

Children's nutrition, physical and sexual health: victims of HIV/AIDS, children with disabilities, child refugees, children who suffer from malnutrition, pre natal, natal and post natal traumas

Giving Children a Voice: The transforming role of the family in a global society.

World Congress on "Children without Childhood: Awareness and Action"

January 3-7, 2009. New Dehli, India

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Each of us

Sister and Brother, Mother and Father, Teacher and Student, Manager and Worker, President and Prime Minister must add a voice to this call for action.

Not tomorrow or the next week – but now.

Nelson Mandela, at the Fifth World Congress on Family Law and Children's Rights. Cape Town, South Africa, 2005.

Abstract

Children's nutrition, physical and sexual health: victims of HIV/AIDS, children with disabilities, child refugees, children who suffer from malnutrition, pre natal, natal and post natal traumas

The birth of a baby is a time of transition and it is just the beginning of major change in the life of its parents. However, postnatal care and outcome studies usually focus on the mother and her baby only, and they only rarely consider the family context. During the life cycle offspring may suffer from the conditions of their parents – what effects the family effects the offspring. Young children are highly sensitive to the quality of care they receive, and the child's brain development depends directly on the interaction with the family. Professionals in the area of child development must be aware, that the vast majority of interpersonal violence takes place within the family environment. Family members, who commit harm to their offspring, are simultaneously in the role of care-givers – the traumatic results lead to a complex disturbance in affected children, and has long lasting effects. The presenter will focus on the evidence based facts provided by Attachment Theory to understand the needs of offspring and the traumatic results, when these conditions are not provided. Emphasis will also placed on the importance of training professionals in this area.

During the life cycle offspring are threatened from their earliest beginnings to suffer from the conditions of their parents – what effects the parents effects the offspring (Finkelhor 1984). Human beings are depen-

dent on their caregivers not just in physical terms but also in emotional terms. The presenter will focus on the evidence based facts provided by Attachment Theory (Bowlby 1988) to understand the needs of offspring and the traumatic results, when these conditions are not provided.

Preparing for parenthood

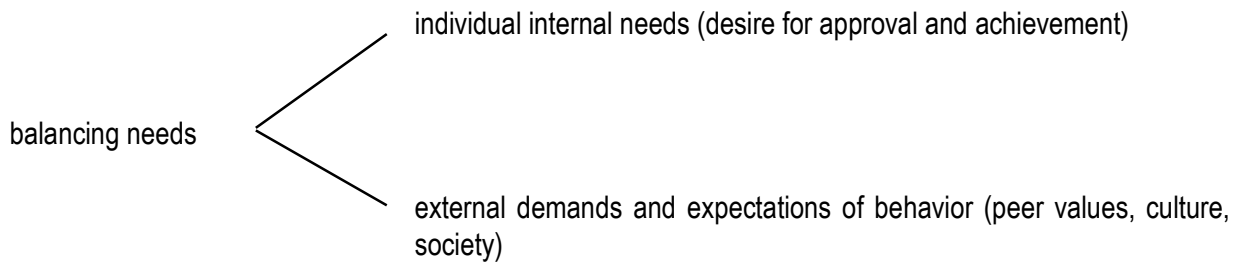
The number of men present during their partner's labor has increased to nearly 100% today in Western countries. Decades ago, the medical professionals rejected fathers' presence for a variety of reasons. What has become evident in the meantime is that women who have their partners present while attending 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 during 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 to reinforce 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 initiates a time of transition and it 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 series 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. This is mirrored in the Congress' subtitle: "*The transforming role of the family in a global society*".

Postnatal care and outcome studies usually focus on the mother and her baby. When the father is considered, in most cases it is as the absent father. In Western counties the number of single-parent families or functional single-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 marital 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 family (Glaser 2000). Data on psychosocial interventions clearly indicate that prevention of postnatal depression by offering intervention courses such as "preparing for parenthood" are effective (Wheatley et al. 2003).



