



NEW ZEALAND COLLEGE OF MIDWIVES (INC)

JOURNAL

New Zealand Research

Exercise barriers faced by first-time mothers

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The faces of mentoring in New Zealand: Realities for the new graduate midwife

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Surfing the net

Sarah Stewart

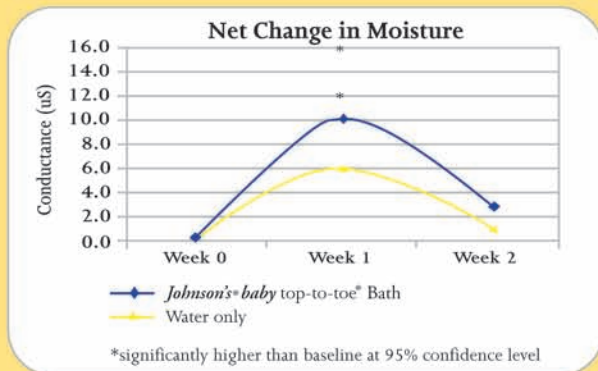
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In addition to the core group of reviewers for the journal, we have many people who share their expertise and time reviewing articles. The Editorial Board thanks the following people for their work during 2006.

- Annemarie Jutel
- Nicky Leap
- Sarah Stewart
- Ann Yates
- Sandra Elias
- Mereana Roberts

Editorial Board Comment

We welcome you to the 35th issue of the Journal. It contains a range of interesting and diverse materials. These provoke thought on areas of practice such as exercise in pregnancy and bi-polar disorder. We have the return of the 'Surfing the net' column with a focus on mentoring. There is a group of book reviews which will whet your interest for sitting in a comfortable chair on a Spring evening to

read about diverse topics such as breastfeeding, mentoring and 'gentle' practice. Many of you may be familiar with accessing the Journal online on the College website (www.midwife.org.nz). Issues are posted there 6 months after publication. The College website is becoming increasingly used with 9,198 people visiting it in January 2005, rising to 20,445 in June 2006. We encourage

you to tell people about the website and the Journal issues in order to share information about topics that are important to pregnancy, birth and midwifery practice. And, if you are keen to publish in the Journal then we would like to hear from you. The guidelines for contributors are on page 36 and are also on the College website.

NEW ZEALAND RESEARCH

Exercise barriers faced by first-time mothers

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Abstract

This qualitative research project explored the experiences of first-time mothers attempting to resume exercise after pregnancy. Emerging themes indicated that from pre-pregnancy to postpartum, barriers to exercise for first-time mothers increased and changed. Furthermore, the findings suggested that although the mothers shared several common barriers, each mother's experience was unique. The non-resumers accepted their inability to undertake exercise and did not seek to negotiate

their barriers. In contrast, resumers perceived that exercise was an important part of their new lifestyle and utilised cognitive and/or behavioural strategies to avoid or negotiate these barriers. These findings have implications for midwives, health and exercise professionals who are involved in helping first-time mothers resume exercise. In order to provide appropriate advice and support it is paramount that midwives, health and exercise professionals identify the mother's expectations, knowledge, benefits, barriers, preferences and goals towards exercise.

Introduction

A substantial body of scientific evidence demonstrates that exercise provides benefits for health and well-being for most people (Pate et al., 1995). However, these benefits may only accrue to those regularly participating in 30 minutes of physical activity on most days (Pate et al., 1995). A New Zealand physical activity survey has identified that women between the ages of 25-34 years have the highest inactivity levels when compared with the rest of the adult population (SPARC, 2003). It has been suggested that having children (Brown & Trost, 2003), and family responsibilities could be the main reasons for decreased physical activity levels within this age range (SPARC, 2003). Studies from Canada and Australia have also noted that mothers were less

likely to exercise than women without children (Brown, Lee, Mishira & Bauman, 2000; Verhoef & Love, 1992a; Verhoef & Love, 1992b).

In this respect Borgatta, Bulcroft, Montgomery and Bulcroft (1990) claim that lifestyle transitions can be a major factor influencing changes in personal health attitudes and practices. *"The transition into motherhood is a period of social, psychological, behavioural and biological change in women's lives"* (Devine, Bove & Olson, 2000, p. 567). Women who become pregnant and care for their child typically suspend participation and observe a 'natural' break from exercise (Currie & Develin, 2000).

Benefits are particularly apparent for those exercising postpartum and are postulated to be maintenance or improvement, in physical ability, emotional stability, and in developing new coping skills.

(Clapp & Little, 1995).

Nevertheless, some mothers are eager to resume exercise during the postnatal time (Schelkun, 1991). This is supported by findings that this childbearing age group had the most interest in becoming more active (SPARC, 2005). Indeed, exercise is beneficial for women's physical and psychological health during any part of the reproductive process (Clapp & Little, 1995). Benefits are particularly apparent for those exercising postpartum and are postulated to be maintenance or improvement in, physical ability, emotional stability, and in developing new coping skills (Clapp & Little, 1995).

Exercise barriers faced by first-time mothers

However, the presence of barriers has been suggested as reasons why some mothers do not resume their exercise (Cody & Lee, 1999). For the broader New Zealand population, barriers to physical activity and/or exercise have been found to be; lack of time, other responsibilities, lack of motivation or willpower, social expectations and a perception of limited activity options available (LINZ, 1994). As a sub-population, mothers with dependent children have arguably a greater number and perhaps some unique barriers to exercise compared with women without children (Verhoef & Love, 1994). Specifically, barriers for mothers with young children include; tiredness, lack of time, organisational demands, lack of spousal/social support, and childcare issues (Currie & Develin, 2000; Cody & Lee, 1999; Genet, 2000; Thomas, 1985; Verhoef & Love, 1994). Furthermore, deeper psycho-social themes such as 'ethic of care', 'lack of entitlement', body image, and guilt have emerged from some of these studies.

Limited research or theories have attempted to explain and understand the issues relating to the resumption of exercise in previously active men and women (Sallis & Hovell, 1990). More recently, ecological models have found favour as a means of understanding health behaviours such as exercise (Sallis & Owen, 1997). Ecological models emphasise that many variables can influence exercise behaviour, and attempt to consider connections between the person and their environment. These variables can affect exercise within a number of different levels including; intrapersonal (e.g. beliefs, attitudes, self-efficacy), social /cultural (e.g. roles, responsibilities, social support), physical environment (e.g. access to facilities, availability of walking tracks), and policy (e.g. available funding for recreation facilities or walking tracks) (Sallis & Owen, 1997). Ecological explanations suggest that even if positive changes are made at the intrapersonal level, individuals may find it very difficult to adopt or sustain the preferred exercise behaviour if the social/cultural and environmental influences remain negative (Drew & Paradise, 1996).

Remaining active throughout the lifespan can be challenging, especially when women make the transition into motherhood. However, few studies have examined the barriers to exercise faced by mothers, and no study to date has specifically sought to identify the barriers to exercise that first-time mothers face. The purpose of this study was to explore the experiences of first-time mothers attempting to resume exercise. By identifying barriers experienced by first-time mothers, this study aimed to address a research area that is poorly understood, and to provide

further insight for midwives, health and exercise professionals involved in helping first-time mothers resume exercise.

Methodology

The current project was a qualitative investigation that sought to understand the perspectives of mothers. The study was informed by the interpretivist notion that people make meanings and understand their lives differently in relation to their personal histories, biographies, gender, social class and ethnicity. The study also drew on the liberal feminist notion that research should not only describe the experiences of women, but do so with a view to enhancing the quality of their lives (Henderson, Baileschki, Shaw & Freysinger, 1996).

Participants

The study was conducted in the Otago Region, in the South Island of New Zealand.

In-depth information was being sought; therefore the researcher chose a small sample size, selecting participants who had certain characteristics deemed to be of interest (Lincoln & Guba, 1985; Patton, 1990; Thomas & Nelson, 1996). Therefore, ten mothers were purposively selected as follows; first-time mothers, 3-15 months postpartum who were active (involved in at least two and a half hours of structured exercise per week) before becoming pregnant. Five mothers who had resumed exercise (resumers) and five mothers who intended resuming exercise (non resumers), were sought. These distinctions, between resuming and not resuming, were based on the mother's own perception of what 'resuming' meant. The term 'exercise' connotes planned, deliberate, and regular physical activity and is more clearly distinguishable from 'physical activity', which could encompass the childcare and incidental activity common to all new mothers.

Data Collection

Qualitative methods were employed in order to best understand the mothers' perceptions of their experiences in terms of the barriers faced, and how some mothers avoided or negotiated these barriers to resume their exercise. Each mother took part in one face-to-face in-depth interview within her own home. The questions followed an open-ended interview guide where the researcher's interview approach was guided by feminist researchers Oakley (1990) and Cotterill (1992). In particular this meant paying attention to the following issues of: ethical conduct, friendship, reciprocity, vul-

nerability, power and control, and collaboration. Research procedures were reviewed and approved by the University of Otago Ethics Committee and also the National Plunket Ethics Committee. Finally, confidentiality was assured where by each mother was assigned a pseudonym.

Data Analysis

Each interview was audio-taped and transcribed verbatim. The data content was analysed using content procedures that aimed to uncover patterns or themes within the raw data (Maykut & Morehouse, 1994). The researcher used procedures defined by Maykut and Morehouse (1994),

The non-resumers believed that their time belonged to their baby and their partner, and very rarely prioritised exercise time for themselves.

including grouping quotes with similar meanings and separating these from quotes of differing meanings. Categories were formed using inductive procedures where similar 'meaning units' were brought together to form themes (Maykut & Morehouse, 1994). Trustworthiness was established using methods common to interpretive studies including; credibility, transferability, dependability and confirmability (Lincoln & Guba, 1985).

Findings

Due to the participant selection criteria, few barriers were perceived by the mothers prior to becoming pregnant, with exercise being a regular part of their weekly routine.

Within the postnatal time, there was a proliferation of unique and additional barriers. Several barriers were shared by the mothers, yet other responses were not shared and therefore were categorised as unique. Five main barrier themes emerged from discussions with these first-time mothers. These were intrapersonal (e.g. tiredness, low energy, low motivation, soreness and complications, low exercise tolerance, high expectations, and appearance concerns), interpersonal (ethic of care/sense of entitlement, domestic chores, unpredictable routines, organisational demands, the health and mood of their baby, and lack of partner support), socio-cultural (lack of support from family, friends, and other mothers), physical environment (lack of access to preferred exercise environment, available finances and weather) and healthcare environment (lack of information, advice or encouragement). Within this article some of the interpersonal, socio-cultural and physical environment variables that impacted on some of the mothers' ability to resume exercise will be explored.

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Exercise barriers faced by first-time mothers

NON-RESUMERS

Ethic of care

Priorities changed for all mothers once their babies were born, as they believed that caring for the baby was their main responsibility and were committed to taking care of the baby's needs, keeping the baby healthy and happy over and above their own needs. The non-resumers believed that their time belonged to their baby and their partner, and very rarely prioritised exercise time for themselves.

So it's probably Hamish [baby], Jason [husband], and then me. You know in order at the moment. So, yeah, I don't mind so much. Every now and then I think 'argh give me a break'. (Emma)

Three non-resumers devoted most of their spare time to being attentive to their baby's needs, entertaining them throughout the day. They described playing with their babies all day as they perceived that they needed to keep them alert, stimulated, and distracted.

It's just playtime really. The whole day is just playtime until he has his sleep which is usually after lunch. And then it's playtime again. Occasionally we go down the beach and have a play on the sand. But as far as me walking, I do a lot less now than what I did when he was smaller. (Emma)

The non-resumers mentioned that they recognised their own needs for exercise but often other commitments and demands took precedence. If these mothers did find some free time it was often devoted to household tasks.

