



**The Australian Society for Psychosocial
Obstetrics and Gynaecology
(ASPOG)**

Annual Conference

**YOUNG WOMEN'S SEXUAL HEALTH:
PREGNANCY AND BEYOND**

Friday 27 and Saturday 28 August, 2004

Swiss Grand Hotel
Bondi Beach, Sydney

PROGRAM AND ABSTRACTS

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PROGRAM – FRIDAY 27AUGUST, 2004

8.45-9.00 **Opening** **Julie Quinlivan**

9.00-10.00 **Session 1** (Chair: Julie Quinlivan)

Medical Negligence Claims and Reproductive Health: A Plaintiff Lawyer's Perspective
Bill Madden

10.00-10.30 *Morning Tea*

10.30-12.30 **Session 2** (Chair: Heather Rowe)

10.30 **Invited Address**

'I Feel Like an Alien' – What is it About, Premature Menopause?
Desiree Yap

11.30 Time Course Changes in Psychological Symptomatology after a Diagnosis of a
Gynaecological Cancer
Petersen RW, Graham G, Quinlivan JA

12.00 The Distress of Chronic Pelvic Pain
Jacqueline Stacy

12.30-1.15 *Lunch*

1.15-3.15 **Session 3** (Chair: Nigel Humphreys)

1.15 IVF with Preimplantation Genetic Diagnosis for Sex Selection
Sarah Nichols, Kylie de Boer, Steven McArthur, and Robert Jansen

1.45 The Relationship Between Stress and Miscarriage
Devora Lieberman

2.15 Psychological Implications of Informed Decisions in Prenatal Genetic Screening
Heather Rowe, Jane Fisher, and Julie Quinlivan

2.45 Assisted Conception: A Risk Factor for Postpartum Admission to a Private Hospital
Mother Baby Unit?
Jane Fisher, Karin Hammarberg, Gordon Baker

3.15-3.45 *Afternoon tea*

3.45-5.15 **Session 4 –Invited Workshop** (Chair: Eilis McKensey)

Guilt, Shame and Perinatal Grief
Peter Barr

7.00 for 7.30 pm **Drinks, dinner and the 2004 Derek Llewellyn Jones Oration**
Pavilion Ballroom 1, Swiss Grand Hotel
(Chair: Julie Quinlivan)

Professor Bryanne Barnett:
"The Whole Duty of Obstetricians"

9.00-10.30 Session 1 (Chair: Heather Rowe)

9.00 Psychological Features are the Main Predictors of Functional Gastrointestinal Disorders in Patients with Eating Disorders
Catherine Boyd, Suzanne Abraham & John Kellow

9.30 Exercise Behaviours and Feelings in Eating Disorder and Non-eating Disorder Groups
Catherine Boyd, Suzanne Abraham and Georgina Luscombe

10.00 Teenagers who Plan Parenthood
Julie Quinlivan

10.30-11.00 *Morning Tea*

11.00-1.00 Session 2 (Chair: Eilis McKensey)

11.00 The Father's Inner World. Birth and Trauma
Brian Hunt

11.30 Workshop
"We can't have half a child!"
Sarah Jones

1.00-1.45 Lunch and AGM

1.45-3.45 Session 3 (Chair: Amanda McBride)

1.45 Psychosocial Risk Factors and Rates of Depression at First Antenatal Visit and Six Weeks Postpartum in a Public Hospital Obstetric Service in a Socioeconomically Deprived Region
Belinda Edwards, Tracy Semmler-Booth, Cherrie Galletly, and Gustaaf Dekker

2.15 Workshop
Thinking Touching Feeling: Pre and Postnatal Intervention Through Psychodynamic Thinking and Baby Massage
Elke Andrees, Maureen Armitage and Sandra Rees

3.45-4.15 *Afternoon tea*

4.15-5.15 Session 4 (Chair: Amanda McBride)
Invited Address

Misconceptions about Endometriosis
Associate Professor Thierry Vancaillie (School of Women's & Children's Health, University of NSW)

Thinking Touching Feeling: Pre and Postnatal Intervention Through Psychodynamic Thinking and Baby Massage

Elke Andrees*, Maureen Armitage* and Sandra Rees**

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The Early Intervention Program provides long-term infant-parent psychotherapy for families who have been identified as at-risk for pre and post natal stress and depression, reporting a history of emotional, physical and/or sexual abuse. In this paper we will describe a three-tiered approach to facilitating positive attachment patterns through therapeutic group work. By means of antenatal, baby massage and mother-baby groups women are given the opportunity to prepare for parenting and to address their concerns and anxieties about the emotional impact of having a baby in often challenging personal circumstances. This integrated approach through group work focuses on facilitating the infant-parent relationship with the goal of laying a foundation for positive attachment outcomes.

In the workshop we will discuss the underlying rationale and processes for this three-dimensional intervention and offer case material to demonstrate our work.

Psychological Features are the Main Predictors of Functional Gastrointestinal Disorders in Patients with Eating Disorders

Catherine Boyd, Suzanne Abraham and John Kellow

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Background: Gastrointestinal symptoms, occurring in the absence of structural gastrointestinal disease, are a well recognised feature of patients with eating disorders (EDs). Despite this, the spectrum and predictors of specific functional gastrointestinal disorders (FGID's), including irritable bowel syndrome, documented using standardized and validated questionnaires, have received little attention.

Aims: (1) To describe the prevalence and type of FGID in patients suffering from anorexia nervosa (AN), bulimia nervosa (BN) and eating disorder not otherwise specified (EDNOS). (2) To determine relationships between psychological features, eating disordered attitudes and behaviours, demographic characteristics and the type and number of FGIDs present.

