Psychological Challenges in Obstetrics and Gynecology
Foreword

This book goes a long way to remind us that the patient is both mind and body, and that the best medical practice recognises this and is learned in this context. It is therefore a great pleasure for me to have been asked to introduce and recommend this book, which represents a very considerable volume of work, enhanced by the contributions of so many distinguished practitioners and specialists. Whether for learning and knowledge, or used as a reference, this book will meet a need that is now both recognised and better understood. Many of the chapters are a real pleasure in themselves, and the book is packed with sound evidence, factual material and new information.

Don’t delay being acquainted with its contents. It has been my pleasure and privilege to have been asked to review the book and to write this foreword.

ALLAN TEMPLETON
Regius Professor of Obstetrics and Gynaecology
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Foreword

I am delighted to write a foreword for this innovative and thought-provoking book, which gives an excellent overview of the field.

Psychological challenges in obstetrics vary from the expected adjustments that every new mother faces through to high-risk pregnancies in which infant or maternal death is a possibility. It is crucial to know that suicide is the leading cause of maternal death in the United Kingdom and to realise that prevention of suicide needs psychological and psychiatric problems to be recognized early in pregnancy by everyone involved in maternity care.

A woman’s mental state will also affect other aspects of her health and her ability to access both obstetric and gynecologic services. At the Royal College of Psychiatrists, we assert that there is no health without mental health. This book supports our assertion, and I hope readers have a better understanding of their own role in helping women to achieve health outcomes through recognising this.

PROFESSOR SHEILA HOLLINS
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Preface

We have set out to make this a practical book to help all those working in Obstetrics and Gynecology to incorporate psychological aspects of care into their everyday work. By listening to our patients and colleagues, it has become increasingly clear to us that integration of mind and body is essential to the future of our specialty. When highly trained doctors find that their technical expertise is of no benefit to their patients, or indeed on occasion harmful, they are left feeling lost and inadequate. Their patients are also lost when the emotional aspects of their symptoms are neither recognised nor acknowledged. The patients tend to wander from doctor to doctor, using up resources and losing faith in the health system.

There is accumulating scientific evidence that mind and body are connected. The discipline of science has been evolved to look at that which is measurable, relegating the feelings and emotions that make us human and disconnecting them from the organic processes of the body. This narrow scientific approach has its limitations; it is not a reason to dismiss what we refer to as psychosomatic medicine. The scientific community is beginning to recognise research which shows that emotions and physiology are indeed connected. We in medicine must move forward and embrace this integrated approach. Psychosomatic is a maligned and misunderstood word, but it is only incorporating the mind and the body, which is the ideal way to practise all medicine.

But where to start? We wanted to write this book to collect together our current knowledge of the role of the psyche in obstetrics and gynecology, and also to be practical in showing how this can be used in the clinical situation. There is much we can do and learn, recognising at the same time that there is much we do not know or understand. We need to learn to modify our approach, to use both the medical models, but be able to incorporate psychological thinking as well. This book provides an introduction to some of the more common issues in obstetrics and gynecology. The chapters are easily read, are short enough to read in an evening, and also have useful references and websites to help the reader find out more. This book is unique in that the experts have covered both an up to date theory base and also given useful tools for immediate application to the clinical situation. It can be read as a stand-alone handbook or used as a reader after an interesting clinic or case when you want to think and explore more about a single issue or feeling that has come up. It covers topics not covered in other textbooks.
Part One covers basic issues, from improving “listening” in the clinic – important for all training and medical practice – and covers some basic issues that are changing in this advanced technological age. Obstetrics and gynecology is the specialty of life, love, sex and death, all the big things that underpin our lives as human beings. Our experience of these has been changing as society changes. We have also included some basic ideas as to how psychosomatic medicine should be incorporated in training. Continental Europe is more advanced in this respect than the UK.

Part Two gathers together both techniques to help the normal obstetrician understand how the patient is coping and how that manifests itself physically, giving some structure to our thoughts. We then cover some of the commonly seen topics in obstetrics.

Part Three is conventionally gynecology. Fifty per cent of the patients in a gynecology clinic have significant distress as well as the physical problem they present with. The topics covered are again the more common topics that challenge us everyday.