Yeah, and also there's something in the back of your head saying, if you've got time you should be probably doing some housework. (Fiona)

As the non-resumers devoted both their physical and mental time to their babies, most said that they found it difficult to find room to think about other things. They mentioned that they were so wrapped up in their babies, tending to their needs, that they didn't spend time thinking about exercise and time for themselves. A lack of motivation could have stemmed from the mother being focused solely on the baby, being mentally tired, and therefore forgetting about her own needs.

I really wanted to get straight back into exercise, but you're thinking about her 24 hours a day and it's just that you can't be bothered. I just haven't room to think about it. (Jodie)

The feeling of guilt was a barrier for the non-resumer mothers. They believed that they were responsible for the baby's care 24 hours a day, and

felt it selfish to ask others for help with childcare. They felt uncomfortable burdening others with their baby, especially if the baby was unsettled or unwell.

I feel really guilty leaving her with Geoff [husband] not because I am leaving her, but because it is extra work for Geoff [husband] or she might be particularly cranky. (Kath)

The non-resumers perceived their partners showed little or no support or encouragement towards them incorporating exercise into their lifestyle. Some mothers perceived that their partners were not happy with caring for their baby while they took time out for exercise. The mothers mentioned that their partners would often worry or panic if the babies began to cry or became unsettled. Perhaps some of the lack of confidence stemmed from the partners not being around their babies as often as the mother. This in turn led the mother to respond by doing the majority of the care-giving, and not being able to find time for exercise.

He [husband] wasn't as confident as I was with looking after her, so it took a few months to build up that confidence and not to panic when I wasn't there. (Jenna)

One non-resumer perceived her husband, a full time student, was reluctant to care for their baby. She said that it caused a lot of friction within their relationship, as she was training towards a half marathon walk. She reported that her husband became really annoyed when she went out for a walk at night, as he was left to put their unsettled baby to bed. This was a barrier for her completing regular walks and it also made her feel under pressure to return quickly, negating any positive benefits of taking time out to do her exercise.

We did have a big row about how much time I was taking to walk in building up to the marathon. I just said, I thought that you would support me, because I need to do this for my osteoporosis and I acknowledged that it was hard for him at times and reiterated it that I wouldn't be taking this much time later. (Kath)

This mother perceived she was entitled to exercise and rebelled and argued when her partner did not want her to go for a walk. While this mother managed a small amount of walking, she found it hard to cope with the guilt and the lack of support from her husband.

Yes I do and that is how I get over the guilt because if I go off and feel guilty I go off and think you have got to do this for you. You deserve this you are entitled to do this and you are entitled to do this for your own health. Because you don't do much for yourself and this is the one thing that I do for myself. (Kath)

Lack of access to preferred exercise environment
In most cases, inclement weather lowered the motivation of the non-resumers to walk. Three out of five of the non-resumers shifted house during their pregnancy, moving into homes or environments that were more suitable for raising a family. The new physical environments often impacted on the mothers' interest or ability to resume exercise.

I don't like walking on the beach very much. I guess I always been out in the woods type person. (Fiona)

Typically mothers have a break from work to recover from the birth and to become accustomed to their new lifestyle. The consequent drop in financial income was perceived to be a barrier towards exercise, especially for the non-resumers whose partners had low-paying jobs or were full time students. One non-resumer perceived she was unable to continue her gym membership, and two other non-resumers perceived that they could not afford a suitable pushchair to enable them to resume their walking.

When he [baby] started getting bigger, he was too big for me to even put in the backpack. We don't have a mountain buggy. (Emma)

Access to childcare options was perceived to be a barrier towards exercise for the non-resumers who did not have family in their immediate area or had limited finances. Identifying trustworthy caregivers was perceived to be of the utmost importance for the mothers, especially when the baby was still young or unsettled.

Well David [husband] still doesn't like leaving Laura [baby] with other people. Not yet. So even though, I don't know, she's just too young. But he's pretty firm. (Fiona)

Three of the non-resumers perceived that they could not resume their exercise classes, as they believed they could not afford to pay for childcare. Some mothers also perceived that it was difficult to access childcare facilities.

All of the resumers had a strong sense of entitlement and desire to exercise and made an effort to try and have exercise as a priority.

She [carer] can only have 4 children at any one time and because she is such a good carer she is booked up. So it is pretty hard for me just to ring her up and ask can you take Annie [baby] for half an hour so I can go for a swim because she probably has about 4 kids. (Kath)

RESUMERS

Entitled to exercise

All of the resumers had a strong sense of entitlement and desire to exercise and made an effort to try and have exercise as a priority. Although still seeing their baby and their partner as a priority, the resumers also perceived that their own health and time-out from their baby were important for their new lifestyle.

Mike [husband] and Jacob [baby] are the priorities in my life. And just making sure that they're all right and I'm all right. I'm a priority. (Linda)
I suppose I make sure I set time aside. (Ali)

The resumers all perceived that they had supportive partners, however this may have been a result of the mothers' own assertions.

I said this is what I'd like to do and he said okay well I can do this day and this day and I'll organise it around that. (Sarah)

One mother mentioned that her partner knew the consequences if she didn't get a chance to exercise, and she believed that he preferred to go out of his way to make sure she did her exercise.

Exercise was perceived to be a priority over housework for the resumers. These mothers stated that they were reasonably relaxed if their house was in slight disarray, expecting that this was part of having a young baby around. One of the resumers mentioned that she did her housework while her baby played by herself.

I fit my housework in while she's napping ... she plays and entertains herself quite well now, so I quite often do my housework while she's boogying around or crawling on the floor. (Jenna)

Support of social environment

Having a supportive social environment certainly assisted some mothers in resuming their exercise. Most of the resumers perceived they had supportive families who were willing to care for their babies while they exercised. One of the resumer's mothers was highly supportive in both caring for her grandson and encouraging her daughter to exercise.

I'll [mother] come out everyday at some stage that suits you and then you can go for a walk. (Linda)

The resumers perceived they had access to family, friends and work colleagues to call on if they needed help with childcare. Some of the resumers exercised with other friends who had babies, which proved to be great motivation.

I have started walking a lot with my friend who has just had a baby. (Linda)

Although postnatal support groups are not suitable for everyone, they can provide mothers with long-term benefits both socially and in terms of exercise support. Three mothers in the resumers group were part of a regular postnatal group and found that going for walks with other group members helped them return to their exercise. They were more than happy to ask each other for help in looking after their baby while they exercised.

Access to preferred exercise environment

Most resumers either had the available finances to purchase mountain buggies (approx. \$600) and backpacks (approx. \$150) or they had it as a purchase priority. Most of the mothers who resumed exercise had rain covers for their mountain buggies and therefore did not perceive the weather as a major barrier to their exercise. One mother who did not have the available finances purchased a second-hand mountain buggy for \$150. Backpacks were also a common commodity of the resumers who found that they were able to create flexibility with their exercise and the baby's routine.

If she is not tired she much prefers the backpack. If she's tired she prefers the pram, because she can sleep. (Jenna)

Three of the five mothers resumed their gym sessions around 3-5 months after their babies were born and had access to a crèche which was available free of charge. These mothers were more willing leave their baby's within a crèche where it was perceived to be lead by trustworthy crèche workers. Although the crèche fees were included in gym memberships, mothers had to book in for set days due to demand for the service.

It was a really good service to be able to offer and it's a good crèche. I like what the staff do with the kids. They've got a ten-minute rule. If they can't settle a child after about ten minutes, they come and get you and that's great. (Jenna)

Discussion

First-time mothers in this study perceived different and more barriers towards resuming their exercise,

Erratum

The Editorial Board apologise an error in the April 2006 issue. In the topical discussion article by Elaine Gray "Midwives as mentors" a cited report did not include the name of the second author. It should have read:

Stewart, S., & Wootton, R. (2005). *Mentoring and New Zealand midwives: A survey of mentoring practice amongst midwives who are members of the New Zealand College of Midwives*. Christchurch: New Zealand College of Midwives.

when compared to their barriers prior to pregnancy. The transition into motherhood created a dramatic change in their lifestyle, bringing with it changes in personal and situational factors that impacted on their ability to be active. Anecdotally, it has been suggested that the barriers to resuming exercise during the postpartum time include '...physical changes, competing demands, lack of information about weight retention, fear of interference with breastfeeding, and stress incontinence' (Ringdahl, 2002, p. 32). Furthermore, heavy breasts, the physical nature of the birth, and complications from the birth or physical rehabilitation, may also affect the mother's ability to resume exercise (Difore, 1998; Sweet & Tiran, 1999).

However, it was apparent within this study that there were multiple influences, within the wider environment that impacted on the mothers to be more active. Ecological models posit that in order to understand and explain exercise behaviours, it is crucial to take into account the potential factors or multiple levels of influences that can impact on the behaviour (Sallis & Owen, 1997). Within this study, many factors were experienced by the mothers, therefore they were grouped into the following themes; intrapersonal, interpersonal, socio-cultural, physical environment and health-care environment.

Many of the barriers identified by non-resumers, related to their perceived role as a mother. Most of the non-resumers demonstrated a strong 'Ethic of Care'; a belief that their most important role in society is to care for and nurture others. This strong 'ethic of care' meant that taking care of their baby, partner, and their home were top priorities (Bialeschki & Henderson, 1986). The mothers perceived that these priorities were legitimate and appropriate uses of their time, and they were likely to feel selfish or guilty if they responded to their own needs over the needs of those close to them (Henderson & Allen, 1991). It was therefore extremely difficult for the mothers to step outside

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Exercise barriers faced by first-time mothers

of this view of their lives to give themselves permission to prioritise their own activities and interests over the needs of others (Drew & Paradise, 1996). These mothers recognised their exercise needs but other obligations took precedence. These mothers had a lower sense of entitlement and/or desire and did not have exercise as a high priority. This directly impacted on their desire and motivation to resume exercise.

On the other hand, the resumers had exercise as a more important priority, their ethic of care was still a priority but they had a more balanced approach to managing their priorities. Additionally, the resumers identified strategies to successfully negotiate barriers in order to resume exercise, whereas non-resumers perhaps not seeing themselves as a priority or not having the desire, did not even consider thinking about or negotiating barriers. By seeing themselves as a priority, the resumers utilised cognitive and behavioural strategies to enable resumption of exercise. Resumers were more realistic about their exercise tolerance and their new lifestyles, saw their own time and health as a priority, had supportive families, and had access to their preferred exercise environments. They also sought and accepted help, accepted compromised housework standards and planned prioritised and delegated tasks (Schelkun, 1991; Remington, 2000). In addition the resumers involved themselves more in community-based groups such as postnatal groups. While it could be argued that the resumers faced fewer barriers than the non-resumers, this may have simply seemed the case as they made it easier on themselves and circumvented potential barriers.

The general population often report a number of surface barriers to exercise (e.g. time, lack of motivation) (LINZ, 1994). Underlying or deeper barriers such as a fear of failure, and the image of physical activity, are often the true reasons that prevent people from participating (LINZ, 1994). In this study, first-time mothers claimed a number of barriers to being active, but a pervasive underlying barrier may have been the fear of not being a 'good' mother. Fear of not being a 'good' mother, or the fear of being selfish, may be a powerful deeper psychological barrier emanating from socio-cultural expectations. It has been found in 'constraints negotiation research', that if people perceive that anticipated benefits are important, this acts as a strong motivator for them to successfully negotiate constraints (Nadivova

& Jackson, 1999). Conversely, where potential negatives are perceived; for example, fear of not being perceived as a good mother, these could act as a strong de-motivators and decrease the desire to resume exercise. Here, the fear of not being a good mother may far outweigh any of the perceived benefits.

