will need less medication, and have shorter labors (Niven 1985). Fathers attending the birth of their baby feel confirmed as fathers, and often reported that their presence in the labor facilitated a close relationship with the child, and that their involvement in the day-to-day care of their baby was easier to perform (Palkovitz 1987). To be involved in the birth attendance and antenatal care often gives fathers the feeling of being the parent and not just the provider, which helps reinforcing both the role of fathers and male role-taking. Finally, fathers must realize that they are involved in the pregnancy not only for the benefit of their partner and the baby, but also for themselves.

The birth of a baby is just the beginning of major change in the life of its parents. There is no question that the mother is the one most profoundly affected. We fully agree with Ball (1995), when he states: "as childbirth is such a common experience, it is perhaps easy to overlook the tremendous and unique changes which it brings." Contrary to the general joy and delight related to the offspring, the process of pregnancy and parenthood leads to a serious of losses: loss of control over one's physical state, loss of control over lifestyle and the loss of sleep which caring for a small baby brings (Ball 1995). The tremendous changes require a period of adjustment and adaptation. The birth of a baby is not only the beginning of the infant's life, but it is also a major life-

change for the entire family and the wider society. In most cultures the birth is marked by a variety of rituals and rites of passage.

Postnatal care and outcome studies usually focuse on the mother and her baby. When the father is considered, in most cases it is as the absent father. The number of single-parent families or functional single parent-parent families (due to the absence of one parent, in most cases the father) has increased over the years and is estimated to touch the 50% rate soon. Fathers-to-be, especially first-time-fathers, are often suffering from couvades (??) syndrome. The prevalence varies from 10% to over 60% (Khanobdee et al. 1993). Men suffer from postnatal depression up to 9% (Ballard et al. 1994). Several risk factors identified for women as increasing the likelihood of postnatal depression, are directly related to their partners' mental health, e.g. poor martial relationship and lack of social support. Again, there is an abundance of literature examining postnatal depression in women, but not in their male partners. Studies suggest that non-depressed partners may buffer the effects of infants having depressed mothers (Hossain et al. 1994). The quality of the relationship is an important source for the woman's well-being, and caregivers should therefore encourage both parents to discuss any difficulties they may be having in the transition of parenthood.

Although positive aspects will counterbalance the stress provoked by any major life-change, some fail in the transition process. The satisfaction of personal needs produces a state of emotional security which can be described as an internal feeling-state of confidence and emotional well-being. When the normal mechanisms for dealing with changes are not effective, some degree of stress will be experienced. Postnatal depression (onset within one year after childbirth) is the most common mental health problem after childbearing, affecting approximately 10-15% of all women. The baby blues has a considerable impact both on the newborn (Grace et al. 2003), as on the mother and the family. Young infants are highly sensitive to the quality of care they receive, and the child's brain development depends directly on the interaction with the mother (Glaser 2000). Data on psychosocial interventions clearly indicate that prevention of postnatal depression by offering intervention courses such as "preparing for parenthood" is effective (Wheatley et al. 2003).



The coping process as described by Lazarus (1969). The coping process illustrates how a person responds to change or stress. Lazarus places great emphasis on the need to understand the coping process in the context of the individual's environment and the socio-cultural support someone receives.

To remain realistic, it is important to consider data from young urban adolescent girls, which often suffer from a compounded community trauma, and a high proportion among them become teenage mothers. In interviewing these young mothers Horowitz et al. (1995) reported that: “only in their relationship with their young baby they are able to experience a zone of safety, connectedness, and trust otherwise missing in their lives.” Just referring them to a psychiatrist does not work. “.. the high rate of avoidance symptoms noted in these adolescent girls is one indicator of the unlikelihood that they would seek or accept standard psychiatric treatment ...” (Horowitz et al. 1995).