After reading this we expect you to feel more in control and more understanding of the issues and their complexity. You will have the tools to actually recognise if the patient is not coping, rather than just having “a gut feeling”. We hope you will have a structure for your intuitive thoughts, as well as some practical ideas on easily helping the majority of women, at least by recognition and validating and getting the problems out in the open so that they can be thought about. This will also give you the confidence to make good and appropriate referrals to the limited-support psychological services that are so pitiful in today’s health system.

We particularly wanted to write this book for those who are training in obstetrics and gynecology. Too often the technical solutions seem inadequate. Despite trying your best, the consultation feels unsatisfactory. Complex patients are demanding and difficult, and there is no training for these situations. Too often trainers hide behind dismissive attitudes and blame the patient, or just delegate the difficult patients, or if it doesn’t respond to surgery discharge them to the GP.

This book can also provide information and help to GPs who already have some training in the social and psychological aspects of ill health, to work more closely with patients in the community setting. Sadly, being a hospital doctor these days seems to mean that you leave the community behind. We regret this and feel that it dilutes the quality of care.

Midwives, nurses, physiotherapists and all health workers in related fields will find plenty that is relevant to them, particularly as often the patient will speak to you, rather than the doctor. Whilst training in these areas may include more community aspects, we hope to provide a useful grounding in what is known in psychology and psychotherapeutic practice, that is useful to add to the repertoire.

We hope that medical students will read this book and gain inspiration. Many medical students are reported to feel that their humanity and caring are removed during their training. We believe this is because the feelings and
psychological aspects are removed both for the patient and for the doctor, leaving the new enthusiast feeling sterile and removed from the patients. This book is easy to understand, and we hope it will inspire you to stay with your enthusiasm for healing. Technology has a very important place, accept that, but be prepared to look out for the practitioners who are able to be with their patients in understanding the problems in the context of the patients’ lives, not just a set of algorithms.

We also have enjoyed reading all the contributions and have learned a lot, and clarified our thinking. Thus, we hope that many more senior clinicians will enjoy and learn from this book. Many of us have had to learn the hard way, seeking out information that was scrappy and not integrated. We also hope it will help all trainers by providing a basic text and starting point.

This book is not to make us psychologists – that has its own training – but should help make us more aware, help provide an integrated psychological, social and biological approach for our patients, thus helping many more than we do. Giving us confidence to work in this area, providing better service for our patients, and helping us feel more satisfied with our work and less scared of the complex problems for which we were previously ignorant and untrained.

JAYNE COCKBURN
MICHAEL E. PAWSON
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Part One
Background for the Study of Psychosomatic Obstetrics and Gyneocology
1 Teaching Psychosomatic Obstetrics and Gynecology

Johannes Bitzer

1.1. The Essentials of Psychosomatic OB/GYN

Residents in gynecology as well as specialists have been trained for many years in accordance with the concepts of biomedical thinking and practice. This basic way of understanding patients’ health problems can be described as follows:

Symptoms are caused by objectively measurable (biological) factors, which constitute disease entities independent of individuals. These diseases are defined in the biomedical code and structured into subunits like etiology, pathophysiology, diagnostic procedures and therapeutic interventions. This code is international, is continuously adapted and the “truth” of the code is evaluated by using scientific evidence, which is the basis of standardized practice.

This approach is very useful and successful in a large number of clinical situations. Daily practical experience shows, however, that in a considerable part of the working time gynecologists and obstetricians are confronted with problems which do not fit into the biomedical model:

- The same disease entity evokes completely different responses in different individuals like a miscarriage, a cancer, a bleeding disorder, and so on. Where do these differences come from and how should the doctor understand them?
- The presented symptoms do not fit into any known disease entity like feeling bad, feeling exhausted and tired, feeling nauseated, feeling pain in different body regions without a detectable cause. Where do these symptoms come from and how should the doctor handle it?
- Patients and gynecologists are confronted with situations in which there is no one single evidence-based solution but patients have to make personal choices. How should gynecologists help in shared decision-making?
- A therapeutic intervention is well founded on scientific evidence but the patient does not comply. The health risks of some behaviors are very well proven but still the patient maintains her risk-prone behavior. What type of disease is this and how should the doctor diagnose and treat it?
Patients present personal problems like sexual difficulties, partner and family conflicts, stressful life events in the context of adolescence, pregnancy, postpartum, perimenopause, and postmenopause and seek help from their gynecologists. How can the doctor respond to these demands and problems?

Patients are experienced as difficult and demanding, and the gynecologist feels exhausted and burned out. Is there any disease category relating to the doctor–patient relationship and how should these disorders be treated?