To help mothers resume their levels of exercise it is important to identify individual barriers and

Identifying the mother's knowledge, benefits, barriers, preferences, goals and expectations in terms of her resuming exercise will help set the scene for creating an appropriate exercise plan.

to encourage mothers to identify ways to negotiate these obstacles in order to resume exercise. Mothers' historical, socio-cultural, and ideological contexts are an important consideration in this process. Encouraging disclosure of beliefs and expectations attached to the motherhood role is one approach

that may help in identifying underlying barriers to exercise resumption. In turn, this may require reassurances to dispel any fears that the mother has concerning being selfish, or not being a good mother if they exercise. In this respect, it is important to help the mother find a balance between spending time on themselves and on others (Henderson & Allen, 1991), and encouraging the mother to recognise that giving themselves permission to take time for their own needs is both desirable and acceptable. Everyone is entitled to time for themselves, and exercise is a legitimate and appropriate use of time (Drew & Paradise, 1996) in terms of remaining psychologically and physically healthy.

This study identified that these mothers were not a homogenous group. It is therefore important that midwives, health and exercise professionals endeavour to understand the mother's unique situation from her perspective. Identifying the mother's knowledge, benefits, barriers, preferences, goals and expectations in terms of her resuming exercise will help set the scene for creating an appropriate exercise plan. Thorough lifestyle profiling of the mother's daily routine is important in order to find potential time for exercise and to think of creative and flexible strategies to help the mother get back into exercise. Taking an ecological perspective, it is necessary to profile the social and cultural influences, and consider the physical environment issues and the exercise information or encouragement received from healthcare providers.

Lack of partner support and encouragement featured as a perceived barrier for the non-resumers within this study. In terms of the wider family

support the non-resumers perceived they had access to this but they did not seek it. Therefore, it depended on the mother's ability to request and ask for this support. The resumers however tended to be more assertive and actively sought this support. Depending on their family situation, mothers could be encouraged to seek support resuming exercise and negotiate with their partners for exercise time. Similarly, encouraging mothers to make use of postnatal groups may also help some mothers resume exercise. Finally providing mothers with information about exercise classes, groups, facilities, and walking tracks that are appropriate for mothers in the postnatal period may also facilitate mothers in resuming their exercise. As an outcome of this study an exercise brochure has been produced for local (Dunedin) mothers (Dunedin City Council, 2005).

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Introduction

I am pleased to introduce this issue's Practice Wisdom Column which holds stories from the lives and work experiences of two practising midwives. The first is a case study by Gail Kiss, midwife and mother of 7 children, from Auckland. Gail's story draws on recent personal experience and highlights that our personal lives impact on and grow our midwifery practice and 'knowing'. The second is an exemplar written by Anita Bain, independent midwife from Otorohanga, which is moving, thought provoking and empowering of midwifery practice. Both stories are a reminder that many midwives walk between the worlds of being a woman, mother and midwife.

As always I warmly invite response and reaction to this column from readers. Letters to editors and journals are rare this century it seems. We would consider written responses/contributions by email.

Rhonda Davies

One mother's experience – one midwife's lesson

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Until recently reflux was one of those issues that I brushed off as an "overused label" that anxious parents gave to their fussy babies. It was of no interest to me as a midwife. Karma has a way of making you sit up and take notice. Since the birth of my 6th child I have ridden the "reflux rollercoaster" and had to embrace and confront my ignorance of this condition. Over the past year I have come to realise how traumatic having a reflux baby can be for parents and that reflux is a midwifery issue.

Midwives are almost the sole practitioners caring for mothers and babies in the first 4-6 weeks post partum, when this condition manifests. Midwives specialise in sharing knowledge, and empowering parents. Midwives have an obligation to keep their knowledge current, continue throughout their professional lives to learn, and to strive to meet

the information needs of women.(Standard 10, NZCOM, 2005).

Having a reflux baby is like riding a rollercoaster blindfolded. The only difference is you can't get off when you have had enough. Give women the information they need and you remove the blindfold and make the ride much less stressful. My personal experience of reflux, which I relate below, compellingly informed my practice as a midwife, and has motivated me to try to reach and educate as many of my colleagues as possible.

Vinnie's story

In late 2004 I gave birth at home (as planned) to my sixth much loved baby with the support and care of a wonderful midwife. Those first few days were contented and enjoyable as our family welcomed and got to know this little blessing. By day 10 it was becoming evident that all was not well. While Vinnie had initially taken to breastfeeding like a dream, he was becoming quite unsettled within moments of latching on. We checked carefully for signs of oral thrush. We tried different positions. I altered my diet and cut out foods that might have caused him wind. By day 14 it was no longer a pleasure to nurse, and feedtimes had become a battleground. Our GP checked for ear and throat infection and suggested it might be early colic. We tried every colic remedy ever invented, and then some.

Our midwife (wise woman that she is) suggested that it may be reflux. I purchased infant Gaviscon and hoped our troubles were over. But they were not. Not only is it next to impossible to convince an exclusively breastfed baby to swallow 10ml of thick gooeey paste, but keeping it down also became a problem. Up until we introduced Gaviscon he hadn't really vomited much. That changed rapidly. The few times we managed to force all of the Gaviscon down (and it remained down) we found his reflux improved marginally. He was able to breastfeed for about ten minutes and then sleep for half an hour before feeding again. It became an endless cycle of forcefeeding Gaviscon, cleaning up vomit, forcefeeding more Gaviscon, ten minute breastfeed, half an hour sleep, ten minute breastfeed.....

By 3 weeks it seemed inevitable to me that breastfeeding was not going to work. It all seemed so much simpler to merely mix the Gaviscon in with some EBM and bottle feed the lot to him. And so a cycle of pumping, mixing, feeding, pumping..... began. Our success was shortlived. Within two weeks, the Gaviscon was less effective. He was

continued over...

One mother's experience – one midwife's lesson

back to fighting, arching his back and screaming after swallowing a few mouthfuls. By this stage the whole family dreaded feed times. It would take two hours of short feeds, burping, walking while he digested what he had swallowed and back to feeding, to get him settled. He was sleeping in short bursts, often waking screaming in obvious pain, and inconsolable. At night he woke hourly. Cuddling up in bed, and co-sleeping became impossible. By now he was vomiting some of every feed back and we needed to have a plastic mac and towels over his mattress to effect a quick change in the middle of the night.

We were due to be discharged by our midwife at this stage, but thank goodness she had some knowledge about gastric reflux and pointed us in the right direction. We went off to the GP and asked for Zantac. The GP wasn't entirely convinced but we came away clutching the script, praying for a miracle.

Only 1ml of Zantac is needed twice a day. It seemed so easy. Unfortunately it is an extremely bitter liquid that babies loathe. Although it seemed to help the reflux considerably, our poor baby hated taking it and fought us hysterically, then sobbed himself to sleep in distress. He developed an aversion to his change table where we lay him to administer the Zantac and after reading up that many babies go on to develop oral aversion and refuse to either take a bottle/breast or solid foods, we felt in the depths of despair. It was about this time that I abandoned all pretence of being a "responsible health professional" and put him on his stomach to sleep, with his cot tilted alarmingly. Finally he was able to settle into a deep sleep that lasted an hour or two.

Apart from the aversion to the taste, Vinnie showed signs of improvement within a week. He no longer fought the breast quite so much but needed short and frequent feeds or the vomiting intensified. We hoped we had found the cure.

Once again it was a false sense of security. Within two months he was back to screaming and arching his back at feeds, and was sleeping less and less. By now he was three and a half months old and while he had gained weight, it was not as much as it should be. Smiles were infrequent and he rarely laughed or played. He spent his time either screaming in pain or sleeping fitfully. We tried my much-loved sling, a front pack, a bouncer seat, a battery swing...some things gave relief for a couple of hours, others did nothing. Over time we learned that he needed to be propped at a certain angle. Too high or too flat and he became distraught. The angle had to be just so....

and flat on his back caused him to panic. It was kind of like being Goldilocks trying out the three bears' beds.

At 4 months he was still waking 5 times a night on a good night, and 8 times on a bad one. Sleeping prone meant trips out were curtailed, as sleeping in the buggy was impossible, and he spent much of the time screaming. I was feeling housebound and sleep deprived. None of my other babies had been this demanding and I began to feel that nothing I did was making a difference. I couldn't comfort him – he didn't like being held and he couldn't nurse for comfort as he now associated it with pain. The walls were closing in and this new baby was no longer a joy. When anyone asked after him it was difficult to find anything nice to say. I got sick of saying "he's getting there".

I feared postnatal depression as I was certainly not enjoying my life anymore. Days were spent anxiously waiting for the next bout of screaming, the other children resented my lack of patience with them, and nights were a frenzy of broken sleep and frequent breastfeeds. I figured that if the milk was just going to come up again anyway, I may as well give up breastfeeding and turn to formula. This way my husband could do one feed at night and I could manage 4 hours unbroken sleep. As it turned out, I couldn't give up breastfeeding entirely: the guilt of weaning my most needy baby so young was too overpowering. I had breastfed all the others to between 15 and 22 months and to give up at 4 months seemed like I was rejecting him. Besides, he did not take to formula at all well, his vomiting increased and he became more unsettled so I went back to breastfeeding with mixed emotions.

I took him to a homeopath, an osteopath and a herbalist. Nothing helped. The only saving grace was my return to work part-time. I couldn't get out of the house and away from the screaming fast enough. For a few brief hours I could escape from the stress and feelings of frustration. It prevented me from going mad.

At five months I found out more about reflux and came across information about Losec – prescribed for adult sufferers with gastric reflux. Some doctors were using Losec on infants with gastric reflux. I knew my mother had taken Losec and that she

had had a life-threatening reaction to it. I struggled with the thought of giving an adult drug to a tiny baby. It took two weeks to get over my fear, and by then I knew in my heart that I had exhausted all other avenues. I finally approached my GP who checked with a paediatrician and prescribed it for us.

We had been warned it would take up to 3 weeks for his severe oesophageal inflammation from refluxing to heal. However, almost immediately he started to be more settled, would sleep for 2-3 hours at night and only wake 3 times on a good night, and breastfed longer, with less of a battle. He started to become more social and interact with the family, smiling more and laughing occasionally. It seemed that life was becoming normal and we could finally enjoy this baby.

His weight gain had dropped off in the past month, and knowing that reflux babies often cope better with cereal to thicken the stomach contents, I started him on solids. This proved reasonably successful as he was eager and happily swallowed the food I offered. I kept to pure foods as much as possible. I started him on baby rice and then introduced apple. Within a month he was eating baby rice, apple and avocado mashed with banana.

It became easier to add his Losec to his morning cereal. He didn't even notice it going down.

I wouldn't say he was a happy or settled baby, but he was much much better than he had been. Some days he was abominable and some days he was fine. Occasionally we left the house. But steadily the bad days started to outnumber the good days again. I was at my wits

end. There were no other options if the Losec stopped helping so I started reading everything I could on reflux.

I paid to see a private paediatrician who could only tell me what I already knew: Vinnie had severe reflux and I was doing all I could. He also told me to try giving him kiwifruit to counteract the constipation.

Quite by chance I stumbled on a colleague who knew someone with a reflux baby and she recommended a website called www.cryingoverspiltmilk.co.nz (the official Infant Gastric Reflux Support Network of NZ website).

Parents of reflux babies often report feelings of frustration at their inability to help their baby. They struggle through trying to find what helps and what doesn't. The monetary cost of medications, alternative therapies, equipment for propping and positioning can be very daunting.

The night I went to that website and read the information, I cried my eyes out. I cried for the agony and suffering my baby had endured, I cried for the needless time wasted getting the correct medication and most of all I cried with anger for the misinformation I had been given. In retrospect I realise that my GP and the paediatrician I had seen simply didn't know better. Often you just don't know **what** you don't know.

Happily for Vinnie, I had finally found the information we needed: the Losec had stopped being effective when I started putting it with his cereal because it is deactivated by milk, and it needs an acid to activate it. The website info suggested sprinkling the granules onto pureed pear. Apple (which formed the basis of Vinnie's diet) was known to be particularly bad for reflux babies. Banana also. Avocado affected some babies but not all. Kiwifruit being very acidic and very hyperallergenic is an absolute no-no, and caution should be taken with potatoes and kumara. Many reflux babies are also lactose-intolerant and breastfeeding mothers may need to eliminate all dairy from their diets. Losec should be given at LEAST half an hour before a milk feed and it may be necessary to adjust the dosage as the baby gains weight.