Subjects and Methods: 101 consecutive female patients admitted to an eating disorder unit (AN 44%, BN 22%, EDNOS 34% mean age 21 years), completed the Rome II modular questionnaire, and a range of other validated self-report questionnaires detailing illness history, psychological features and eating and exercise behaviour.

Results: 98% of the sample satisfied criteria for at least one FGID. The most prevalent FGIDs were irritable bowel syndrome (IBS; 52%), functional heartburn (FH; 51%), functional abdominal bloating (31%) functional constipation (FC; 24%), functional dysphagia (23%) and functional anorectal pain disorder (FAno; 22%). 52% of the sample satisfied criteria for at least three coexistent FGID's. Significant predictors of specific and ≥ 3 coexistent FGIDs were psychological variables (somatization, neuroticism state and trait anxiety) age, and binge eating.

Conclusions: FGIDs are present in most individuals admitted for treatment of an eating disorder. Specific psychological traits and age, but not disordered eating characteristics, are largely predictive of FGID type, and of multiple coexistent FGID's. These findings support the role of specific psychological features as contributors to certain FGIDs, and highlight the importance of the assessment of gastrointestinal symptoms in people who have an eating disorder, or who are recovering from an eating disorder.

Exercise Behaviours and Feelings in Eating Disorder and Non-eating Disorder Groups

Catherine Boyd, Suzanne Abraham and Georgina Luscombe

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Background: The recognition and management of exercise problems in young women with eating disorders is one of the challenges faced by clinicians. The exercise behaviours and feelings of people with eating disorders, and how they compare to non-eating disordered individuals are not well understood.

Objectives: To compare exercise feelings and behaviours between eating disorder (n=287) and non-eating disorder (n=613) groups. To determine which exercise feelings and behaviours are best associated with an eating disorder diagnosis.

Methods: Nine hundred females completed a computerized examination (EEE-C), containing questions about exercise behaviours and feelings over the previous month.

Results: The eating disorder group did similar amounts of exercise, and days of exercise to the non-eating disordered group. The eating disorder group scored higher on all other behaviours and on exercise feelings except feeling that exercise was important for mood, and feeling that exercise was important for weight loss. The best predictors of an eating disorder diagnosis (VE 15.2%) were; “being annoyed, angry or agitated if exercise is interrupted” (OR: 1.49; 95% CI 1.04-2.15), “others feeling that you exercise a lot” (OR: 1.61; 95% CI 1.06-2.44), “feeling bad if unable to exercise a certain amount” (OR: 1.53; 95% CI 1.34-1.74), and “feeling that you have/have had a problem with exercise” (OR: 2.12; 95% CI 1.33-3.39).

Conclusion: In assessing individuals with eating disorders, these specific feelings towards exercise, rather than exercise amount or frequency, should be addressed.

Psychosocial Risk Factors and Rates of Depression at First Antenatal Visit and Six Weeks Postpartum in a Public Hospital Obstetric Service in a Socioeconomically Deprived Region

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Pregnancy and the postpartum period are times of great change and significant stress for a woman. It has been suggested that antenatal depression is more common than postnatal depression. A number of psychosocial factors have been identified as contributing to a woman's risk of depression at this time.

The rates of teenage pregnancy at the Lyell McEwin Health Service (LMHS) are much higher than the state average (15% at LMHS versus SA mean of 5.4%). The women delivering at LMHS have a number of problems such as poverty, poor housing, lack of social support and alcohol and drug use.

This study aimed to identify psychosocial risk factors using an antenatal assessment questionnaire (AAQ) initially developed by Dr S. Matthey at South West Sydney Area Health Service and modified by the Strengthening Links project at Women's and Children's Hospital Adelaide. Women were also asked to complete the Edinburgh Postnatal Depression Scale (EPDS) antenatally and at six weeks postnatal.

A total of 421 women participated in this study. Our results show that these women are disadvantaged in a number of areas, and display high rates of distress and probable depression. Antenatal and Postnatal EPDS data will also be presented, demonstrating the effectiveness of the AAQ in the prediction of postnatal distress and depression.

The results of this research will help us to further develop the recognition of women at risk of problems, and to develop appropriate pathways to assist these women to minimize their potential impact.

Assisted Conception: A Risk Factor for Postpartum Admission to a Private Hospital Mother Baby Unit?

Jane Fisher*, **Karin Hammarberg***, **Gordon Baker****

* *Key Centre for Women's Health in Society, School of Population Health, The University of Melbourne*

** *Department of Obstetrics and Gynaecology, The University of Melbourne*

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Objective: To investigate whether assisted conception is associated with an increased risk of admission to a residential early parenting program for treatment of maternal mood disorder or infant feeding or sleeping disorders in the postpartum year.

Design: Systematic audit of consecutive medical records.

Setting: Masada Private Hospital Mother Baby Unit (MPHMBU), Melbourne, Australia

Patients: Medical records of all mother-infant dyads admitted to MPHMBU between July 2000 and August 2002.

Main outcome measures: Modes of conception and delivery of index infant, maternal and infant age on admission, multiplicity of birth, infant birthweight and Edinburgh Postnatal Depression Scale scores.

Results: A total of 745 records were audited and mode of conception had been recorded in 526 (70.6%). Overall 6% (45 / 745) of the admitted infants had been conceived through ART compared to 1.52% in the general population (RR 4.0, 95% CI 3.0 - 5.4). Admitted mothers who had conceived with ART were older and more likely to have had caesarean and multiple births than those who conceived spontaneously.