All these situations point to the necessity of a complementary working model. This model can be called the biopsychosocial model of health and disease (1,2).

This model is characterized by the following features:

Symptoms as the manifestation of individual suffering are the result of an interaction of biological, psychological, and social factors, specific to the patient. This means that the basic unit of observation is the interaction of the disease process and the individual person in her life situation. Diagnostic procedures have therefore to add to the detection of measurable biological abnormalities an understanding of the patient’s life situation and patterns of thoughts, feelings, and behavior relevant to the illness state. Therapeutic plans take into account the characteristics of the motivation, the objectives, the decisions, and the behavior of the patient.

Enabling gynecologists to integrate this model into their daily working routine is the aim of teaching psychosomatic obstetrics and gynecology.

1.2. Teaching Basic Communicative Skills

1.2.1. Contents

As shown above, the principal component of psychosomatic thinking and practice lies in shifting the focus of attention from an isolated disease perspective to a balanced disease–person interaction view. To integrate more of the person into the consultation, physicians need a type of communication style which differs from disease-centered techniques (3,4):

Disease-centered communication: In disease-centered communication, the physician quickly takes the lead and determines the agenda. He/she uses the classical history taking with a catalogue of preformed questions, which usually should be answered as yes or no. These questions are based on disease entities and serve the purpose of reaching a diagnosis quickly. The patient is a passive recipient of a therapeutic prescription.
**Patient-centered communication:** In patient-centered communication, the patient gets space and time to tell her story (narrative). The questioning is much more of a Socratic dialogue with reference to the patient’s expression and feedback. There is respect for and response to emotions. The patient defines the agenda. The patient is an active partner in therapeutic decisions and interventions.

The basic elements of patient-centered communication are as follows (5,6):

**Active listening:** The gynecologist learns to listen in a way that encourages the patient to tell her story by

- **Waiting:** Giving the patient time to think and express herself. This means that the physician has to learn “not to talk” but use silence and pause as a means of encouragement.
- **Echoing:** Repeating a specific word or expression of the patient to signal attentive listening and that the physician follows the patient’s story.
- **Mirroring:** Reflecting body language or a whole verbal sequence in the words of the patient.

**Checking back and summarizing:** The physician summarizes in his/her words what he/she has understood from the patient’s story. This is the basis of mutual understanding by assuring that the physician and the patient have found a common language of exchange of information and the patient’s needs and her agenda have been understood.

**Response to emotions:** This is a difficult task which needs considerable exercise. The different steps are as follows:

- The physician first needs to become aware of his/her own emotions (e.g., feeling irritated, sad, worried, helpless).
- Then the physician has to try to perceive the emotions expressed by the patient (How does she feel?).
- Next the physician should try in his/her mind to verbalize the emotions expressed by the patient (she feels sad, worried, angry, frustrated, overwhelmed, etc.).
- The emotions perceived by the physician can then be reflected to the patient in a respectful way using sometimes the form of a question: “I can see that you are frustrated and angry. This situation must evoke a lot of anger and frustration, mustn’t it?”

**Information exchange:** A large part of a medical consultation deals with information giving. Physicians inform patients about risks and frequency of diseases, diagnostic measures and the diagnosis found, the prognosis of a disease, therapeutic options with success rates and side effects. This educational part needs didactic skills and some basic knowledge about how to transmit information.
Information giving is not a one-way process. It is always an information exchange process:

- In the first step the physician has to elicit the patient’s needs for information, her expectations, and her preexisting knowledge about the subject she would like to talk about.
- In the second step the physician gives a defined quantity of information. It is important that the information is given in small units and well structured, important parts are announced, and the patient is encouraged to interrupt this phase by direct questioning.
- The third step is equally important. The physician should elicit the patient’s understanding and interpretation of the information. This can be done by asking about the quantity, the speed, the clarity, and the understandability of the information given. In some situations (see later), it is equally important to ask the patient about the emotional meaning she gives to the information: “What does this information mean to you? Is it reassuring or worrying? Are there new questions coming up?”

In case of new questions the exchange process described above can restart.