Vinnie went onto 10mg twice a day, and finally he started to have more good days than bad. At 7 months, he had a growth spurt and he started to crawl. He learned to play and he developed a routine of sleeping twice a day for 3 hours and all night. He stopped vomiting and the screaming was only heard when an older sibling thieved a toy from him. Now when people asked after him I could respond that he was a darling and doing well.

I also found a discussion board at this website and discovered many other mothers who had exactly the same story to tell and the same frustrations with lack of information and knowledge out there. I joined a local support group and gathered strength from their experiences and empathy. We laughed and cried together about our battle to get the information we needed. We vowed to get it out there for others to access. I talked with other mothers about the effect having a reflux baby has had on them and what they felt their midwives could do. This article is based on our personal experiences.

I recently took Vinnie to our GP and while there mentioned the website. She has since visited it, and learned more about reflux and how to treat it. She reports that she is now passing on the correct information to other parents and is sympathetic to my feelings of frustration at the long journey we faced getting treatment right.

Vinnie is now a thriving, happy toddler of almost 2 and a half. He weaned completely from Losec at 20 months and can tolerate almost all foods now, apart from apple.

A midwifery issue:

Reflux is estimated to be present to some degree in up to 50% of babies. It is related to the immaturity of the digestive system, in particular the Lower Oesophageal Sphincter (LES). This valve doesn't function properly and contents of the stomach are able to regurgitate into the oesophagus, causing pain and irritation. Some refluxers merely vomit copiously but don't suffer from pain. The "Crying over spilt milk reflux" website indicates that most babies outgrow reflux by about 2 years old.

Parents of reflux babies often report feelings of frustration at their inability to help their baby. They struggle through trying to find what helps and what doesn't. The monetary cost of medications, alternative therapies, equipment for propping and positioning can be very daunting. They face daily battles trying to convince doctors something is wrong, and disapproving looks from other parents who insinuate its something the parents are doing wrong. They feel frustrated trying to get the right medication and the information they need to cope with this condition.

Many mothers give up breastfeeding in the mistaken belief that it is their milk (or lack of), or their diet that is causing the symptoms. Faced with a "failure to thrive" baby, how could any woman not doubt her ability to adequately nourish her child?

Many mothers of reflux babies develop postnatal depression and some have limited their family size due to the fear of having another reflux baby.

So what can midwives do?

The most important thing midwives can do is GET EDUCATED. Go to the website and learn about the signs and symptoms, in particular the very early symptoms of screaming, unsettledness, poor feeding, poor weight gain, frequent hiccoughs, dusky/mucousy episodes and apparent pain. Prepare parents and tell them what to watch for and what to expect. Diagnose early, and then refer them to a good paediatrician who knows about reflux.

Reinforce that breastfeeding is the BEST thing she can do. Many women give up breastfeeding because they don't realise the problem is reflux, or because it just seems easier. Reassure her that it is not her milk making the baby unsettled and that formula presents its own problems, but consider advising a dairy free diet to see if this helps.

Suggest the simple things that may help like: tilting the cot, trying different sleeping positions, finding the right angle to prop their baby on, how to hire equipment like swings and exersaucers (anything to keep baby upright). Reinforce the need to thoroughly burp their baby and suggest short frequent feeds instead of long ones. Focus less on weight gain and more on wellness. Suggest the baby

doesn't wear any clothing with tight waistbands, and prepare her that she may need lots of bibs.

Put her in contact with support groups, and encourage her to get out of the house as much as possible. Prepare her for, and watch for, postnatal depression. Suggest her partner does whatever possible to let her get some unbroken sleep. Suggest she borrow a sling or front pack to carry the baby around in (what works for one baby may worsen the symptoms of another).

Above all: if a newborn in your care shows any of the symptoms of reflux, mention it to the parents and warn them that it may or may not be reflux. Tell them to see their GP if they feel it is worsening and that there is medication available, and an end in sight. Knowledge is power and parents of reflux babies need that power in order to get their baby treated appropriately and quickly. And remember, the website www.cryingoverspiltmilk.co.nz provides some excellent, evidence-based information for families and professionals.

Postscript

Gail has since had a seventh child, another beautiful boy, who also has reflux but who is very well controlled on 20mg of Losec daily. His reflux did not develop until 10 weeks of age and they went straight to Losec without trying the other medications.

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The challenges of offering post mortem: an exemplar

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Six thirty am and the phone was ringing. I was happy. It would be the lady who was five days overdue; finally we would be underway. It was, however, not to be. The call was from a woman who was only 35 weeks pregnant and who had had a stillbirth less than a year ago. She was bleeding. I was on the road within minutes after having rung my colleague to attend first as she was only three minutes' drive from their house.

My fifteen-minute drive had me covering many things in my mind but not the one I was greeted with. No fetal heart. The bleed was minimal. I had seen much more than that during labours with other women. The loss of the baby was huge. We transferred in the ambulance to the base hospital one hour away. We hoped for the best while we travelled.

On arrival an ultrasound was performed which confirmed that the baby had died. We shed tears and struggled to believe that it could happen again. The woman went on to birth beautifully a very normal looking daughter. However this story is not about the birth but about the decision to proceed with a postmortem and the challenges that this presented to me as a midwife.

There were no investigations undertaken after the previous stillbirth. So, while the woman was in early labour, I discussed with the couple the possibility of a postmortem, which may give them some answers. I had been fortunate to hear a neonatal pathologist speak last year and so I was able to explain the procedure. They did not hesitate but agreed immediately. The couple were Maori and I knew that it is not the custom of the Maori people to undertake a postmortem without very good cause. The postmortem, which needed to take place in a different city, was arranged for the following day.

Following the birth, a staff member came to me and said that the baby would have to transfer to another hospital two hours away to be prepared for a flight to the place of the postmortem. I was also told the baby would go to the morgue overnight. Without consulting with the family I said that this would be unacceptable, as they would not allow the baby to go to the morgue. It is not

the custom of Maori to leave the bodies of their people alone while awaiting burial. It is a custom that I fully support having worked in a geriatric nursing facility where often bodies were left in rooms alone. Reentering those rooms for me was always difficult if there were no family present. The staff told me that this was just how it had to be and there was no way round this dilemma. I repeated that there would have to be a solution found and asked why the baby could not travel the following morning and still be in time to catch the plane? The base hospital manager could not be reached and again I was told that this was the protocol and so this was what would need to happen. It was time to talk to the family.

My talk with the family confirmed that their baby going to the morgue was not an option and if that had to happen the postmortem would not proceed. I returned to the office where the manager had finally been reached on her day off. The result was the same.

- This was the protocol
- It was not customary for the family to travel with the body
- This was just the way it was and the family would have to accept this if they wanted the postmortem

I was very unhappy with this response from the manager. Firstly, this family had just had their second stillbirth in less than twelve months and they needed some answers if there were any. Secondly, there is inequity between the health of Maori and pakeha in this country; not seeking an answer exacerbates this situation. This couple deserved to have answers; they were also entitled to have their culture respected and adhered to. I had believed, naively, that there was a much wider understanding of the processes around death for Maori by members of the health profession.

I had offered the family the opportunity to travel with the baby as I had heard the neonatal pathologist state that family were welcome to attend. I offered it to the family when we initially discussed the possibility of postmortem knowing the importance of family staying with the body. The cost had to be borne by the family.

I can appreciate why at this point many midwives would have given up and said it was too hard to argue the protocol. I certainly felt that way. I had just been at the birth of a stillborn baby. I felt cheated. I was suffering from the stress of an antepartum haemorrhage event, and the postpartum complications. The disappointment I felt for the family was indescribable. As I walked down the

corridor to their room I felt like admitting it was too hard to sort. That was only a momentary passing thought though. I do not believe that obstacles are insurmountable and I placed a call directly to the Forensic Pathology Unit (FPU) staff who were responsible for organizing the process.

The response I received over the phone from this department was a relief.

The FPU person said there was no problem with us keeping the baby overnight but asked the family to be at their Unit at 7 am the next morning. They arranged transport for the family to the postmortem even though they had never been in the position of taking family with them before. Transport was arranged to the airport. I worked with whanau to organize transport from the airport to the hospital, where the postmortem was to take place, as the hospital was unable to provide it for the family. The return trip was done in the same way.

The family later told me that on the day everything went smoothly. They said the pathologist was excellent as were all the people they came into contact with that day. They were told they were the first family members to attend with their baby.

My true appreciation of how big a decision it was for this family to undertake the postmortem came when I asked about the funeral. It is the custom where they are from to bury stillborn babies within 24 hours of being born. We had held that baby back for 48 hours and I was awed by the sacrifice they had made to undertake a process that required them to put aside their customs.

What have I learnt from this experience and what do I want others to know?

- Protocols are not set in concrete and often do not reflect the needs of families, nor respect different cultures. Sometimes they only seem to

Bipolar disorder: Implications and guidelines for midwifery practice

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Abstract

Research suggests that potentially 2-2.5% of childbearing women in New Zealand may be affected by bipolar disorder; a psychiatric illness characterized by acute alterations in mood. It is therefore probable that midwives will provide care for women affected by this illness. This article examines the incidence of bipolar disorder and the implications for midwifery practice and maternity care provision in New Zealand. Guidelines are proposed for midwives, who provide care for women affected by this disorder during pregnancy, labour and the postpartum period. Maternal, fetal, and neonatal implications of standard pharmacological therapy for bipolar disorder are presented in tabular format.

Introduction

Bipolar disorder is a psychiatric illness characterized by acute alterations in mood. Research suggests that potentially 2-2.5% of childbearing women in New Zealand may be affected by this illness. As the majority of maternity care in New Zealand is provided by midwives, the management of bipolar disorder, and the associated maternal, foetal and neonatal risks during childbirth pose particular challenges for the profession. Guidelines for providing midwifery care to women affected

by the disorder during pregnancy, childbirth and the puerperium are outlined, and discussed in this paper.

What is bipolar disorder?

Bipolar disorder is a psychiatric illness characterized by acute alterations in mood, from persistent elation or irritability (mania) to severe depression. The disorder is diagnosed according to various clinical presentations of affect and behaviour. Signs and symptoms of mania include; increased physical and mental activity, heightened mood, exaggerated optimism and confidence, excessive irritability, aggression, grandiose delusions, a decreased need for sleep, increased sex drive, racing speech, thoughts, or flights of ideas, reckless behaviour, distractibility, impulsiveness, substance and alcohol abuse, provocative, intrusive behaviour, and denial that anything is wrong. During a depressive episode, individuals may experience prolonged sadness, unexplained crying spells, loss of pleasure in activities once enjoyed, including sex, agitation and anxiety, feelings of guilt/worthlessness, inability to concentrate, memory lapses, indecisiveness, extreme lethargy, significant changes in appetite and sleep patterns, social withdrawal, unexplained localized pain, and suicidal ideology (American Psychiatric Association, 2000).

Bipolar 1 disorder is defined as one or more mixed or manic episodes that alternate with major depressive episodes. Bipolar 2 disorder is diagnosed when individuals experi-

ence one or more major depressive episodes accompanied by hypomania, a milder form of mania (Griswold & Pessar, 2000). Other variants of bipolar disorder include rapid-cycling when four or more acute episodes occur within 12 months, and cyclothymia characterized by extreme mood swings (Newman, Leahy, Beck, Reilly-Harrington & Gyulai, 2002). Diagnosis may be further complicated by the existence of co-morbidity such as substance abuse, anxiety, or personality disorders (Bauer & McBride, 2003). Consequently, affected individuals may become severely ill and can exhibit symptoms of catatonia, melancholia and/or psychosis before diagnosis is confirmed (American Psychiatric Association, 2000).

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reflect essentially the culture of the health profession.