Conclusions: Assisted conception appears to be associated with a significantly increased rate of early parenting difficulties. Women who experience assisted conception, especially those who have multiple or caesarean births may require additional support after their babies are born.

The Father's Inner World Birth and Trauma

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When a man and a woman establish a relationship which has as one of its functions, the making of babies (whether this is consciously realized or not) a profound process is commenced which leads to the conception, birth and growth of another human being.

The transformations that the primary dyadic relationship undergoes have immense impact on the psychic organization of both parents. Much work has been done and great deal of literature created concerning the effects on the mother and on the infant-mother relationship. While, the dramatic and sometimes frighteningly painful emotional responses of the father seem a great deal of the time to be overlooked.

This paper seeks to explore and explain some ideas about disturbed paternal emotional responses and their pathogenesis. To do this I will present three case histories that will be looked at in order to illustrate some of the following ideas:

1. The holding or containment of depressive states via a narcissistic cathexis in the prenatal dyadic relationship. In the euphoria of romantic focus the partner is the 'object of desire', depression is apparently relieved and the 'self' is defined by the 'other'. This is very much the state of feeling reflected in the others eyes.
2. Conception and birth as traumatic events. The causing of a wound. The creation of a mother. Men who have been traumatized by fathers who were physically and /or sexually abusive to the mother often see pregnancy and birth as 'wounds'.
3. Depressed states; the withdrawal of libidinal cathexis of the mother. Feeling abandoned as a result of maternal preoccupation the father may abandon the mother.
4. Defenses against the terrors of the incest fantasy and the fear of wounding.

In summing up I hope to draw conclusions from these particular examples of disturbance about the general difficulties facing fathers and fathers to be in understanding their roles and relationships with 'mother' and 'infant' in the light of their own experience of being parented and being a parent.

Couples In Antenatal Crisis: Just One Child Too Many OR Not Enough!

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Many couples may experience conflict regarding differences in their preferred number of children. A pregnancy exacerbates this conflict, potentially creating a relationship crisis of considerable proportions. A pregnant woman may not reveal this problem to antenatal staff, or it may be a significant consideration within antenatal management. The woman may present in crisis made more urgent by the time limits for legal terminations.

This workshop addresses how professionals may sensitively intervene and how to assess for a psychological referral. Case examples from both individual and couple counselling will be used to illustrate the kind of work demonstrated.

A woman is often torn between her emotional need for this baby and her partner's preferences. The conflict can be expressed in terms of considerations of other children, housing or finances, but may reflect underlying problems within the relationship. Does she continue the pregnancy and precipitate a relationship crisis of uncertain consequences for her and the infant? Does she terminate a wanted pregnancy? What is the experience for the partner? Without help there could be a problematic pregnancy, a request for late termination, relationship breakdown, or parent-infant problems.

The workshop will include:

- How professionals can make an initial assessment and raise the appropriateness of referral for counselling?
- The male missing link? How to engage the partner in this process.
- Examples of counselling interventions and outcomes.

The Relationship Between Stress and Miscarriage

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Miscarriage is the most common adverse reproductive outcome in women. Generally, the causes of abortion are classified as genetic, endocrinologic, anatomic, thrombotic or microbiologic. In addition, a significant volume of work has focused on potential autoimmune and alloimmune causes of pregnancy loss. Despite intense research efforts, however, in approximately 50% of couples with recurrent pregnancy loss, no cause can be identified.

During the past ten years, new studies relating pregnancy loss to social and environmental factors, such as stress, have been reported. These studies were conducted during a time of tremendous social change for women, as job stress and a more intense career focus have become increasingly common during the past few decades. Increased educational and economic opportunities for women have resulted in an increase in maternal age at the time of the first pregnancy. Further, there might be increased exposure to stress-related factors associated with employment compared to former times when women were largely not in the workplace, but rather had a full-time job at home.

Despite evidence that negative life events increase the risk for a number of medical disorders and play a role in the spontaneous abortion of chromosomally normal embryos, their role in pregnancy disruption is poorly understood.

Presently, the mechanisms by which psychological stress may lead to reproductive failure have not yet been identified. A search of the bibliography databases revealed that about 20,000 papers have been published to date on the effect of stress on the endocrine, nervous and immune system in mammals. Since a well-balanced network of these three systems is also important for the maintenance of pregnancy, presumed mechanisms and first insights on how stress may affect pregnancy outcome will be discussed in the present paper.

Medical Negligence Claims and Reproductive Health: A Plaintiff Lawyer's Perspective

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Since 2001, there have been a series of significant changes to the law concerning civil liability for medical negligence. Those changes encompass substantive law issues such as the definition of negligence, failure to warn / informed consent issues and restrictions on the award of damages. More recently some ad hoc changes have been made in areas relevant to reproductive health, such as claims for the cost of raising a child.

Over the same period there have been a number of cases brought concerning reproductive health matters, including contraception, terminations, IVF, antenatal investigations and management of pregnancy and labour.

This presentation undertakes an overview of the law changes and cases, with a view to identifying trends and potential issues in the future.

IVF with Preimplantation Genetic Diagnosis for Sex Selection

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Sydney IVF

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IVF and PGD for determination of blastomere sex chromosome number is the most effective method known for choosing the sex of a future baby. With such certainty comes ethical controversy. The subject was debated in public in Australia at the 1999 World IVF Congress: Chalmers, an academic lawyer, examined on what ethical, juridical, social or factual basis has a society the legitimate authority to interfere with the liberty of the parents, concluding that in a liberal society there is no prevailing reason for prohibition. Sydney IVF adds particular requirements: an absence of obvious or disproportionate harm, an acceptance on the part of the parents of any lingering biological uncertainty in the IVF process, no compromise to recipients of IVF/PGD for medical indications, no financial subsidy on the part of the community, and a duty to report to the community the characteristics of, and outcomes for, couples electing sex selection.