1.2.2. Educational Methods

The above-mentioned techniques and their flexible use can be taught by means of

- **Critical incident reporting**: The resident in training gets the basic format of critical incident reporting. This means that in clinical situations in which the trainee feels that something went wrong she/he will try to recall the sequence of events commenting about the type of difficulty encountered. Then the supervisor can brainstorm together with the trainee about alternative options of communication and so on.
- **Video clips**: Videotaping of consultations including educational videos (videos with real patients and simulated patients).
- **Role play**: This is a useful instrument in which the trainees change roles. The roles are patient, physician, and observer. This helps them to experience the patient’s position and feelings.

1.3. Teaching Communicative Skills in Special Clinical Situations

1.3.1. Contents

There are special clinical situations which need specialized skills, based on the above-described techniques. These skills integrate elements of counseling and psychotherapy.
Breaking bad news: The situation of breaking bad news occurs frequently in oncology and infertility, less frequently in pregnancy care. The basic elements are as follows:

- Preparation for the encounter (Quiet setting, enough time, is all the information needed available? Does the patient come alone or accompanied by a family member or friend? What is the emotional situation of the physician?).
- Introduction (Joining with the patient by using a more personal issue, a brief summary of the previous events, and the objective of the consultation).
- Announcement (“Unfortunately I have to give you bad news”).
- Statement (Give the diagnosis in simple words).
- Waiting for the individual reaction of the patient (Stunned, paralyzed, confused, shocked, desperate, crying, stoic, denying, etc.).
- Response to the reaction (Emotion handling, reflecting, summarizing).
- Encouraging questions and giving further information in small pieces.
- Give hope (There is always something that can be done).
- Structure the near future (What is the patient going to do next – define the next steps to be taken and give appointments).

Risk and decision-making counseling: These situations occur in menopause, oncology, and so on. The physician needs some basic knowledge about risks and shared decision-making.

Basic principles of risk counseling are as follows:

- Clarify the needs, values, and objectives of the patient related to the specific issues of risks and decisions to be made.
- Elicit the need for information and the preexisting knowledge.
- Give a framework of risks relating to everyday experiences.
- Give absolute risk numbers; don’t use relative risks and conditional probabilities.
- Visualize risk numbers showing the relationship between risk and chances.
- Point to the other side of the risk, namely the chances.
- Encourage the patient to reflect about her values and the individual importance which she attributes to the benefits and risks shown.

1.3.2. Educational Methods

The techniques can be trained by the following:

- **Video clips**: Videotaping of consultations including educational videos (videos with real patients and simulated patients).
- **Role play**: This is a useful instrument in which the trainees change roles. The roles are patient, physician, and observer. This exposes them to new experiences.
1.4. Teaching the Application of the Biopsychosocial Model in Obstetrics and Gynecology

1.4.1. The Psychosomatic Diagnostic Process

1.4.1.1. Contents

The gynecologist in training and the practicing specialist will meet complicated cases in which a gynecological and/or obstetrical diagnostic entity cannot be established and the standardized somatic interventions cannot be used or are inefficient. The typical clinical situations are as follows:

- The patient with physical symptoms that cannot be explained by organic pathology (the “psychosomatic or somatoform” patient).
- The patient in whom the response to a disease leads to severe psychological symptoms (the “somatopsychic” patient).
- The patient with mental and behavioral problems interacting with gynecological and obstetrical diseases (the “comorbid” patient).
- The patient with sexual and relational problems (the “sexual dysfunction” patient).

For all these patients the psychosomatic diagnostic approach demands the integration of psychosocial information into the working hypothesis of a clinical problem. This means that we need some knowledge and concepts concerning psychosocial pathogenetic factors.

From clinical experience and the literature, we have developed the following mnemonic (12, 13):

- **A = Affect**: This means that the physician should be aware of a predominant affective state like depression, anxiety, and so on. This also includes some basic knowledge about the prevalence and the diagnostic possibilities to detect affective disorders.
- **B = Behavior**: Frequently, risk-taking or health-damaging behavior plays an important part in the pathogenesis or complication of clinical disorders in OB/GYN. This is especially true in obstetrics, where behavioral problems have an important impact on the health of the mother and the child.
- **C = Conflict**: Conflicts can be either external or internal and can be subdivided into attraction versus attraction, avoidance versus avoidance, and attraction versus avoidance types of conflicts. Chronic unresolved conflicts lead to chronic stress, reduced motivation, depressive and anxious mood, and social difficulties, which may all together impair health.
- **D = Distress**: Distress describes a condition in which a person is confronted with external or internal stressors, which overwhelm the person’s coping capacity. This includes transitional periods in the course of one’s life. Distress leads to psychoendocrine, psychovegetative, and psychomotor responses which may be hazardous to the patient’s health.
$E = \text{Early life experiences}$: This refers to previous life events, which may date back to childhood and adolescence. Traumatic experiences may have an impact on neurobiological pathways which may increase the patient’s vulnerability to later stressful life events and may induce repetitive health-damaging behavior. Also, emotional deprivation and neglect may have long-term consequences regarding the emotional development and interpersonal competence of patients.