- There is still a huge gap in the knowledge of health professionals as to the basic cultural beliefs and customs of Maori people, whilst I acknowledge not all Maori will have the same cultural perspective. Cultural safety education for midwives and other health professionals must be on going. Also at times there is a simple lack of respect for anybody who dares to be different or wants to challenge the system.
- It is possible for a postmortem to be arranged in a sensitive and compassionate manner, that accommodates the culture and beliefs of the family.
- If you look hard enough and long enough, somebody, somewhere will help.
- When you have put into motion a process that you believe in, the next thing is to trust that the right people will do the right thing at the right time and be in the right place!
- Do not ever give up!

Postscript

I am the facilitator of our local antenatal classes. Recently my phone rang at 1.30am and the caller was a woman who had attended three months earlier. She was not a client of mine. A family member had just had a stillborn baby and the baby was going to have a postmortem but they were facing resistance from staff about the family traveling with the baby. She phoned me to confirm it was possible as I had talked about it in the class on the "What happens when things don't go as planned" night. The ensuing conversation resulted in the family accompanying their baby. There was a huge satisfaction for me knowing that my talking and being open about things that can happen has resulted in another family's needs being met. It also encouraged me to have this article published so that more midwives can have this knowledge.

Bipolar disorder: Implications and guidelines for midwifery practice

Table 1. The Maternal, Foetal and Neonatal implications of Standard Pharmacological Therapy for Bipolar disorder

Drug	Drug classification	Drug dose	Drug administration	Drug Effects during : 1. Pregnancy	
Lithium	Mood stabiliser	Commence with 750-1000 mgs daily. Serum levels checked after 5 days.	Oral Tablet If possible Lithium level should be slowly reduced prior to conception and during first Trimester.	Woman Hypothyroidism, Goitre, Tremor, muscle weakness, impaired renal function decreased cognitive function, drowsiness, weight gain, maculo-papular rash, diarrhoea. Increased risk of polyhydramnios.	Foetus 3.5% risk of cardiac anomalies. Epstein's anomaly in tricuspid valve. 1.2% risk of congenital anomalies e.g. nephrogenic diabetes insipidus.
Carbamazepine	Anticonvulsant	Commence with 200-400 mgs daily. Serum levels checked after 5 days.	Oral Tablet If possible Carbamazepine level should be slowly reduced prior to conception and during first Trimester.	Dizziness, ataxia, visual disturbance. Nausea, vomiting, Transient sedative effect and reduction in red & white blood cells. Raised GGT level. Thyroid dysfunction.	0.5-1.0% risk of Spina bifida, neural tube defects, craniofacial dysgenesis and growth retardation.
Valproate	Anticonvulsant	Commence with 400-800 mgs daily. Serum levels checked after 5 days.	Oral tablet	Muscle tremor, appetite stimulation, substantial weight gain, hair thinning, ankle swelling. Rare effects include thrombocytopenia and hepatic failure.	6.7% risk of teratogenesis. 1-5% risk of Spina bifida, microcephaly, craniofacial dysgenesis e.g. oral facial clefts, growth retardation ear deformities.
Lamotrigine (Lamotrigine)	Mood stabiliser	Commence with 12.5 to 25 mgs and increase weekly. Average dose: 200 mgs daily Max: 400 mgs.	Oral tablet	May interfere with folate metabolism and cause life threatening rash (Stevens-Johnson syndrome, Toxic epidermal necrolysis). Headaches common.	2% risk of teratogenesis, neural tube defects, delayed ossification of the long bones.

Bipolar disorder and childbirth in New Zealand: Incidence and implications

Recent survey results examining the health status of New Zealanders, suggest that 1 adult in 40 has been diagnosed with a serious chronic mental disorder such as schizophrenia, chronic depression or bipolar disorder (Ministry of Health, 2004). McGorry (2004) contests that result, and suggests that due to misdiagnosis the incidence of affective disorders particularly bipolar disorder is probably higher, potentially 2 or more cases per 100 adults. This incidence equates with research results from Australia that suggest an incidence rate for bipolar disorder of 2.5% amongst the adult population (Goldney, Fisher, Grande, Taylor, & Hawthorne, 2005). Bipolar disorder affects women more frequently than men therefore potentially 2-2.5% of childbearing women in New Zealand may experience this illness. Consequently, the incidence of the condition in childbearing women may have

significant implications for maternity care provision, more particularly for independent midwifery practitioners providing lead maternity care.

Genetic liability and gene-environment interactions account for some maternal and neonatal outcomes during childbirth. However, pharmacological, biological and behavioural concomitants of severe mental illness also appear to be major determinants for increased reproductive pathology. Jablensky, Morgan, Zubrick, Bower, and Yellachich (2005) suggest that women affected by bipolar disorder have an increased risk of placental abnormalities, antepartum haemorrhages and fetal distress. They propose that risk reduction may be achievable by adopting a multidisciplinary approach to providing continuity of care for women affected by bipolar disorder throughout the childbirth experience.

Guidelines for midwives caring for women affected by bipolar disorder during pregnancy

Although some studies (Grof et al., 2000; Marzuk et al., 1997; Sharma & Persad, 1995) suggest pregnancy may reduce the risk of an acute episode occurring during, and immediately postpartum, evidence is conflicting. Freeman et al. (2002) and Viguera et al. (2000) propose women affected by bipolar disorder have a substantially increased risk of relapse during pregnancy. Grof et al. (2000) suggest the risk of relapse is particularly high from 34 weeks gestation, and if mood-stabilizing treatment is discontinued. Antenatal considerations for the midwife are discussed in the following sections.

1. Interdisciplinary Consultation

A potentially increased incidence of antepartum illness suggests that midwives caring for women affected with bipolar disorder should,



2. Labour	3. Postpartum		Drug Interactions
Woman If possible reduce serum lithium level prior to delivery to decrease risk of neonatal toxicity, & maternal lithium toxicity due to interaction with opiates.	Woman Same as during pregnancy. Breast Milk concentration 24-72% maternal serum concentration.	Newborn May cause hypotonia, lethargy, cyanosis hypoglycaemia, cardiac arrhythmias, gastrointestinal problems, impaired thyroid function long term. Highly elevated serum levels in breastfeeding, infants & poor suckling.	Diuretics & NSAIDs: decrease serum lithium clearance. ACE inhibitors: lithium toxicity. Calcium channel blockers: Tremors, ataxia, nausea, vomiting, SSRIs: dizziness, agitation.
Increased risk of nausea & vomiting.	Same as during pregnancy Increased risk of PPH.	Possible association with Hyperbilirubinaemia and Hepatitis in breastfeeding infants, however serum level in breast milk is usually 1-5% of maternal level, and not usually associated with side effects.	Oral contraceptive effectiveness reduced. Erythromycin, & Cimetidine decrease serum carbamazepine clearance Phenytoin increases serum carbamazepine clearance.
Increased risk of fluid & electrolyte imbalance.	Increased risk of PPH. May be associated with polycystic ovarian syndrome.	Withdrawal symptoms noted in Newborns. Serum concentration in breast milk 1-5% of maternal level, serum level in breastfeeding infants is lower. Valproate Anticonvulsant syndrome may occur in neonates.	Carbamazepine: increases serum Valproate clearance Aspirin & Warfarin: may inhibit the metabolism of Valproate. Alcohol : increased CNS depression.
Physiology may trigger Stevens-Johnson syndrome. Associated with life threatening fever.	Same as during pregnancy, nausea, vomiting, ataxia, dizziness.	May result in low birth weight as easily crosses the placenta during pregnancy.	Carbamazepine, and oral contraceptives decrease the serum half life of Lamotrigine. Valproate increases the serum half life of Lamotrigine.

4. Referral to mental health care providers

Mental health care providers can provide ongoing psycho-social and pharmacological treatment, and reviewing maternal serum medication levels to ensure that levels remain adequate to control symptomatology (Kusumakar, MacMaster, Kutcher & Shulman, 2002). Within New Zealand, maternal mental health care providers may assist with specialised care provision and organise respite care for family members. However, due to the increasing demand for mental health services within the community and economic constraints, continuity of support for women and their families has been fragmented, and referrals to specialist mental health services have been prioritised and in some instances not accepted.

Simpson and Jamison (1999) estimate 15% of individuals affected by bipolar disorder commit suicide and approximately 30-56% of affected individuals will attempt suicide. Therefore due to the increased risk of self-harm, a woman suffering an acute episode of illness is

with women's consent and participation, adopt an interdisciplinary approach to planning and providing maternity services and consult relevant obstetric, psychiatric, and community health professionals.

2. Antenatal Booking

Stewart and Henshaw (2002) recommend that midwives conducting an antenatal booking, document the specific psychiatric diagnosis, history of disease presentation, past and current co-morbidity, past and current psychotropic drugs, dosages and treatment responses, and any familial history of mental illness. Women's adherence to treatment and any evidence of self harm, destructive or impulsive behaviours should also be recorded.

3. Antenatal Care

Brockington (1998) and Needham (1997) report that bipolar disorder may have a negative effect

on women's self care abilities specifically hygiene, nutrition, and sleep patterns as well as maintenance of the home environment. During antenatal checks midwives evaluate women's physical and psychosocial health through observation and discussion. If bipolar symptomatology is suspected, midwives with relevant knowledge and education may administer initial screening questionnaires for mood disorders (Tully, Garcia, Davidson, & Marchant, 2002). Screening assessments for evaluating depression and mania are available online (Mayo Clinic, 2003).

Substance abuse disorders are commonly associated with bipolar disorder. Clarke and Paine (1997) propose that midwives observe women for evidence of intoxication, hallucinations, and other aberrant behaviours. Midwives may also refer pregnant women for fetal amniocentesis, nuchal and morphology scans to assess for medication-induced teratogenicity.

considered to be in an emergency situation. It is essential that midwives promptly refer such women to the Crisis Assessment and Treatment (CAT) mental health team for care.

5. Genetic counseling

Gershon (1990) estimates offspring of a woman with bipolar disorder have a 12-20% lifetime risk of developing the disorder and suggests the risk increases if there is a multigenerational and or paternal history of bipolar disorder. Carlson-Sabelli and Lessick (2001) suggest early onset of the disorder in women may also increase the risk for offspring and recommend access to psychiatric, and genetic counseling so that affected women and their partners may be informed regarding the inherited risk for their children. Ideally, counseling should occur prior to conception. However, following obstetric consultation and at the request of pregnant women who are affected by bipolar

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disorder, midwives may initiate a referral for counseling.

6. Targeted antenatal education

In consultation with psychiatric health professionals, midwives may provide information encompassing the following:

- a. **Disease Presentation:** Discuss with women and their families the potential impact of pregnancy and childbirth on disease manifestation, such as exacerbation due to childbirth-associated stress and the influence of hormones as physiological triggers for acute episodes of mania or depression (Clarke & Paine, 1997).
- b. **Maternal and fetal medication implications:** Outline the maternal advantages (control of illness), and disadvantages (side effects, pregnancy complications) associated with standard and alternative mood stabilizers (Lithium, Lamotrigine, Carbamazepine, Valproate). Explain to women the teratogenic risks of these medications, and inform women regarding the potential consequences of pharmacotherapy for newborn babies. The details related to commonly prescribed drugs are outlined in Table 1 (Altshuler et al., 1996; Bowden et al., 2004; Briggs, Freeman & Yaffe, 2002; Burt et al, 2001; Chaudron & Jefferson, 2000; Cohen, Sichel, Robertson, Heckscher & Rosenbaum 1995; Cohen & Rosenbaum 1998; DeVane & Nemeroff, 1998; Gagliardi & Krishnan, 2003; Gold, 2003; Hansen, Peacock & Yankowitz, 2002; Llewellyn, Stowe & Strader Jr, 1998; Moore, Turnpenny & Quinn, 2000; Moretti, Koren, Verjee, & Ito, 2003; Pinelli, Symington, Cunningham & Paes, 2002; Viguera & Cohen, 1998; Wyszynski et al., 2005).
- c. **Promotion of health:** Encourage women to plan and execute self care activities such as daily exercise, adequate nutrition and hydration, setting realistic personal goals for coping with pregnancy, planning enjoyable activities, avoiding or reducing alcohol and drug consumption, and taking time to rest or sleep.
- d. **Co-morbidity:** Midwives may discuss the potential consequences of alcohol and substance abuse during pregnancy and childbirth. These include: maternal antepartum haemorrhage, cardiac arrhythmias, placental abruptions, and miscarriage; fetal microcephaly, growth retardation, mental retardation, maxillary hypoplasia, genitourinary malformations, and facial dysmorphism; and neonatal withdrawal symptoms including apnoea, irritability, weight loss, and seizures (Beischer, MacKay & Colditz, 1997).