Quantitatively, a total cohort of 268 sex selection cycles were completed at SIVF, briefly summarised among different ages:

| | Av. age | # cycles | # transfers | # clinical pregnancies | % clinical pregnancies |
|---------------|---------|----------|-------------|------------------------|------------------------|
| < 35 years | 31.2 | 127 | 83 | 30 | 36% |
| 35 – 40 years | 37.3 | 116 | 72 | 29 | 40% |
| > 40 years | 42.7 | 25 | 11 | 3 | 27% |

Qualitatively we examined two aspects of the sex selection service. Firstly, data collected from a specific questionnaire that queries motivation was analysed. Overall, experience with clinically effective sex selection in Australia revealed a small but statistically significant excess of couples attempting a daughter. Women were more likely than men to regard themselves as the driving partner seeking sex selection, usually for a daughter after a series of sons.

In most cases, sex selection is a non-medical service. It is expensive, it has the inherent risks of any IVF/PGD cycle, and the couple must accept that there is sometimes still a chance of ambiguity in the test results. The clinic has a responsibility to help couples to carefully consider the outcome of the analysis before the procedure is undertaken, so that issues such as the intended fate of the opposite sex embryos can be considered and decided well ahead of the day the results become available.

Time Course Changes in Psychological Symptomatology after a Diagnosis of a Gynaecological Cancer

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Introduction: The aim of this study was to explore the wider psychological symptomatology experienced by women with a new diagnosis of a gynaecological cancer at the point of diagnosis and 6 weeks later.

Methods: A prospective cohort study was performed with ethics committee approval and informed consent. Women were recruited from 3 tertiary hospitals in Australia over a 4-month period. In order to cover a diverse range of potential symptomatology, we utilised the Hopkins Symptom Checklist –90 (HSCL-90) that covers 90 separate psychological symptoms which may then be coded into 8 domains. Women also completed questions relating to their perceived level of social support, and demographic data were collated separately.

Results: Key findings were that levels of symptomatology remained uniform across the first 6 weeks following the diagnosis of the cancer. Women with ovarian cancer experienced more symptoms in the domain of retarded depression at baseline and in the domain of Anger-Hostility at both baseline and follow-up time periods 6 weeks later, but the significant differences did not persist on multivariate analysis. In contrast, across the spectrum of symptomatology domains, the median scores were higher in women with poor supports compared to those with higher support levels. Several of these differences were statistically significant. At baseline, significant differences were observed in somatization, agitated depression and psychoticism between women with poor and good social supports. At 6 weeks follow-up, scores remained significantly higher for retarded depression, somatization, obsessive compulsive and agitated depression domains. In multivariate analysis, differences remained significant in respect to agitated depression at baseline and 6-weeks ($p=0.03$ and 0.04 respectively).

Conclusion: Diverse psychological symptomatology is experienced by women with a new diagnosis of a gynaecological cancer. Symptoms persist over the first 6 weeks and are higher in women with poor social supports. Interventions to resolve symptomatology need to be tailored to the type of symptoms experienced.

Teenagers who Plan Parenthood

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It is clear that a variable number of teenage mothers have, to some extent, planned parenthood. From an evolutionary perspective, it could be argued that teenage childbearing may in fact be a positive adaptive mechanism for humans raised in a hostile environment. Life history theory suggests that in risky and uncertain environments the optimal reproductive strategy is to reproduce early in order to maximise the probability of leaving any descendents at all. If some teenagers are planning or hoping for pregnancy, it is possible that some positive behavioural changes may be observed. This has proven to be the case with many teenagers altering their risk taking behaviours in the anticipation and expectation of pregnancy. There is now substantial evidence that teenagers who become pregnant were at higher risk than the general population for using cigarettes, alcohol, and marijuana. However, once pregnant, rates of consumption are usually lower compared with their non-pregnant peers or even their own personal pre-pregnancy rates of consumption. Therefore, for some teenagers, the conscious or unconscious prospect of pregnancy represents a potential space in which to rethink behaviours that may be harmful to themselves as a future mother, and also to their child. Given that teenage motherhood is not going to simply vanish, it is important to remember to focus research and services on validated interventions that may assist teenage mothers fulfil their ambitions of parenthood and simultaneously provide the best outcomes for their offspring. Evidence-based interventions focus around sustained home visitation by nurses, with limited evidence supporting the use of volunteers. In contrast, evidence suggests that home visitation by paraprofessionals may not be effective. Other strategies that may be helpful include the use of multidisciplinary teenage pregnancy clinics that have been noted to be associated with improved pregnancy outcomes. The role of new mothers groups, other community based group activities, peer support workers and intensive educational interventions to encourage return to schooling may be useful but have not been subjected to randomised evaluation. Such evaluation needs to occur.

Psychological Implications of Informed Decisions in Prenatal Genetic Screening

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Objectives

Prenatal genetic screening for Down Syndrome through second trimester maternal serum screening is becoming part of routine care in Australia. Public health policy emphasises the need for decisions to participate in screening programs to be informed. There is little evidence regarding the influence of emotional factors such as anxiety on women's capacity to comprehend complex information required to exercise informed choice. This may be especially pertinent for younger women who may have no reason to regard themselves as at risk of having a baby with Down Syndrome. Furthermore such decision making occurs in the context of growing attachment to the unborn baby, but systematic investigation of the potential that prenatal screening has to disrupt this relationship is lacking.