Sex offenses are generally thought of as being committed by men. There is increasing knowledge about female sexual offenders (Cavanagh Johnson 1989). At the same time, in her article Cavanagh Johnson noted that 100% of the examined females who molested children had been previously sexually abused, and 85% of them by family members. Despite the fact that articles from 50 years ago had already pointed out that incest is far more prevalent in our society that one would estimate (Raphling et al. 1967), the vast majority of professionals tend to ignore the disturbing facts. To simply expect that women will disclose things such as maternal-neonatal incest is unrealistic (Chasnoff et al. 1986). However, such things do happen, as unbelievable as it may sound.

As professionals involved in child birth and neonatal care, our understanding should be based on scientific results rather than on general assumptions. We should take note of these facts, which help us to enlarge our understanding of certain problems. Most of the knowledge about the associations of sexual trauma and the impact on personal development has been gained through therapeutically working with both victims and offenders. The professional community should take note of these findings, because there is increasing evidence that a history of sexual abuse constitutes a major risk factor for the development of severe mental problems (Heim et al. 2001, 2002). Whether these experiences constitute a major risk factor for pregnancy difficulties, birth complications, and postpartum maternal imbalances, including family disturbances, should be carefully examined.

As a mother once told me during a treatment session: “The abuser of my son not only abused my loved one, but he also abused the whole family.” Sexual abuse always has an impact on associated victims as well. Partners of victims of sexual abuse need help and support, often to a greater extent than the effort for the direct victim. The lack of general awareness of their situation and the help offered to these associated victims is often minimal.

Medium and long term care

Experiences of sexual trauma and emotional neglect can have a direct impact both on women’s health as well as an indirect impact on their infants and their partners. There is an increased risk for suicidal and even homocidal behavior, and for negative health behaviors such as failure to maintain healthy body weight (Springs et al. 1992, Felitti 1991). Substance abuse and excessive smoking among traumatized women has been demonstrated by various studies

(references see Rodgers et al. 2003). In a paper presented by Legl to the 7th Conference of IATSO Vienna 2002, he reported that among the patients admitted to the substance abuse treatment unit, about 80% of all women and about 60% of all men reported histories of sexual abuse. Traumatized women also smoke more heavily than non-traumatized women (Anda et al. 2002). Smoking puts mothers at an increased risk for having spontaneous abortions. Offspring of smoking women are at a considerable risk for thyroid enlargement (Chanonie et al. 1991), low birth weight and deformities (Haustein 1999).

The experience of sexual trauma is also associated with risky sexual behavior (Springs et al. 1992). Some of them engage in promiscuous and abusive relationships, where they are re-traumatized. They have sex without contraception, have multiple sexual partners, often without knowing their partner's sexual history, all of which puts these women at a greater risk of acquiring STDs (sexually transmitted disease) such as HIV. The consequences of adult sexual traumatization and domestic violence are greater in persons suffering from CSA due to the re-traumatization. STDs are clearly linked to a variety of adverse pregnancy outcomes, including ectopic pregnancy, preterm birth, puerperal sepsis, and abnormalities of the major organ systems (Moodley et al. 2000).

With the focus on attachment interventions, psychiatry provides a trans-generational understanding of adverse personal experiences on human interactions and development (Levy et al. 1998). The inner working model of relationships and related social expectations are based on the basic experiences provided by attachment figures such as parents. Other data on relational aspects are gained from an area which seems to be far away from the subject we are dealing with, which is the individual's vulnerability to combat stress. A regression analysis indicated that the father's negative parenting behaviors were more predictive of PTSD symptoms severity and at relatively lower levels of combat exposure in Vietnam veterans (McCranie et al. 1992), than the direct combat influence itself. It is therefore not surprising that in a study published by Cohen et al. (2000), they found that childhood sexual abuse was strongly associated with later domestic violence.