$F = \text{False beliefs}$: False beliefs relate to general patterns of thinking which are likely to increase the vulnerability to life stressors: low self-esteem, pessimism, generalization, self-reference, and so on.

$G = \text{Generalized frustration}$: Life situations in which essential needs are unmet. These situations may lead to depression, anxiety, loss of self-esteem, and somatization.

In the biopsychosocial diagnostic workup these factors are combined with biological findings in what we call the nine-field diagnosis.

In this nine-field diagnosis there are three types of factors (biological, psychological, and social) which on a timeline are subdivided into predisposing, precipitating, and maintaining factors (Table 1.1). This information is obtained by the use of different techniques and instruments.

The final step in the diagnostic workup is the elucidation of the patient’s concept about her disease as well as her previous coping style and resources.

### 1.4.1.2. Educational Methods

In two educational sessions of 2–3 h duration the basic elements of psychosocial pathogenetic factors and the nine-field diagnosis are presented.

In group case discussions and group supervision the trainee will learn to use this diagnostic framework by means of cases the trainee presents either as report or audiotaped or videotaped. Another tool is that the supervisor presents a case which is then discussed in a group of six trainees. The trainees

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<th>Table 1.1. Nine field diagnosis</th>
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should learn to establish a comprehensive biopsychosocial diagnosis in all the patient groups mentioned earlier (Table 1.3).

### 1.4.2. Psychosomatic Therapeutic Interventions

#### 1.4.2.1. Contents

For the psychosomatic management of the above-mentioned patient groups the trainee needs to learn to establish a helpful patient–doctor relationship with the help of the three elementary attitudes of empathy, respect, and congruence. Based on this he/she should learn some basic therapeutic techniques which can be summarized under the notion of “supportive and/or coping counseling/psychotherapy.” By this we mean an integrative approach which contains different elements directed at the above-described pathogenetic factors. The therapeutic elements can be summarized under CCCISH (14,15):

Catharsis: The gynecologist encourages the patient to express her emotions and talk about her feelings (affects). He/she shares these emotions by nonverbal and verbal reflection, summarizing, and checking back.

**Example:** A 36-year-old primagravida comes for an ultrasound scan at 20 weeks’ gestation. The scan shows a missed abortion with fetal structures without heart activity. The patient is desperate. The physician invites her into a separate room and encourages her to talk about her emotions and the questions she might have. She reveals that at the beginning of the pregnancy she did not want this child and she was thinking about abortion. Now she is convinced that the intrauterine death is god’s punishment and that “it is all her fault.”

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**Table 1.3. Comprehensive biopsychosocial diagnosis**

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<th>Conditioned</th>
<th>By predisposing, precipitating, and maintaining biological, psychological, and social factors</th>
<th>And</th>
<th>Patient’s concepts and resources</th>
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<td>Symptoms and problems as descriptive summary</td>
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The physician is just listening and holding the hand of the patient. She keeps on talking about her feelings of guilt and her sadness. After a while the physician responds,

**Physician:** I can imagine the overwhelming pain you feel about the loss of the child which is even aggravated because you put the blame on yourself. Let me tell you that many women have mixed feelings at the beginning of a pregnancy and that this ambivalence is a normal feeling. I am very sure that you are not responsible for this death. You should give yourself permission to mourn and to be supported in this mourning process.

**Clarifying of conflicts and conflict resolution:**
The general principles of conflict clarification and resolution are as follows:

- Clarifying the individuals’ views of the problem and the related causes.
- Increasing the understanding of biographical factors influencing these views.
- Delineating and verbalizing the elements of the conflict.
- Brainstorming about possible options of conflict resolution.
- Help in conscious and transparent decision-making.