This study is investigating these psychological implications of informed decisions in prenatal screening. Results reported here describe the suitability of the published, validated Multidimensional Measure of Informed Choice (MMIC) (Marteau et al 2001) in a population of women attending for antenatal care in Australia.

Methods

Women were recruited during their first antenatal visit and completed a questionnaire containing the MMIC and measures of maternal mood and attachment to the unborn baby.

Results

Pilot data of 20 participants indicate that this sample scored consistently low on the knowledge dimension of the MMIC (mean (SD)=3.93 (1.90) out of a possible score of 8), but had on average very positive attitudes toward the MSS test (mean (SD)=23.29 (5.11) out of a possible score of 28).

Conclusions

Results confirm previous findings that screening tests provided as part of routine care have high acceptability and rates of uptake in the presence of poor knowledge of either the test or its possible consequences. The MMIC appears to be acceptable to Australian women. Further findings will contribute to understanding of pregnancy psychology in an era of increased antenatal surveillance.

The Distress of Chronic Pelvic Pain

Jacqueline Stacy

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A scientific workshop run in the UK in 1981 devoted to chronic pelvic pain was entitled 'A Gynaecological Headache'. I would like to explore if this is still the case.

At the 24th ASPOG Conference at Club Med in 1997, I presented my first years experience of running a pelvic pain clinic at Monash Medical Centre in Melbourne. Six years on what have I learnt?

The distress is real for the patient with often multiple operations, unresolved pain, and a feeling of being 'fobbed off'. Still one hears 'I was told it was all in my head'. I believe there is a large percentage of missed musculoskeletal, myofascial pain, which can be relieved by appropriate physiotherapy.

This leaves only a small percentage of distressed patients where I feel somatization plays a part. These are the ones that continue to cause distress for the clinician.

I will be illustrating the talk with case presentations and will seek to glean advice from the wealth of experience present.

'I Feel Like an Alien' – What is it About, Premature Menopause?

Desiree Yap

Monash Menopause Clinic and Jean Hailes Foundation, Melbourne

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Menopause marks the end of a woman's reproductive life and many of the physiological changes affect multiple organ systems. Menopause typically occurs at the age of 50 years. Premature menopause may be defined as menopause occurring before the age of 40 years. It is a common disorder affecting approximately 1% of women. For the majority of women with premature menopause, there is no identifiable cause. Significantly, these younger women have a two-fold age-specific increase in mortality rate.

Menopause occurs following the depletion of gonadotrophin-responsive primordial ovarian follicles and a diminution of estrogen production is a consequence. The menopause represents a dramatic endocrine change and is unique amongst primates.

Typical-age Menopause:

The menopausal transition, also known as the peri-menopause or climacteric, precedes the menopause, usually spans several years, and is characterised by a fluctuating hormonal milieu. It

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is often accompanied by symptoms including menstrual abnormalities, vasomotor symptoms and genital atrophy. Additional features can include emotional lability, insomnia, depression and psychosocial changes. The postmenopausal period is characterized by further endocrine changes with a decline in oestrogen levels to nadir. The postmenopausal period is associated with an increased risk of osteoporosis and cardiovascular disease and pre-existing symptoms may become more severe. The relationship of menopause with changes in cognition, Alzheimer's disease and colon cancer is still under investigation.

Premature Menopause:

Premature Menopause can occur for a variety of reasons including chromosomally incomplete ovarian failure; receptor abnormalities contributing to a resistant ovarian syndrome; auto-immune ovarian failure; enzyme deficiencies including galactosaemia, radiotherapy; chemotherapy and surgical removal of the ovaries. However, by far the commonest reason remains idiopathic premature ovarian failure.

As a subject, literature regarding premature menopause is relatively scant. Symptoms are similar to those experienced typically, as are the long-term risks. The psychological effects on women with premature menopause and the efficacy of different treatments are poorly described. Phenomenological studies have found that for these women, early menopause can come as a shock, is associated with a multitude of issues related to the timing of the event and can result in multiple disruptions in the women's lives. It is perceived as a major epiphany in their lives. For women experiencing premature menopause as a consequence of treatment for a malignancy, it can be an additional stress.

Women experiencing premature menopause face some unique challenges not necessarily encountered by those experiencing typical-age menopause. For example, apart from the considerations associated with symptoms, signs and a recommendation for hormone replacement therapy being required at an 'a-synchronous' time with respect to their peers, many with premature menopause are confronted with infertility-related issues. In addition, diagnosis can be delayed.

Studies investigating psychological features of typical-age menopause have reported increased dysphoria, nervous tension, feelings of sadness, difficulty concentrating, lack of energy and insomnia in community based samples of menopausal compared with premenopausal women. In addition, other investigators have demonstrated an association between adverse psychological factors, social variables and symptoms reported. However, it is unclear as to whether women with premature menopause demonstrate similar patterns.

Women presenting with premature menopause require a thorough assessment, sex-steroid replacement and long-term surveillance to both monitor their therapy and the development of potential complications such as osteoporosis. In addition, we hypothesize, that they may have additional psychological needs and different responses to treatment when compared to their typical-age counterparts.