According to Monk (2001), maternal anxiety disorders are associated with low birth weight and irritable neonatal behaviors. Other researches, such as Seng et al. (2001), have reported that women diagnosed with PTSD were at higher risk for ectopic pregnancy, spontaneous abortion, and hyperemesis, than those without this diagnosis. Currently, there is no literature available that shows whether psychiatric treatment will have an effect on pregnancy outcomes in affected women. Hypothetically we can assume that analogous to the influence on stress related symptoms, psychotherapeutic interventions will have an effect on these women (Heim et al. 2002). There is a clear need for further research in this area. We can assume that untreated psychiatric conditions put both women and their offspring at higher risk for many negative outcomes during pregnancy and in the postpartum time.

Psycho-educative interventions about personal risk factors associated with earlier life experiences and their relations to current symptoms as well as their relation to birth and postnatal problems are an essential part of every therapeutic strategy. Many patients reported that they have never been asked about their trauma history, especially never about devastating experiences with other professionals. According to our experience, affected women appreciate it very much when these issues are being addressed. The general belief shared by many professionals is that asking about bad experiences will always lead to detrimental effects. However, this is a misconception and probably has more to do with a negative attitude towards the reality these women suffer from. It is disturbing to hear these stories without knowing what to do professionally, so there is a clear need to integrate this topic in medical formation and training.

Integration into medical formation curriculum

Emotional and psychosocial aspects are often considered as mere addenda in traditional medical formation. The subject of sexual violence - which highly influences women and children's personal development - is often neglected by academic teachers (WHO 2002) Even professionals working in the area of CSA treatment did not receive systematic training on the topics of sexual violence (Campbell et al. 1995). Decision makers tend to consider sexual violence more as a problem of the criminal justice system then that of health care. Without question, the participation in specific training programs improves professionals' knowledge about sexual abuse issues (Hazzard et al. 1986, Hibbard et al. 1987).

There is an urgent need, from both economic and developmental consequences, to integrate this topic into medical school curricula. Switzerland, as many other countries, failed to do this in its most recent update of learning objectives for medical training (Buergi et al. 2002). We see a considerable bias among academic teachers related to the issue of sexual violence. This bias is even greater when related to PSM. Consequently health care professional have no awareness of the magnitude of the problem, and due to this lack in psychopathological knowledge are often unable to diagnose sexual and domestic violence in their patients. The recent discussion about patients' safety has clearly shown that the health care system needs fundamental changes (see report: To err is human, 2001).

Establishing a comprehensive care program with close cooperation between obstetricians and psychiatrists helps the physicians gain awareness of the underlying psychological problems. The cooperation also helps to overcome the "single-disciplinary ghetto effect", a traditional formation we still have today. By establishing an interdisciplinary approach, both psychiatry and obstetricians can share their experiences and create a framework for how to approach the issue scientifically. The program provides an in-depth awareness for participants, which enables them to establish an effective prenatal risk assessment and to identify those women who are in need of supportive psychiatric treatment. This paradigm shift is in concordance with the most recent medical guidelines (Charter 2002), which stipulates under professional

responsibilities a commitment to professional competence: „Physicians must be committed to lifelong learning and be responsible for maintaining the medical knowledge and clinical and team skills necessary for the provision of quality care. More broadly, the profession as a whole must strive to see that all of its members are competent and must ensure that appropriate mechanism are available for physicians to accomplish this goal."

The charter also stipulates an integration of practical knowledge of those working in the field: "Physicians must be dedicated to continuous improvement in the quality of health care. This commitment entails not only maintaining clinical competence but also working collaboratively with other professionals to reduce medical error, increase patients' safety, minimise overuse of health-care resources, and optimise the outcomes of care. Physicians must actively participate in the development of better measures of quality of care and the application of quality measures to assess routinely the performance of all individuals, institutions, and systems responsible for health-care delivery. Physicians, both individually and through their professional association, must take responsibility for assisting in the creation and implementation of mechanisms designed to encourage continuous improvement in the quality of care."

Emphasis should also be given to the fact that working with patients who has personal traumas can be very demanding and therefore, caregivers, too, need to be supported. We should not forget that the impact of working with the problem of sexual abuse can be seen as paralleling the impact of sexual abuse itself. Denial, secrecy, rationalization, avoidance, disbelief and victim-blaming are all the factors influencing professionals (Erooga 1994). The impact of sexual violence remains highly controversial, leading to ambivalent attitudes and many tensions within the professional community. There is lack of consensus, which for sure does not help victims to overcome their devastating experiences.