7. Community resources

Midwives may inform women and their family about, and facilitate access to, websites, community resources and support groups or associations such as Legal Aid, Plunket Family Centres, Pregnancy Help, and La Leche League. Support services specifically designed to aid individuals experiencing mental ill health, and their families, include Balance - New Zealand Manic Depressive Bipolar Network, Bipolar Manic Depression Society, and the Mental Health Foundation of New Zealand Resource and Information Centre. The Mental Health Foundation of New Zealand also provides resources for health professionals.

8. Familial involvement in care

Midwives can encourage familial involvement in supporting pregnant women because family can maintain a supportive environment, obtain treatment and services when women are acutely ill, support compliance with medication, provide reassurance and encouragement to women regarding their ability to manage pregnancy, and participate in treatment and low stress activities (Miklowitz & Goldstein, 1997).

9. Family support

Due to the high-risk behaviour frequently exhibited by women with bipolar disorder, family members, in addition to maintaining the home and caring for the affected individual, may have to interact with the legal, and health care systems simultaneously. Griswold and Pessar (2000) suggest that family members are subjected to considerable stress and cope with feelings of grief, anger, and guilt, and the stigma associated with mental illness with minimal community support. Daly (1997) recommends midwives support family and close friends by providing information regarding community resources and initiating referrals to support groups, counselors, and relevant professionals.

10. Childbirth management plan

If women are experiencing an acute episode of illness they may exhibit excessive irritability, anger or aggressive behaviour. Midwives can develop a comprehensive birth plan in consultation with women, their families, and relevant supporters that incorporates pre-agreed interventions and routines such as timing and justification of vaginal exams, to reduce or prevent illness-related non-compliance with care requirements during labour, and the level of stress experienced by women during intimate interventions, and during the postpartum period.

11. Hospital notification

Midwives may notify maternity staff regarding pending or potential admission of acutely ill women, or women affected by bipolar disorder who have received little or no maternity care, and or who have poor self-care skills.

Guidelines for midwives caring for women affected by bipolar disorder during childbirth

Freeman et al. (2002) suggest that women affected by bipolar disorder, particularly an acute episode of illness, experience physiological changes during labour that in conjunction with psychotropic/analgesic drug interactions, may seriously compromise their physical and psychosocial health, and the well being of their unborn children (See Table 1). Recommendations for maternity care providers are discussed in the following section.

1. Notification of psychiatric staff

When a woman affected by bipolar disorder is admitted, the midwife informs relevant psychiatric personnel to ensure prompt access to emergency care (psychiatric assessment, and prescription of psychotropic drugs such as anti-psychotics, mood stabilizers, or sedatives), and professional support from mental health professionals who are familiar to and accepted by the woman (Royal Australian and New Zealand College of Psychiatrists Clinical Guidelines Team for Bipolar Disorder, 2004).

2. Implementation of care plan

Spielvogel and Wile (1992) suggest acutely ill women are able to detect signs of labour and cooperate with caregivers during labour. However labour is psychosocially, emotionally and physiologically stressful. Prompt implementation of a pre-agreed care plan for childbirth provides women, particularly those experiencing an acute episode, with structure and familiarity, and may reduce the level of stress experienced and facilitate women's ability to cope with childbirth.

3. Psychosocial and Physical Environment

Midwives can minimise women's exposure to bright light and loud noises, and either remove potentially hazardous material or substances e.g. unsecured sharps and chemical solutions, from the birthing environment, or ensure potential hazardous items that may be required during childbirth are not readily accessible, to potentially reduce the level of stress experienced by women (Needham, 1997). Recommendations for reducing maternal anxiety include provision of continuity of care by familiar and reassuring health professionals, limiting social access to the birthing room, and only having individuals in the birthing room that are acceptable to the labouring woman (Clarke & Paine, 1997).

4. Medication during labour and childbirth

Midwives work collaboratively with mental health professionals during labour. Mental health professionals will prescribe relevant mood stabilizers and midwives, in consultation with mental health professionals, monitor compliance with medication, and observe for side effects due to altered maternal physiology during labour, and drug interactions (See Table 1).



5. Monitoring client status

Women experiencing mania will have an increased risk of dehydration and hypoglycaemia during labour due to rapid calorie metabolism (Viguera, Cohen, Baldessarini & Nonacs, 2002). Monitoring and facilitating women's nutrition, hydration, and elimination is an essential midwifery practice during labour. If women are experiencing an acute episode, midwives may need to provide them with intensive support to promote maternal self-care.

6. Obstetric complications

Research undertaken by Kinney, Todd, Tohen and Tramer, (1998) suggests women affected by bipolar disorder may experience an increased incidence of obstetric complications such as post partum haemorrhage, and caesarean births, however current evidence is not conclusive. Browne et al. (2000) propose that obstetric interventions such as the application of forceps or ventouse to effect delivery and caesarean sections are associated with increased episodes of mental illness during the postpartum period, and recommend that if women are coping well with labour, and there is no evidence of fetal distress, midwives should support women affected with bipolar disorder to have a vaginal birth with minimal intervention. However, midwives are advised that due to the increased risk of neonatal compromise, the attendance of a neonatal paediatrician at the birth is strongly recommended.

Guidelines for midwives caring for women affected by bipolar disorder during the postpartum period

Freeman et al. (2002) and Viguera et al. (2000) suggest approximately 60% of women affected by bipolar disorder experience manic or major depressive episodes within three to six months of childbirth. Several studies (Abbott & Katona, 2000; Austin, 1992; Robling, Paykel, Dunn, Schopf & Rust, 1994; Sharma & Mazmanian, 2003) report that many women presenting with puerperal psychosis also develop bipolar disorder. Liebenluft (1996) proposes the hormonal cascade associated with the reproductive cycle may precipitate episodes of acute illness and increase rapid cycling of affect postnatally. Wisner, Hanusa, Peindl, and Perel (2004) agree with Liebenluft's premise and suggest that the most prudent pharmacological approach should be to treat individual women with the drug they have responded to most favourably prior to pregnancy, and prepare a plan for rapid augmentation of treatment if a breakthrough acute episode occurs. Sharma, Smith and Khan (2004) propose that partly due to sleep deprivation, there is a high risk of reoccurrence of an acute episode in the immediate postpartum period, and recommend comprehensive follow-up care by maternity care providers. Specific care recommendations for midwives are discussed in the following section.

1. Postnatal serial screening

Due to the high incidence of relapse and increased severity of illness, Cohen, Sichel, Robertson, Heck-

scher and Rosenbaum (1995) suggest midwives serially screen for bipolar symptomatology during the postnatal period to facilitate rapid augmentation of pharmacological and cognitive therapy.

2. Mental health care initiatives

Newman, Leahy, Beck, Reilly-Harrington and Gyulai (2002), and Bauer and McBride (2003), recommend that midwives provide care that supports mental health initiatives such as cognitive therapy goals and or psychotherapy interventions so that affected women receive continuity and consistency of care. Ball, Mitchell, Malhi, Skillecorn and Smith (2003) propose that midwives with appropriate training may be directly involved in schema-focused cognitive therapy to facilitate adjustment to motherhood. Training is available in these treatment measures for mental health specialists in New Zealand, and midwives wanting to support therapy initiatives may contact the relevant mental health teams for more information. Midwives may be able to access support from care providers specialised in maternal mental health. However, due to the high rate of mental ill health experienced by childbearing women during the postnatal period, specialist services are restricted and increasingly referrals are forwarded to the community mental health teams. Additionally, within New Zealand there are very few mother/baby units, that can cater for a woman who is affected by an acute episode of mental illness, and that have direct access to core midwifery services.

3. Familial support issues

Bipolar disorder is a chronic psychiatric illness that may seriously impact on a woman's ability to care for herself and her newborn child. During the postnatal period, midwives continue to support and educate family members, whanau, and close friends who may be providing support, regarding how to best care for the newborn baby and support the woman during her transition to motherhood. In some urban centres, respite support for family members may be arranged by midwives in consultation with community mental health teams.

4. Family planning

Packer (1992) and Viguera, Cohen, Bouffard, Whitfield and Baldessarini (2002) suggest women with bipolar disorder may encounter negativity from health professionals regarding pregnancy, and that midwives should discuss the option of psychiatric preconception counseling to examine the genetic, drug related and disease manifestation risks associated with, and facilitate clinical planning for, future pregnancies.

5. Self care strategies

Sharma and Mazmanian (2003) have identified sleep deprivation as a causative factor for precipitating acute illness and psychosis during the postnatal period. Griswold and Pessar (2000) recommend limiting caffeine intake, exercising regularly, ensuring adequate nutrition and participating in leisure activities to maintain postnatal health. Midwives can encourage women to maintain psychosocial and physical self-care practices through education and discussion in the postnatal period.

6. Infant care

Transition to motherhood is particularly stressful for women experiencing mental illness. Midwives can facilitate this transition by providing women with comprehensive information regarding, and

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physical assistance with, infant care practices, psychosocial support, and reassurance. Specific guidelines on infant nutrition may be necessary if women are receiving pharmacological treatment that may contraindicate breastfeeding (see Table 1).

Women who experience an acute episode of illness in the postpartum may have delayed bonding with

their newborn babies (Cicchetti, Rogosch & Toth, 1998). However, Hipwell, Goossens, Melhuus and Kumar (2000) suggest that delayed maternal bonding and infant insecurity regarding maternal attachment primarily occur when women experience an episode of depression rather than mania. Consequently midwives are encouraged to provide support and care for women who experience an acute episode of illness similar to the care recommended for women experiencing postnatal depression.

Midwives should initiate a referral to the paediatrician for follow-up assessment if infants are breastfeeding to ensure, regular monitoring of serum levels of pharmaceuticals. If the infant is not breast feeding, although very uncommon, the midwife should observe for withdrawal symptoms (depressed reflexes, hypotonia, lethargy) and promptly refer to the paediatrician for further assessment and care.

7. Postpartum medication

Altshuler et al. (1996) and Cohen, Sichel, Robertson, Heckscher and Rosenbaum (1995) recommend postpartum treatment with mood stabilising drugs, and suggest that lithium be commenced within 48 hours of birth, as it appears to reduce the incidence and severity of acute illness by 40%. Lithium prophylaxis is not recommended when women are breastfeeding their babies because high

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serum concentration in breast milk can cause neonatal compromise (Briggs et al., 2002; Chaudron & Jefferson, 2000; Kozma, 2005). Liporace, Kao and Abreu (2003) suggest that serum Lamotrigine levels in breast feeding babies are highly variable due to individual physiology and may approximate adult therapeutic levels, predisposing the infants to severe side effects. Midwives may discuss drug contraindications and alternative mood stabilising options during the puerperium, with the woman and mental health professionals. These may include carbamazepine or valproate as they concentrate in breast milk at only 1-5% of maternal serum levels (Hansen, Peacock & Yankowitz, 2002). Midwives may also encourage maternal self-medication with pharmacotherapy. The details related to pharmacotherapy during the postpartum are outlined in Table 1.