PRESENTER BIOGRAPHIES

Elke Andrees

Elke Andrees is a psychologist and psychotherapist in private practice and is Clinical Supervisor of The Benevolent Society's Early Intervention Program. During her work with the program over the past ten years she has developed expertise in therapeutic and preventative approaches with parents and infants, especially with high-risk families. This includes antenatal therapeutic intervention, group work and home based infant-parent psychotherapy. Elke has co-authored and developed the antenatal therapeutic group program which forms part of the mental health initiative of the Royal Hospital for Women. She provides clinical supervision for the Graduate Diploma and Master of Infant Mental Health Programs at the NSW Institute of Psychiatry. Elke has presented a wide variety of papers at conferences in Australia and New Zealand. Elke is a member of the NSW Institute of Psychoanalytic Psychotherapy and has completed their Child and Adolescent Training.

Maureen Armitage

Maureen Armitage has a background in Nursing with qualifications in Child and Family Health and a Diploma in Infant Mental Health from the NSW Institute of Psychiatry, and is currently completing the Adult Training with the NSW Institute of Psychoanalytic Psychotherapy. For the past five years she has worked as an Infant-Parent Therapist with the Benevolent Society's Early Intervention Program. She is part of the home-visiting program as well as a facilitator of the antenatal groups and mother-baby groups. In private practice as a psychotherapist she works with individuals and as a group facilitator. She has a special interest in working with women both antenatally and postnatally.

Bryanne Barnett

MBChB, FRANZCP, MD

Professor Barnett has a postgraduate degree from the University of New South Wales, and held a Chair of Perinatal and Infant Psychiatry at that University. The topic of her doctoral thesis was "Maternal anxiety and its effects on parenting and child development". She is also the Director of Infant, Child and Adolescent Mental Health Services for South Western Sydney and Chair of the Board of Karitane, Caring for Families. Bryanne manages the NSW component of the 'beyondblue' National Depression Initiative's Postnatal Depression Program.

Bryanne is a foundation member and Past President of the Australian Association for Infant Mental Health, the Australian Society for Psychosocial Obstetrics and Gynaecology, and the Australasian Branch of the Marce Society.

Bryanne's key interests are the health and wellbeing of infants, children, and their parents, especially from the aspect of reducing risk and enhancing protective factors. To that end she has established various services addressing the needs of families and is involved in a research program on issues relevant to prevention, early intervention and health promotion. She specialises in establishing cross-disciplinary collaboration. The Integrated Perinatal Care Program, which is to be implemented throughout NSW, is an initiative of South Western Sydney. She has also worked for many years with Juvenile Justice in NSW.

Peter Barr

OAM, MBBS PhD, FRACP

Peter Barr has been a newborn intensive care physician in Sydney, Australia for more than 30 years. Currently, he is Senior Staff Physician in Neonatology at the Royal Alexandra Hospital for Children. Peter has a long-standing and passionate interest in perinatal bereavement. He was co-founder of the New South Wales SANDS (Stillbirth and Newborn Death Support) self-help support group. He co-authored with his wife, Deborah de Wilde, the book Stillbirth and Newborn Death: Death and life are the same mysteries. Peter, Deborah and psychologist, Julie Dunsmore, made the 1985 award winning documentary film, Some Babies Die. Peter has recently completed an empirical research study of the negative self-conscious emotions (shame and guilt) and their relationship to grief and psychological distress following a stillbirth or death in the newborn period. Peter was awarded the Medal of the Order of Australia (OAM) in 1992 for his work in the area of perinatal bereavement. He lives in inner metropolitan Sydney with his beloved Deborah and their two daughters, Freya and Madeleine, who provide him with nurture and give his life its essential meaning.

Catherine Boyd

BSc(Med), Syd Uni 1998; DOB: 9.1.78

Current Study: PhD (Dept O&G, part time), MBBS (full time, final year, University of Sydney)

Authored and co-authored several manuscripts; published in the Psychosomatic Journal of Obstetrics of Obstetrics and Gynaecology, accepted in the International Journal of Eating Disorders and recently submitted papers to Journal of Human Nutrition and Dietetics, British Journal of Sports Medicine and Gut. These latter two have been submitted as abstracts for the ASPOG conference.

Conference presentations include: The Asian Pacific Eating Disorders Conference in November 2002 (Melbourne), Digestive Diseases Week May 2003 (Orlando, Florida), and WPA - Diagnosis in Psychiatry, June 2003 (Vienna).

My fields of interest include eating and exercise disorders, women's and adolescent health, and functional gastrointestinal disorders.

PRESENTER BIOGRAPHIES

Belinda Edwards

Dr Belinda Edwards graduated in medicine from the University of Adelaide in 1985. She went on to train in General Practice and obtained the Diploma in Obstetrics in 1988 and the FRACGP in 1990. After 8 years in general practice and a flash of inspiration, she commenced Psychiatry Training on a part time basis in 1996. Having successfully completed the training requirements she will receive the FRANZCP in November, 2004. Her clinical work, over the past two years, has involved the development of a perinatal psychiatry service at the Lyell McEwin Health Service in South Australia. Her interest in perinatal psychiatry began in general practice and has developed ever since.

Jane Fisher

Dr Jane Fisher is Senior Lecturer at the Key Centre for Women's Health in Society, in the School of Population Health at the University of Melbourne and has been on the staff there since 1994. Her broad research interest is in mental health particularly during reproductive life. She has investigated the psychological impact of fertility difficulties, pregnancy loss and operative intervention in childbirth and factors associated with maternal adjustment in the early postpartum period. This research has been conducted in Australia and in Vietnam.

Jane Fisher teaches in the area of psychological practice and health care in the postgraduate courses offered at the Key Centre for Women's Health in Society and supervises higher degree research students. She is currently the Secretary of the Marcé Society, which is the international professional society for research and practice in mental health, psychiatric illness and childbearing.

Jane Fisher practices as a Clinical Psychologist in the fields of mental health, reproduction and psycho-oncology. She has been the Consultant Clinical Psychologist to the Masada Private Hospital Mother Baby Unit since it opened in 1996.