Conclusions

- To provide optimal care, identification of psychological risk factors is important early in pregnancy.
- A comprehensive risk assessment is based on both emotional and somatic problems.
- The high prevalence of sexual abuse makes it likely that a substantial proportion of pregnant women have been victims of sexual trauma at some point in their lives.
- PSM (Professional Sexual Misconduct) does not just happen elsewhere, it also takes place within gynecologists, midwifes, as well as nursing and other hospital staff.
- The identification of histories of sexual abuse and emotional neglect is only possible if professionals know what and how they have to address these issues.
- Increased physician monitoring of those patients suffering from devastating life experiences may significantly reduce pregnancy complications and poor pregnancy outcomes.

- The subject of sexual violence and its impact remains highly controversial, therefore lack of consensus in the professional community, which impedes helping victims overcome their devastating experiences.
- Referring patients with histories of sexual abuse and emotional neglect as early as possible to psychotherapeutic treatment is essential.
- There is clear need to a curricular integration of sexual and domestic violence into medical formation and training.
- Women and their partner also need education about risk factors and their impact on personal developments and outcomes.
- Cooperation between psychiatry and obstetricians helps overcome the single disciplinary ghetto effect, and also helps with better identifying possible risk factors in pregnancy.

References

- Anda RF, Croft JB, Felitti VJ: Adverse childhood experiences and smocking during adolescence and adulthood. JAMA, 2002;282:1652.
- Ball JA: Reactions to motherhood. The role of postnatal care. Books for Midwives, Oxford.
- Ballard CG, Davis R, Cullen PC, Mohan RN, Dean C: Prevalence of postnatal psychiatric morbidity in mothers and fathers. British Journal of Psychiatry, 1994;164:782-788.
- Bloom J.D., Nadelson C.C., Notman M.T. (1999). Physician sexual misconduct. American Psychiatric Press, Washington DC.
- Bridges N. (1998). Teaching psychiatric trainees to respond to sexual and loving feelings: The supervisory challenge. Journal of Psychotherapy Practice and Research 7:217-226.
- Briere J, Conte J: Self-reported amnesia for abuse in adults molested as children. Journal of Traumatic Stress 1993;6:21-31.
- Brown Daniel, Scheflin Alan W., Hammond D. Corydon (1998). Memory, Trauma, Treatment and the Law. W.W. Norton, New York.
- Buergi H, Bader C, Bloch R, Bosman F, Horn B, Im Hof V, Keel P, Spinas GA: Swiss Cataloge of Learning Objectives for Undergraduate Medical Training. Joint Commission of the Swiss Medical Schools, Bern, 2002.
- Campbell JA, Carlson K: Training and knowledge of professionals on specific topics in child sexual abuse. Journal of Child Sexual Abuse 1995;4:75-86.
- Cavanagh Johnson T: Female child perpetrators: children who molest other children. Child Abuse and Neglect 1989;13:571-585.
- Chanonie JP, Toppet V, Bourdoux P, Spehl M, Delange F: Smoking during pregnacy: a significant cause of neonatal thyroid enlargement. Br J Obstet Gynaecol, 1991;98:65.
- Charter on Medical Professionalism: Medical professionalism in the new millennium: a physicians' charter. Ann Intern Med 2002;136:243-46, simultaneously published in: Lancet 2002;359:520-522.
- Chasnoff IJ, Burns WJ, Schnoll SH, Burns K, Chisum G, Kyle-Spore L: Maternal-neonatal incest. Amer J Orthopsychiat 1986;56,4:577-580.
- Cohen M, Deamant C, Barkan S et al.: Domestic violence and childhood sexual abuse in HIV-infected women and women at risk for HIV. Am J Public Health, 2000;90:560.
- Erooga M: Where the professional meets the personal. In: Morrison T, Erooga M, Beckett RC (Eds.): Sexual offending against children. Routledge, London, 1994, pp. 203-220.
- Farber ED, Showers J, Johnson CF, Joseph JA, Oshins L: The sexual abuse of children: a comparison of male and female victims. Journal of Clinical Child Psychology 1984;13:294-297.
- Felitti VJ: Long-term medical consequences of incest, rape and molestation. South Med J, 1991;84:328.
- Fonagy P, Gergely G, Jurist EL., Target M: Affect Regulation, Mentalization, and the Development of the Self. Other Press, New York, 2002.
- Foy DW: Introduction and description of the disorder. In: Foy DW (Ed.): Treating PTSD: cognitive-behavioural strategies. Guilford Press, New York, 1992.
- Glaser D: Child abuse and neglect and the brain - A review. Journal of Child Psychology and Psychiatry, 2000, 41(1):97-118.
- Grace SL, Evindar A, Stewart DE: The effect of postpartum depression on child cognitive development and behavior: A review and critical analysis of the literature. Arch Womens Mental Health 2003;6:263-274.
- Haustein KO: Cigarette smoking, nicotine and pregnacy. Int J Clin Pharmacol Ther, 1999;37:417.