Conclusion

Bipolar disorder is a chronic psychiatric illness that may have a catastrophic effect on women during childbirth. Midwives incorporate interdisciplinary and familial involvement when providing maternity services to affected women. Care is targeted to address maternal, fetal, neonatal and familial issues associated with the disorder, and may include genetic counseling, familial support, and education regarding medication, comorbidity, community resources, and potential obstetric complications. Maternal health is encouraged by providing women-centred and condition-specific antenatal, labour and postnatal midwifery care that incorporates promotion of maternal self-care practices, screening for bipolar symptomatology, monitoring of maternal fetal and neonatal well-being, initiating relevant referrals and supporting mental health initiatives.

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SURFING THE NET

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Whilst mentoring has only recently come to the fore in New Zealand (NZ), when you start to surf the Internet you realize that mentoring has been around for some time. Mentoring is recognised as a valuable resource for personal, educational and career development for any number of people from disadvantaged youth to women working in male-orientated occupations. The Internet provides a vast amount of information about mentoring schemes as well as resources for people wanting to be mentors or be mentored. Here are a few web sites that I have found to be particularly useful.

One of my favorite web sites is the **Triple Creek Associates**. This company specialises in providing mentoring as a business; however it has made some extremely valuable resources on its web site freely available. There are self-paced workbooks for both mentor and mentee. The mentor's workbook takes you through what is expected of a mentor; how to set up a mentoring relationship; mentoring contracts; giving feedback; managing conflict and facilitating an effective relationship. The mentee's workbook looks at all these issues but from the mentee's point of view. There are surveys that help you identify the skills you need to have to be an effective mentor as well as your needs as a mentee. Fact sheets that inform you about what to expect from being a mentor and mentee. A great resource for midwives and students.
www.3creekmentoring.com.

The **National Mentoring Association of Australia** has a web site that is a spring board for investigating online mentoring resources. It hosts links to numerous mentoring resources and schemes such as The Youth Mentoring Network (www.youthmentoring.org.au) and the Australian Women's Mentoring Network (<http://womensmentoring.com.au>). Whilst there is material that does not appear to be relevant to NZ midwifery situation, there are also a lot of ideas that can be adapted to fit our context. Unfortunately the web site is not regularly maintained so it is difficult to assess currency of information.

www.dsf.org.au/mentor/links.htm

Ann Rolfe is a consultant who works with organisations to set up mentoring schemes in Australia. Whilst her web site aims to attract customers, she also allows access to free resources. One resource is a 15 part email 'course' that explains why you need a mentor and handy hints for setting up mentor schemes. On one hand the emails are annoying because they try to hook you into Ann's mentoring schemes but there is some information that is relevant. The other interesting free resources are designed to make you think about why you should be a mentor, and talk about the mistakes that can be made when designing a mentoring scheme.

[www.mentoring-works.com/
free_stuff.htm](http://www.mentoring-works.com/free_stuff.htm)

The University of Queensland (UQ) runs a mentoring scheme for all new staff. The reason I recommend the UQ web site is because it has posted its policy and guidelines which contains best practice guidelines for the implementation of mentoring programs.

According to UQ, the key to a successful mentoring program is careful planning and design, an effective communication policy, and regular evaluation. This echoes Ann Rolfe's assertions that a poorly designed mentoring scheme does more harm than no mentoring at all. The UQ guidelines are detailed, informative and well referenced, and deal with issues ranging from the characteristics of an effective mentor to training and orientation to the mentoring program. The guidelines give ideas for dealing with problems such as mis-matching of mentor and mentee as well as dealing with unfulfilled expectations.

www.tedi.uq.edu.au/mentoring/policy_and_guidelines.asp#the_mentoring_policy

Another web site that I have made good use of is Mentor.Org. **MENTOR** is an American organisation that was set up in the early 1990s designed to match young people with an adult mentor. The pages of particular interest are concerned with program design and development; management and implementation and evaluation. The National Mentoring Centre's mentor training program and curriculum is available which includes modules about recruitment and matching mentors. The evaluation module guides you through the process of deciding what outcomes you want to measure; how to carry out the evaluation and suggests questions that can be asked. The key message from MENTOR is that mentoring programs

must be carefully planned and designed with an in-built evaluation strategy. You have to sift through material because some is not applicable to NZ midwifery, however the general principles are extremely relevant.

www.mentoring.org

Andrew Gibbons is an English consultant who runs mentoring workshops and education programs. His mentoring web site contains a large number of free downloads including definitions of mentoring, skills diagnosis and competency statements. There is also a detailed bibliography. If you want to be slightly distracted, Andrew has also made free downloads about change management, leadership and negotiation. Unfortunately a few of the links are unavailable, but there is the option to email requesting further information.

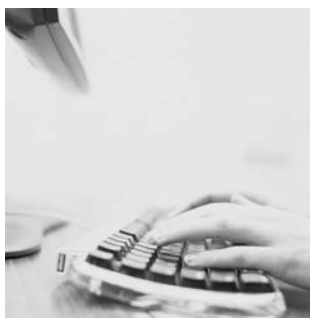
www.andrewgibbons.co.uk/mentoring.html

If you are interested in how other countries have approached mentoring and preceptorship in nursing and midwifery, the Internet gives you access to documents and research from a number of contexts and practice settings. The **Canadian Nurses Association** carried out a project in 2003/4 looking into mentoring and preceptorship. The result of that project was presented in the document "Achieving excellence in professional practice—a guide to preceptorship and mentoring". This document includes guidance for developing programs as well as the results of the Canadian research.

www.cna-nurses.ca/CNA/documents/pdf/publications/Achieving_Excellence_2004_e.pdf

If you cannot get your head around the two terms and the difference, if any, between preceptorship and mentoring, have a look at the comprehensive review that Mills, Francis and Bonner have written and published in the online journal **Rural and Remote Health**. In the paper "Mentoring, clinical supervision and preceptoring: clarifying the conceptual definitions for Australian rural nurses. A review of the literature" Mills et al define and discuss the difference between the different support mechanisms for practitioners. This paper is a good place to start if you want to explore the theoretical underpinnings of each concept.

<http://rrh.deakin.edu.au/articles/sub-viewnew.asp?ArticleID=410>



The faces of mentoring in New Zealand: Realities for the new graduate midwife

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Abstract

This research examines the experiences of nine graduate midwives who were mentored in their first year of self-employed practice.

The research used a feminist phenomenological approach, which gave me the opportunity to honour and respect what the midwives shared with me. In-depth semi-structured interviews were used to collect data that traced the transition the midwife makes in becoming an autonomous practitioner and the importance of a supportive mentoring relationship in assisting this journey.

Being a self-employed midwife carrying a case-load can involve a range of personal and professional stresses. Midwives moving into self-employed practice, although registered competent to practice, identified that they wanted support to help establish confidence and discuss professional issues.

Introduction

Mentoring is the term used in New Zealand to describe the process of supporting, in particular, newly graduated midwives entering into self-employed practice (New Zealand College of Midwives, 2000). Mentoring is a new, exciting concept in midwifery and has mainly been used to assist new graduates make the transition to a confident practitioner.

Mentoring is currently very topical and is being discussed widely within the profession (Gray, 2006; Kensington, 2005; Stewart & Wootton, 2005). The recent article by Elaine Gray (2006) on 'Midwives as mentors' outlines the New Zealand College of Midwives (NZCOM) commitment to establishing a mentoring framework and a conceptual model has been proposed for discussion. On International Midwives Day, 2006, the Minister of Health announced that funding is being made available for the 'The first year of practice' and on May 11th the NZCOM held its first workshop on 'The practicalities of being a mentor' in Christchurch.

The reshaped maternity services in New Zealand entitle every woman to have her own Lead Maternity Carer¹ (LMC) who provides continuity of care throughout the woman's childbirth experience. Currently over 78% of women choose a midwife as their LMC (New Zealand Health Information Service, 2006). Education of midwives is through the Bachelor of Midwifery degree programme and many of the graduates move into self-employed practice as soon as they qualify (Daellenbach, Kensington, Laurenson & Davies, 2006; Pairman & Massey, 2001).

This research uses a qualitative approach to provide an understanding of the context and experience of mentoring. A feminist phenomenological approach was used to describe and analyse the experiences of graduate midwives who were mentored in their first year of independent/self employed practice. The research used Levesque-Lopman's (2000) understanding of feminist phenomenology through the perspective of "listen and you will hear" as a method for "starting from women's lived experiences" (2000, p.103). The emphasis is placed on 'listening' to the participants' experiences and the meanings of their narratives. Feminist phenomenology also allowed me to look beyond the individual midwife and how they experienced mentoring and understand how this is reflective of a highly politicised and gendered context (Fisher, 2000).

The data from the midwives' interviews were analysed using a thematic analysis, which was applied to the transcripts in order to highlight key areas/issues/challenges that graduate midwives identified.

Ethical approval for this research was gained from the Department of Public Health and General Practice, Christchurch School of Medicine and Health Sciences, University of Otago and subsequently from Christchurch Polytechnic Institute of Technology Academic Research Committee.

In order to understand and appreciate the 'many faces of mentoring' it was important to be able to place this research within a context of existing knowledge on mentoring relationships and also explore the development of mentoring. Material from this research illustrates that mentoring of new graduate midwives in New Zealand has elements of mentoring, preceptorship and supervision as described in the international literature (Anforth, 1992; Armitage & Burnard, 1991; Butterworth, Faugier & Burnard, 1998;

Donovan, 1990; Hardyman & Hickey, 2001). This is supported in Stewart & Wootton's (2005) recent research of New Zealand midwives, which found some midwives believe mentoring should also encompass elements of preceptorship or supervision.

Literature: What is mentoring?

There is much academic literature concerning mentorship but little recorded empirical evidence to support its use in nursing and midwifery. Most of the literature on nursing and midwifery is from the United Kingdom (UK) and United States of America (USA) and is situated within institutions. As there is no literature on mentoring within self-employed midwifery I looked at research related to mentoring, preceptorship, clinical supervision and supervision within midwifery and nursing. There is much overlap and confusion between these terms and they are often used interchangeably within the literature.

The origin of the concept of mentoring has been well documented (Andrews & Wallis, 1999; Morton-Cooper & Palmer, 1993, 2000; Watson, 1999). It has its roots in Greek mythology originating from Homer's *Odyssey* in which Mentor, a trusted friend of Odysseus was appointed as a tutor/advisor to his son Telemachus while he was away at the Trojan wars (Cook, 1974).

This story, later seen in fairy tales from other cultures, embodies the concept of transition (Daloz, 1987; Freeman, 1998). The stories relate how young people are faced with a series of obstacles that they have to overcome in order to achieve their desired goal. Along the journey various people play a key role in providing knowledge, support, practical insight and wise counsel. Within this tradition the term 'mentor' has become synonymous with faithful guardian and teacher providing protection, guidance and wise counsel (Daloz, 1987; Freeman, 1998; Morton-Cooper & Palmer, 2000).

The mentoring relationship is described as a dynamic and complex concept that can be "naturally or artificially contrived to benefit individuals within a sharing partnership" (Morton-Cooper & Palmer, 2000, p.39). Classical mentoring, also known as informal mentoring (as interpreted by Levinson et al., 1978), is described as a relationship that has as its central focus a partnership based on mutual trust. The relationship is set up naturally and not artificially contrived whereas formal mentoring, also known as contract or facilitated mentoring, is

an adaptation of classical mentoring and is usually determined by the organisation and has a recognised programme of development and support (Morton-Cooper & Palmer, 2000). Mentoring involves negotiating a relationship between two people in which their personal characteristics, philosophies and priorities will interact to influence the nature, direction and duration of the resulting partnership. It is based on mutual regard and common values and, at its core, the process is shared, encouraging and supportive. For mentored people knowing that someone is there, willing to give them support and encouragement, enables them to come to terms with their role in the organisation or professional setting (Morton-Cooper & Palmer, 2000).