Brian Hunt

Brian Hunt has been a practicing psychoanalyst for more than 40 years. During the last 22 years he has worked extensively with post-addictive, severely depressed and borderline patients and their children. Brian is very interested in the dynamics of the family and has worked with the Early Intervention Program assisting in running groups for fathers. Brian's particular interest in the social and cultural impingements on the developmental process grew out of his early work with very young children hospitalized for long periods who suffered the effects of 'a culture of abandonment', on their individual growth. Brian now works in private practice and is an active member of the Australian Association for Infant Mental Health.

Sarah Jones

Sarah Jones is a couple counsellor/psychotherapist with a particular interest in the field of perinatal medicine. She has a background in social work, family and couple therapy and infant mental health. She has trained in Melbourne and London. Until recently Sarah worked at the Royal Children's Hospital in the Mental Health Service, where she developed a strong interest in working with parents and infants.

She currently works in private practice whilst consulting to a number of public health agencies, including the Royal Children's Hospital's Home and Community Care Program and Drummond Street Relationship Counselling Centre in Melbourne. She teaches on several undergraduate and post graduate medical and social science courses through the University of Melbourne and the Victorian Child Psychiatry training program.

Devora Lieberman

Devora Lieberman is currently a specialist in miscarriage and infertility at Sydney IVF, where she directs the Miscarriage Management Program. She returned to full-time clinical practice in December 2003 after three years at Organon, where she was Associate Medical Director, Women's Health, responsible for contraception, HRT and pro-fertility. Devora was appointed to a VMO position at the Menopause Clinic at Royal North Shore Hospital in July 2004, where she has been an Honorary Research Fellow since 1998, and became President of FPA Health (formerly Family Planning NSW) in June 2003.

Prior to migrating to Australia in 1998, when her fiancé told her, "there's no surf in Boston Harbor," Devora was a lecturer at Harvard Medical School in Obstetrics and Gynaecology and received her Masters Degree in Public Health from Harvard in 1996.

PRESENTER BIOGRAPHIES

Bill Madden

Qualifications

Bill Madden is a lawyer and accredited specialist in personal injury law. He is the NSW Professional Negligence partner for Slater & Gordon, the largest specialist injury law firm in Australia.

Current Roles

Bill is a member and past chair of the Australian Plaintiff Lawyers Association Medical Negligence special interest group and a frequent writer & presenter medical litigation topics. His current roles include:

- NSW Law Society Medico-Legal Liaison committee 2004
- Editorial Board; Australian Health Law Bulletin (Lexis Nexis)
- Editorial Board; Civil Liability Law Bulletin (Lexis Nexis)

Previous Roles

- National Convenor – APLA Medical Negligence Special Interest Group
- NSW President – APLA 2002 – 2003
- Australian Council for Safety & Quality in Health Care – Open Disclosure of Adverse Events
- APLA Plaintiff journal editorial committee & NSW representative
- NSW Law Society Medico-Legal Liaison committee 2002 & 2003.
- Australian Health Ministers Advisory Council (Medical Indemnity Jurisdictional Working Party & Consultative Forum) : Legal Process Reform Group 2002.
- Conference Chair – APLA Medical Negligence Conference 2002; Brisbane.
- NSW Health Department consultative group regarding Health Care Liability Act & Regulations
- Conference Chair – APLA Medical Negligence Conference 2001; Sydney.
- NSW Convenor – APLA Medical Negligence Special Interest Group; 1999-2001.
- Member – NSW Supreme Court Working Group for Professional Negligence List Expert Witness Protocol; 2000 – 2001.
- Law Council of Australia Health Law Liability Committee 2001-2002.

Sarah Nichols

Sarah Nichols completed her general nurse training at The Royal Free Hospital in London in 1985 and then Midwifery training in 1987. She practised as a midwife in the UK until 1997. Sarah then moved to fertility nursing and completed her ENB Fertility Nurse Course in 1998 and continued working as a fertility nurse in the UK.. Sarah emigrated to Australia in 2000 and worked at Fertility First before moving to Sydney IVF in Dec 2001. Sarah is now a senior nurse coordinating treatment for couples having IVF with PGD (pre-implantation genetic diagnosis).

Rodney Petersen

Dr Rodney Petersen is a Senior Lecturer at the University of Melbourne in Obstetrics and Gynaecology. He has completed further training in Gynaecological Oncology and has a strong interest in psychosocial issues in oncology and related disorders. He is currently enrolled in an MD in Solution Focused Therapy and its application and role in this field.

Julie Quinlivan

Associate Professor Julie Quinlivan is Head of the Maternity Care Program at the Royal Women's Hospital and works at the University of Melbourne Department of Obstetrics and Gynaecology. She completed doctoral studies in Maternal Fetal Medicine and has ongoing research interests in teenage pregnancy, psychosocial aspects of obstetrics and gynaecology, and women's cancers. She is a government advisor in domestic violence, teenage pregnancy and home visitation programs.

Sandra Rees

Sandra Rees is a Remedial Massage Therapist and Aromatherapist with a background in Nursing and qualifications in Child and Family Health. She has been Clinical Nurse Specialist and Infant-Parent Therapist with The Benevolent Society's Early Intervention Programme for over ten years. Based on her extensive experience with high-risk families she has co-designed and facilitates the Baby Massage Groups offered at the Early Intervention Program. Baby Massage has formed integral part of the group programme provided by EIP over the past four years. Sandra is also in private practice with a special interest in women's

PRESENTER BIOGRAPHIES

Heather Rowe

Dr Heather Rowe is a health scientist with a background in genetics and health promotion.