**Example:** A 35-year-old female suffers from complete loss of libido, which creates a profound conflict with her partner, who feels a deep-rooted sexual desire toward her. During the session with the couple it becomes evident to the male partner that previous traumatizing sexual experiences have conditioned her aversive reactions to his expression of intense desire which is experienced as threatening and aggressive. After encouraging her to verbalize her sexual wishes and needs which are much more directed toward nonpenetrative sex, both can start to negotiate about new ways of sexual expression and encounters.

**Cognitive reframing:** By reframing the cognitive attributions given by the patient to her disease or her symptoms the physician may attenuate the emotional distress caused by catastrophic and pessimistic explanatory styles of patients.

**Example:** A 22-year-old para 0 suffers from chronic pain, which could not be explained by laparoscopic findings. After the operation the physician explains the results. The patient is silent and withdrawn.

**Physician:** This must be somehow disappointing for you, that we could not find a single cause for your pain, which bothers you so much. I can imagine that you might have the impression that we do not understand your suffering.

**Patient:** Yes, this is so frustrating. Do you think that the pain is just in my head...pure fantasy...

**Physician:** Not at all. We know that this pain is real, but that the conditioning factors are complex as we have discussed before. We were talking about the chronic pain as the result of a disturbed processing of signals coming from certain body regions...
Insight and understanding: Increasing insight and understanding of one’s symptoms and problems can be obtained either by information and education provided by the physician or through the help the physicians can offer in a dialogue about the patient’s self-image, view of the world, way of coping, and so on. Through this dialogue the patient may be enabled to correct destructive and distorted patterns of thinking and behavior.

Example: A 52-year-old patient had undergone treatment for mammary carcinoma with lumpectomy, radiation and adjuvant antihormonal treatment. She feels abandoned by her husband and her family and responds with a depressive mood. The physician tries to clarify with her the expectations she has toward her family. By verbalizing her wishes it becomes clear that she had never expressed her anger and frustration about her disease and the deep feeling of the injustice imposed on her by fate or god. She gains some insight into the influence of her own behavior on the withdrawal of the family and she is able to adapt her expectations to the possibilities of her family.

Stress reduction techniques: Distress is experienced if the challenge (threat, change, etc.) imposed on a person cannot be confronted and coped with. The distress reaction on a cognitive level is the lack of a solution, on an emotional level the experience of anxiety and helplessness, and on a physiological level the activation of the sympathetic system and the endocrine response of the ACTH–Cortisol axis. Stress reduction techniques are based on the following elements:

- **Cognitive level**: Reframing, reducing catastrophic thinking, search for solutions.
- **Emotional level**: Creating awareness of the sequence between event-thoughts and emotions to be able to modify affective responses.
- **Physiological level**: Breathing techniques, progressive muscle relaxation.

Example: A 36-year-old patient and her partner undergo assisted reproduction with ovarian stimulation, ovum-pickup, and embryo transfer. After two failed treatment cycles the female patient exhibits a strong vegetative reaction during the ultrasound evaluation of the ovarian response; she starts crying and reports heart palpitations and headache. The physician teaches her some basic breathing techniques. In a separate consultation her way of coping with the treatment is analyzed, showing the enormous pressure she puts on herself and the anticipatory anxiety she develops. In a counseling session with the couple, different ways of coping are discussed: modifying the “fixed” objective of success by all means, defining a plan B, building up compensatory activities, and initiating the learning of a relaxation technique.

Helping in behavioral change: The trainee learns how to practice motivational interviewing. The main elements are the assessment of the patient’s readiness for change, which is determined by the importance attributed to changing behavior and the confidence of the patient in her capacity for change. Depending on the degree of readiness the physician can
either negotiate issues of importance and confidence or elaborate a detailed plan for change.

Example: A 30-year-old primagravida of 8 weeks’ gestation smokes 30 cigarettes a day. In the first consultation she tries to deny a negative impact on her child. It becomes evident that problems with her partner are much more important for her at the moment. After having clarified this the physician can actively re-enter the issue of smoking. She rates the importance to stop at 8 out of 10 points, but her self-confidence in achieving this change is rated by her rather low (4 out of 10). The physician focuses her talk very much on the support of her self-confidence and her ability to learn from previous failures and define an individual strategy. In her case she decided for a compensatory strategy which consisted in active distraction through the Internet.

1.4.2.2. Educational Methods

In two teaching sessions of 4 h duration, the basic elements of counseling are taught. After this, educational videos are used to show the different interventions in clinical settings. The trainees will then practice these techniques in 4–5 videotaped sessions with simulated patients.