- Hazzard A, Rupp G: A note on the knowledge and attitudes of professional groups toward child abuse. Journal of Community Psychology 1986;14:219-223.
- Heim C, Nemeroff CB: The role of childhood trauma in the neurobiology of mood and anxiety disorders: preclinical and clinical studies. Biol Psychiatry 2001;49:1023-1039.
- Heim C, Newport DJ, Bonsall R, Miller AH, Nemeroff CB: Altered pituitary-adrenal axis responses to provocative challenge tests in adult survivors of childhood abuse. Am J Psychiatry 2001;158:575-581.
- Heim C, Newport DJ, Wagner D, Wilcox MM, Miller AH, Nemeroff CB: The role of early adverse experience and adulthood stress in the prediction of neuroendocrine stress reactivity in women: a multiple regression analysis. Depression and Anxiety 2002;15:117-125.
- Hibbard RA, Serwint J, Connolly M: Educational program on evaluation of alleged sexual abuse victims. Child Abuse and Neglect 1987;11:513-519.
- Horowitz K, Weine S, Jekel J: PTSD symptoms in urban adolescent girls: compounded community trauma. J Am Acad Child Adolesc Psychiatry 1995;34,10:1353-1361.
- Hossain Z, Field T, Gonzales J, Malphurs J et al.: Infants of depressed mothers interact better with their non depressed fathers. Infant Mental Health Journal, 1994;15:348-357.
- Khanobdee C, Sukratanachaiyakul V, Gay JT: Couvade syndrome in expectant Thai fathers. International Journal of Nursing Studies, 1993;30:125-131.
- Kitzinger S: Birth and violence against women generating hypotheses from women's accounts of unhappiness after childbirth. In: Roberts H (Ed.): Women's health matters. Routledge, London, 1992, pp. 63-80.
- Lamott F, Pfaefflin F: Bindungsrepresentationen von Frauen, die getötet haben. (No translation available: attachment patterns of women who have killed) Mschr Krim 2001;84:10-24.
- Lazarus RS: Patterns of adjustment and human effectiveness. McGraw Hill, New York, 1969.
- Legl T: Sexual abuse and addiction therapy. Paper presented to the 7th Conference of the International Association for the Treatment of Sexual Offenders, Vienna, September 11-14, 2002.
- Levy TM, Orlans M:: Attachment, Trauma, and Healing. Understanding and Treating Attachment Disorders in Children and Families. CWLA (Child Welfare League of America) Press, Washington DC, 1998.
- Loftus EF, Polonsky S, Thompson Fullilove M: Memories of childhood sexual abuse. Remembering and repressing. Psychology of Women Quarterly 1994;18:67-84.
- Lyons S: Post-traumatic stress disorder following childbirth: causes, prevention and treatment. In: Clement S (Ed): Psychological perspectives on pregnancy and childbirth. Churchill Livingstone, Edinburgh, 1998, pp. 123-143.
- MCCranie EW, Hyer LA, Boudewyns PA, Woods MG: Negative parenting behavior, combat exposure, and PTSD symptom severity. J Nerv Ment Dis 1992;180:431-438.
- Monk C: Stress and mood disorders during pregnancy: implications for child development. Psychiatric Q, 2001;72:347.