She lectures in postgraduate courses in the Key Centre for Women's Health in Society in the School of Population Health at the University of Melbourne.

She has broad interests in the determinants of women's health, and in particular those which are relevant to women's psychological wellbeing during the peripartum period.

She has published in peer reviewed journals and supervisors a number of higher degree research students in this area.

One of her research interests is the psychosocial impact of medical technologies in pregnancy and birth.

Jackie Stacy

Jackie Stacy has been working in Obstetrics and Gynaecology for the past 30 years, with related qualifications obtained in the UK, NZ and in Melbourne. She has her own gynaecology practice and continues to run a pelvic pain clinic through the Monash Medical Centre.

Thierry Vancaillie

Associate Professor Thierry Vancaillie is currently Director of the Department of Endo-Gynaecology at the Royal Hospital for Women. Professor Vancaillie is internationally renowned for his development of principles of surgery and instrumentation in both hysteroscopic and laparoscopic surgery. Notably, his work with the physics and application of electrosurgery in both of these surgical approaches has been a benchmark by which surgical standards have been set internationally. Currently his unit is establishing itself as a leader in the areas of gynaecological pelvic floor surgery, minimally invasive surgery and the treatment of chronic pelvic pain.

The Endo-Gynaecology Clinic - encompassing the Abnormal Bleeding, Pelvic Floor and Endometriosis and Pelvic Pain Diagnosis and Treatment Units - was established in March 1999 independent of the gynaecology services offered in the Outpatient Department.

Desiree Yap

MBBS MRCOG FRANZCOG MPHTM

Dr. Desiree Yap is a Specialist Obstetrician and Gynaecologist with an interest in Menopause, as well as Public Health. She is currently working as a Consultant Gynaecologist in the Menopause Unit at Monash Medical Centre, Clayton, Victoria and the Jean Hailes Foundation, Clayton, Victoria as well as in her private practice in East Melbourne.

She is a member of the Victorian State Committee of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists as well as the President of the Victorian Medical Women's Society.

Since graduating from the University of Melbourne in 1987, Desiree has worked in Melbourne, at the Royal Melbourne Hospital then Monash Medical Centre before completing her specialist training in Canterbury, Kent in the U.K. She has completed a Master of Public Health and Tropical Medicine at James Cook University in Townsville, Queensland, in 1995 and is currently undertaking a Doctorate in Public Health on the management of services for women's suffering from early menopause.

The Monash Menopause Unit has opened the first Premature Menopause Clinic in Australia and we are currently researching psychological and physical aspects of early menopause affecting volunteers attending this Clinic.

PARTICIPANTS

| | |
|---------------------------|-----------------------------------------------------------------------------|
| A/Prof Suzanne Abraham | University of Sydney, NEW SOUTH WALES |
| Ms Elke Andrees | Early Intervention Program, Benevolent Society, NEW SOUTH WALES |
| Mrs Maureen Armitage | Early Intervention Program, Benevolent Society, NEW SOUTH WALES |
| Prof Bryanne Barnett | Paediatric Health, South West Sydney Area Health Service, NEW SOUTH WALES |
| Ms Catherine Boyd | University of Sydney, NEW SOUTH WALES |
| Professor John Condon | Repatriation General Hospital, SOUTH AUSTRALIA |
| Dr Deepali Dhillion | Gynaecologist, VICTORIA |
| Dr Brian Dunne | GP, VICTORIA |
| Dr Astrid Dunsis | Monash Medical Centre, VICTORIA |
| Dr Belinda Edwards | Lyell McEwin Health Service, SOUTH AUSTRALIA |
| Dr Jane Fisher | Key Centre for Women's Health in Society, University of Melbourne, VICTORIA |
| Ms Karin Hammarberg | University of Melbourne, VICTORIA |
| Dr Keith Hartman | NEW SOUTH WALES |
| Dr Nigel Humphreys | GP, NEW SOUTH WALES |
| Mr Brian Hunt | Psychoanalyst, NEW SOUTH WALES |
| Dr Ray Hyslop | Obstetrician and Gynaecologist, NEW SOUTH WALES |
| Ms Sarah Jones | Social Worker/Psychotherapist, VICTORIA |
| Dr Devora Lieberman | Sydney IVF Miscarriage Management Program, NEW SOUTH WALES |
| Mr Bill Madden | Slater & Gordon, NEW SOUTH WALES |
| Dr Amanda McBride | GP, NEW SOUTH WALES |
| Dr Eilis McKensey | Hunter Area Health Service, NEW SOUTH WALES |
| Ms Elizabeth McKensey | Newcastle Medical Faculty, NEW SOUTH WALES |
| Ms Sarah Nichols | Sydney IVF, NEW SOUTH WALES |
| Dr Ann Olsson | Gynaecologist, SOUTH AUSTRALIA |
| Dr Estela Papier | Psychiatrist, VICTORIA |
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| Dr Anne-Marie Rees | Psychiatrist, NEW SOUTH WALES |
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| Dr Jackie Stacy | Gynaecologist, VICTORIA |
| Dr Christine Thevathasan | Obstetrician and Gynaecologist, VICTORIA |
| Dr Jenny Thomas | GP, SOUTH AUSTRALIA |
| A/Prof Thierry Vancaillie | Royal Hospital for Women, NEW SOUTH WALES |
| Dr Yvonne White | Psychiatrist, NEW SOUTH WALES |
| Dr Desiree Yap | Monash Menopause Clinic and Jean Hailes Foundation, VICTORIA |