1.5. Summary

The gynecologist is confronted with many tasks for which he/she needs a biopsychosocial competence: patient education and health promotion, counseling and management of psychosocial problems in various phases of a woman’s life cycle, care for patients with unexplained physical symptoms and patients with chronic incurable diseases. To obtain this competence a curriculum is needed which comprises elements of psychology, psychosocial medicine, and psychiatry adapted to the specific needs of gynecologists in their everyday work. A basic part of the curriculum consists of teaching knowledge and skills derived from communication theory and practice including physician- and patient-centered communication with active listening, responding to emotions, and information exchange as well as breaking bad news, risk counseling, and shared decision-making. Building on these skills, trainees are introduced to the biopsychosocial process of diagnosis, establishing a nine-field comprehensive workup using the ABCDEFG guideline (Affect, Behavior, Conflict, Distress, Early life experiences, False beliefs, Generalized frustration). The therapeutic interventions are based on a working alliance between the physician and the patient and are taught as basic elements, which have to be combined according to the individual patient and situation. The overall technique for gynecologists can be summarized as supportive counseling/psychotherapy (CCCISH) including elements like catharsis, clarifying conflicts and conflict resolution, cognitive reframing, insight and understanding, stress reduction techniques, and helping in behavioral change.
References

The Vaginal Examination

Catherine Coulson

2.1. Introduction

The vaginal examination becomes such a commonplace examination to gynecologists that they may forget its importance to their patients. As doctors, we are privileged not only to hear our patients’ anxieties, fears, and fantasies but also to examine their bodies. Many other people will touch bodies as part of their work—masseurs, physiotherapists, hairdressers, and beauticians to mention but a few. However, most people only expose that private part of their body to have their nappy changed as a small child or to be intimate with a lover as an adult. There are strict societal rules and clear boundaries to make the experience safer. However, there is the potential for complaint, misunderstandings, and harm, as well as for helping the patient.

Many misunderstandings can be avoided by being aware of the process and tuning in to the patient. This chapter assumes basic competence in gynecological skills such as locating the cervix, but aims to explore some of the other processes that are going on at a conscious or unconscious level during the practical examination.

2.2. Communication

An examination rarely occurs in the absence of a preceding consultation. Good consultation skills can be taken into the examination. Misunderstandings are usually the result of failure of communication:

- Be alert to clues. The words used by the patient, the \textit{way they are said}, and the \textit{body language} of the patient help you to understand the patient’s fears.
- Good communication depends on listening in an active way and then feeding back to the patient to make sure you have understood correctly. The patient can give you the history in her own words and you can clarify it with open-ended questions.
- We cannot reassure the patient until we know what she is concerned about.
• Many people choose medicine as career because they like to put things right. If we can tolerate not knowing what to do for a while, we might help the patient to find her own solutions.

2.3. The Role of a Chaperon

**GMC Guidance, December 2001**

The GMC regularly receives complaints from patients who feel that doctors have behaved inappropriately during an intimate examination. Intimate examinations, that is examinations of the breasts, genitalia, or rectum, can be stressful and embarrassing for patients. When conducting intimate examinations you should

• Explain to the patient why an examination is necessary and give the patient an opportunity to ask questions.
• Explain what the examination will involve, in a way the patient can understand, so that the patient has a clear idea of what to expect, including any potential pain or discomfort (paragraph 13 of our booklet *Seeking patients’ consent* gives further guidance on presenting information to patients).
• Obtain the patient’s permission before the examination and be prepared to discontinue the examination if the patient asks you to. You should record that permission has been obtained.
• Keep discussion relevant and avoid unnecessary personal comments.
• Offer a chaperon or invite the patient (in advance if possible) to have a relative or friend present. If the patient does not want a chaperon, you should record that the offer was made and declined. If a chaperon is present, you should record that fact and make a note of the chaperon’s identity. If for justifiable practical reasons you cannot offer a chaperon, you should explain that to the patient and, if possible, offer to delay the examination to a later date. You should record the discussion and its outcome.
• Give the patient privacy to undress and dress and use drapes to maintain the patient’s dignity. Do not assist the patient in removing clothing unless you have clarified with them that your assistance is required.

*Anaesthetised patients*

You must obtain consent prior to anaesthetisation, usually in writing, for the intimate examination of anaesthetised patients. If you are supervising students you should ensure that valid consent has been obtained before they carry out any intimate examination under anaesthesia.