- Moodley P, Sturm AW: Sexually transmitted infections, averse pregancy outcome and neonatal infection. Semin Neonatol, 2000;5:255.
- Niven C: How helpful is the presence of the husband at childbirth? Journal of Reproductive and Infant Psychology, 1985;3:45-53.
- O'Connor AA: Female Sex Offenders. British Journal of Psychiatry 1987;150:615-620.
- Palkovitz R: Fathers' motives for bith attendance. Maternal-Child Nursing Journal, 1987;16:123-129.
- Raphling DL, Carpenter BL, Davis A: Incest - A genealogical study. Arch Gen Psychiat 1967;16:505-511.
- Russel D: The incidence and prevalence of interfamilial and extrafamilial sexual abuse of female children. Child Abuse and Neglect 1983;7:133-146.
- Russel D: The secret trauma: incest in the lives of girls and women. New York, Basic Books, 1986.
- Ryding EL: Investigation of 33 women who demanded a caesarean section for personal reasons. Acta Obstetrica et Gynecologica Scandnavica, 1993;72:280-285.
- Salkovskis PM: Somatic problems. In: Hawton K, Salkovskis PM, Kirk J, Clark DM (Eds.): Cognitive behaviour therapy for psychiatric problems. Oxford, Oxford University Press, 1989.
- Seedat S, Stein MB, Osthuizen PP, Emsley RA, Stein DJ: Linking posttraumatic stress disorder and psychosis. Journal of Nervous and Mental Disease 2003;191:675-681.
- Seng JS, Oakley DJ, Sampselle CM, Killon C, Graham-Bermann S, Liberzon I: Posttraumatic stress disorder and pregancy complications. Obstet Gynecol, 2001;97:17.
- Sharpe M, Carson A: Unexplained somatic symptoms, functional symptoms, and somatization: do we need a paradigm shift? Ann Intern Med 2001;134:926-930.
- Simon R: Sexual exploitation of patients : How it begins before it happens. Psychiatric Annals 1989; 19,2:104-112.
- Sinason V: Attachment, Trauma and Multiplicity. Working with dissociative identity disorder. Brunner-Routledge, Hove, 2002.

- Springs FE, Fredrich WN: Health risk behaviors and medical sequelea of childhood sexual abuse. Mayo Clin Proc, 1992;67:527.
- Tschan W: Missbrauchtes Vertrauen - Grenzverletzungen in professionellen Beziehungen. (No translation available: Breach of trust - boundary violations by professionals) Karger Verlag, Basel, 2001.
- Tschan W, Harder F: PTSD in der hausärztlichen Praxis: erkennen-verstehen-behandeln. (No translation available: PTSD and the general practitioner: diagnosing-understanding-treating). Swiss Medical Forum, 2004;4:392-397, 417-421.
- Wilbers D, Veenstra G, van de Wiel HBM, Weijmar Schultz WCM: Sexual contact in the doctor-patient relationship in the Netherlands. British Medical Journal 1992, 304; 1531-1534.
- Wheatley SL, Brugha TS, Shapiro DA: Exploring and enhancing engagement to the psychosocial intervention <Preparing for parenthood>. Arch Womens Ment Health 2003;6:275-285.
- Wittchen HU, Perkonigg A, Pfister H: Trauma and PTSD - an overlooked pathogenetic pathway for premenstrual dysphoric disorder? Arch Womens Ment Health 2003;6:293-297.

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