The coping process as described by Lazarus (1969). The coping process illustrates how a person responds to change. 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 than one would estimate (Raphling et al. 1967), the vast majority of professionals tended to ignore the disturbing facts for a long time. 25 years ago one could read in top ranking psychiatric text books, that incest is a rare phenomenon, affecting one to two children out of a million. 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.

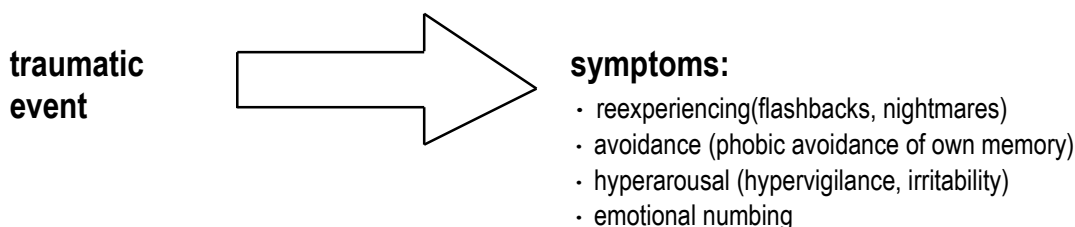
As professionals involved in developmental issues, our understanding should be founded on evidence based facts rather than on general assumptions. We should take note of these facts, which help us to enlarge our understanding of certain problems. Most of the knowledge about the associations of sexual 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.

The family as a place of violence: pre natal, natal and post-natal traumas

The vast majority of interpersonal violence takes place within the (extended) family environment. There are four main avenues which lead to psychological problems related to pregnancy and delivery: (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 of the physicians first tasks. The PTSD concept can serve as a model, how psychiatrists diagnose these effects: 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 in 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. This is mainly related to the fact, that family members, who commit a sexual crime towards their offspring are simultaneously in the position of care-givers. The results are complex and chronic traumatic experiences. Therefore the outcome

is characterized by polytraumatisation, which can be diagnosed as DID, personality disorder, depression, psychosis, substance abuse, somatic problems such as eating disorder, chronic pain disorder, fibromyalgia, chronic urogenital 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 within the last ten years.

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, this leads to a great variation of research findings. The recently published World Report on Violence and Health by the WHO (Krug et al. 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 abuse 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
- lack of 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.

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 pregnancy 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 insecure attachment (dismissing 31%, enmeshed-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.

The aftermath of traumatic events

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 homicidal 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 founded 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 and often overwhelming to hear these stories without a

clear concept on how to react - therefore there is a urgent need to integrate this topic in medical formation and training.

Training of Professionals

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 (Krug et al. 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 than 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 (Professional Sexual Misconduct). Consequently health care professionals 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 mechanisms 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 errors, increase patients' safety, minimize overuse of health-care resources, and optimize 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.

Creating a common language

Although psychiatrists are involved in almost all parts of the life-cycle, their experience and knowledge has been widely neglected by other physicians. Until the mid 1990s only little research has examined the impact of traumatic events on pregnancy and post-partum outcomes. The traditional prepartal 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 quite 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 Herman 1992).

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 specificity), and whether different individuals react in characteristic ways to stimuli (individual-response specificity). 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 available and that the only avenue for further help is through the acceptance of psychological help (Salkovskis 1989). 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 marital 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, pediatricians and other health care professionals who want to improve their risk assessment capacity by including emotional aspects (Sinason 2002). 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 complications, 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 (Van der Hart et al. 2006). 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). The professional community has to take note of these evidence based facts, in order to offer best practice for patient care.

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.
- 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.

Note: This is an up-dated version of a presentation given to the 157th American Psychiatric Association Annual Meeting in New York, May 04, 2004.

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Acknowledgement

I appreciate the work by native English speaking Clare Kenny who improved the style of this handout considerable.