Concepts of preceptorship and supervision

Preceptorship

Preceptorship offers a period of support and attempts to ease the transition into professional practice or socialisation into a new role. The preceptor role provides orientation and support, and teaching and sharing of clinical skills (Armitage & Burnard, 1991; Bain, 1996). It is characterised by a relationship where one person teaches, instructs, supervises or coaches another (Butterworth, Faugier & Burnard, 1998; Donovan, 1990). Preceptor relationships are intended to be short term, are usually assigned, focus on the development of clinical competencies, and may involve judgement of clinical performance (Bain, 1996; Hardyman & Hickey, 2001).

Supervision

Supervision is another form of support that adds to the confusion of the terms mentoring and preceptorship because it has a variety of meanings and influences on practice.

In social work, mental health and the other therapies the supervisor provides a supportive and critical space for the professional practitioner (Morton-Cooper & Palmer, 2000).

Clinical supervision is described (Bishop, 1998 cited in Deery, 1999, p.252) as: *"a designated interaction between two or more practitioners, within a safe/supportive environment, which enables a continuum of reflective, critical analysis of care, to ensure quality patient services"*. Whereas supervision of midwifery practice which became a statutory requirement with the Midwifery Act of 1902 in the United Kingdom (UK) was essentially set up to examine midwifery practice (Williams & Hunt, 1996). All midwives in the UK have a supervisor that they can refer to, consult and with whom

they are required to meet annually to discuss their professional development (Mayes, 1996). Recently there has been movement towards this supervisory relationship being a more supportive, partnership role (Duerden, 2000; Mayes, 1996).

It is important to understand the mentoring experiences of the midwives interviewed in this research within a context specific to New Zealand. This includes the development of mentoring since 1990 and the formation of access agreements (which enabled midwives to provide midwifery care for their clients within a maternity facility). Following a review of existing documentation around the topic of mentoring (e.g. NZCOM National Committee minutes) three key informants were interviewed to help complete information gaps. The key informants were chosen for their background knowledge and involvement within mentoring since 1990. An added advantage was two of the key informants had also mentored midwives and in the course of the interview their views and experiences were shared.

History of mentoring in New Zealand

The Nurses Amendment Act 1990 granted midwives professional autonomy thereby introducing a system of maternity care that enabled midwives to establish themselves as independent practitioners offering their services to women both within the home and hospital (Department of Health, 1990). This change in the delivery of maternity care was part of a cycle of radical restructuring in the health system (Abel, 1997; Barnett & Malcolm, 1997; Hornblow, 1997).

The first six years of independent midwifery within New Zealand were during a period of considerable change and uncertainty. As Abel (1997) comments not since 1938 when the welfare state and free health care were introduced had the maternity services undergone such a change. Despite the uncertainty, the numbers of independent practitioners had grown from less than 50 midwives claiming from the maternity benefit schedule (MBS) in June 1991, to approximately 500 self-employed midwives in 1995 (Guilliland, 1996).

Formation of access agreements

The passing of the 1990 Act meant other legislation required amending. For example, the Area Health Boards Act 1983 was amended to enable

independent midwives² to have access to public hospitals to provide midwifery care for their clients (Department of Health, 1990). In many parts of New Zealand the Area Health Boards eventually made a simple change in wording to their current access agreement to include independent midwives. However, in the Auckland region the

Area Health Board *"chose to totally revise their agreement – a process which took a year"* (Abel, 1997, p.119). The ensuing arguments and debates around the access agreements in Auckland led directly to discussion locally (within the Auckland region of the NZCOM) on a mentor/midwife system and then nationally to the develop-

ment of the mentoring policy by the NZCOM in 1996 (Key Informant; No 2 & 3). Holland (2001) also suggests that the discourse around access agreements gave rise to the formal process of mentoring.

In Auckland there appears to have been a complete 'lack of belief' in a midwife's ability to be autonomous (Key Informant; No 3). In addition, the hospital managers and some core midwives³ had concerns about and lack of faith in the new midwifery education. *"They just assumed the new graduate would be useless and wouldn't be able to manage and I think have sowed the seed so still today it has not gone away"* (Key Informant; No 3). The view that some midwives are still uncertain and question the suitability of midwifery degree education is supported in research conducted recently (Surtees, 2003). The move from hospital to independent practice in the community was very new and not trusted. There was little faith in the midwives' ability to practise outside the hospital.

The negotiations especially in Auckland were particularly problematic with the Maternity Access Agreement Committee (MAAC) attaching restrictions to practice. The new graduate was especially affected with only being granted a one-year temporary contract and needing to be supervised for twenty births with requirements also made of the supervisor/mentor. Effectively these restrictions on new graduates implied that they needed further training.

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(New Zealand College of Midwives, 2000).

The faces of mentoring in New Zealand: Realities for the new graduate midwife

Development of a structured system of support

During these six years many midwives moved out into independent practice and new tensions developed especially around the provision of support for these midwives. The development of a system of support in Auckland was initially discussed as a way of meeting the requirements of the MAAC and access agreements. The involvement of the NZCOM at this time provided an important forum for midwives to discuss their ideas and seek support and direction.

A major issue in this early period was the provision of support for these midwives. The word 'support' came to have different meanings depending on the organisations involved. The impetus for a structured system of support for midwives appears to have come from two major sources: from the access agreements and from the professional impetus of the NZCOM.

In the case of access agreements, some of the agreements drawn up by the hospital authorities, as part of formalising self-employed midwives' access to hospital facilities, required supervision particularly for new graduates and midwives with limited clinical experience. In the case of NZCOM, there have been two arms of support established. One arm provides mentoring support to enable and develop professional confidence while the second arm is the Midwifery Standards Review process, a permanent structure of professional support set up for the midwife on an annual basis.

In early 1993 the first major discussion took place within the Auckland region of the NZCOM about a mentoring support system for midwives. A draft document was developed called *NZCOM: Auckland Region Position Statement on Gaining Practical Experience Using a Mentor System*. The document outlined the role and responsibilities of the mentor and clearly stated the approval process to be a mentor. The Auckland region decided to use the term 'mentor' instead of peer support because the term 'peer support':

seemed to be the phrase coined by the access agreement that sought to define it as a task... it was the same language they used to constrict or control how you provided support to each other (Key Informant; No 2).

However, the position statement complied with the restrictive practices of the maternity facilities and did not uphold the autonomous responsibilities of the individual midwife being mentored. It supported the view that the mentor midwife would be the responsible decision maker in the event of a conflicting view.

The Auckland draft document was taken for discussion at national level within the NZCOM. By 1996 a consensus statement on Mentoring was developed by the NZCOM, which was ratified at a meeting of the National Committee in November (NZCOM, 1996). The College recognised the mentoring relationship in the title of this consensus statement.

We decided mentoring was much more a partnership model approach that was more women friendly. It wasn't a linear, hierarchical or authoritative model. It was autonomous. Both parties were autonomous. The dictionary meaning (of mentor) fitted much better into a partnership model than preceptorship, supervision, protégé... (Key Informant; No 3).

The College acknowledged that midwives moving into self-employed practice, whether new graduates or experienced hospital midwives, may need support, but emphasised that the nature and existence of such a relationship is the prerogative of the individual midwife. This consensus statement described the nature of the relationship between the two registered midwives as one of partnership where the mentor will listen, challenge, support and guide the mentored midwife. It also clearly stated that the mentored midwife remains responsible for her own practice.

At National Committee there was a real need for whatever was developed to not undermine the education of midwives, for what was really, political and social misunderstanding of what midwifery education was about (Key Informant; No.3).

This was an important step for the College, because if it had upheld the earlier view that a mentor had control over the mentored midwife's practice, then this would effectively be saying that the new midwifery education was not adequate.

Over the last decade there has been continued discussion on mentoring and recognition of the need to develop a mentoring framework. The NZCOM ratified their consensus statement on mentoring in 2000 (NZCOM, 2000) and in their strategic plan for 2004-2006 included the development of a mentorship framework (NZCOM, 2004 cited in Gray, 2006 and Stewart & Wootton, 2005). As part of this development a postal survey was conducted (Stewart & Wootton, 2005) and supported by NZCOM, to find out what midwives' experiences and ideas were on mentorship.

The majority of midwives who have graduated in the past 10 years in New Zealand are not previously trained as nurses and their understanding of the culture of the maternity institution is limited to their student experiences. Students' clinical experience involves working in hospitals alongside core midwives or with independent midwives. The main focus of their education is on providing continuity of care as an independent practitioner. This means when a midwife registers she can move straight into independent practice and by-pass the hospital, thereby missing a period of induction into the institution rules and processes beyond that experienced as a student.

What kind of support then did midwives graduating from the degree programmes want and what was their experience as they made the transition into professional practice?

Mentoring Arrangements

The participants in this study are named Elizabeth, Sophie, Zoe, Lauren, Anne, Jonty, Sarah, Robyn and Alice⁴. Elizabeth, Lauren, Sophie, Zoe and Jonty all joined established

practices and their mentors were part of their midwifery practice. Alice also joined an established practice but she did not have a specific person named as her mentor as she was supported by the entire practice. Sarah and Robyn moved straight into self-employed practice, separately establishing practices with other new graduates and Anne joined a midwife who had recently graduated and had moved straight into independent practice. The mentors for Sarah, Robyn and Anne were separate from their midwifery practice.

Practice Arrangements

- Joined established midwifery practices; individual mentor(s) within the practice:
Elizabeth, Sophie, Lauren, Zoe and Jonty
- Set up own midwifery practice with other new graduate colleagues; mentors were outside of their midwifery practice:
Sarah and Robyn
- Joined an established midwifery practice; did not have a named mentor:
Alice
- Joined a new graduate who had moved straight into independent practice; mentor outside of practice:
Anne



Mentoring Styles

I have grouped the participants into two groups 'mentoring within the practice' and 'mentoring outside the practice' to illustrate the diversity of mentoring styles.

Mentoring within the practice –The mentor's role was seen as providing support, advice (seeking a second opinion) and education. With each of the participants in this group the advice and discussion of cases related predominantly to antenatal and postnatal cases whereas the practicalities of 'being there' and giving support were when the woman was in labour and birthing. Other qualities appreciated were the mentor's relaxed approach and nurturing ability. The majority of this group had twenty-four hour access to their mentor. In most cases the mentors had offered to be available twenty-four hours, seven days a week. These findings are consistent with studies (Darling, 1984; Davidhizar, 1988; Spouse, 1996) describing the mentor's main roles as supporting and investing time and energy into the relationship and offering advice and strategies to the mentored person. Interestingly in relation to investing time, none of these studies refer to the mentor being so readily available.

Meeting with the mentor was a mixture of catching up at practice meetings, having a set meeting time (e.g. Jonty, Alice), arranging to see clients in the same facility as the mentor (Sophie) or in a casual set-up as they worked alongside their support person.

Mentoring outside the practice - The mentor's role for all of them was one of support although how the support was realised is different. For Robyn, her mentor provided a mixture of emotional and business management support whereas for Sarah, the mentor's main role was to be a good listener, facilitate discussion and enhance Sarah's ability to reflect. Anne's mentor initially provided practical support and information on how to set up in practice, and then the focus moved to midwifery practice issues related to Anne's clients. Anne's mentor also provided support similar to the group whose mentors were within the practice. She came to a few antenatal appointments and was involved with the first two women's labour and birth where Anne was the LMC.

Meetings with the mentor were different for these three midwives. Robyn only met twice with her mentor over two months whereas Anne met initially weekly for two months and then every second or third week and Sarah maintained a monthly meeting schedule. All three had phone contact with their mentor to discuss midwifery

issues although the amount of contact varied greatly. Robyn and her mentor had an arrangement where the mentor was not available to come and support her in the practice setting; however her mentor did advise Robyn of the importance of ensuring support was available if needed. For Sarah and Anne an available support structure in the practice setting was established. Sarah's mentor would come and support if a particularly distressing situation arose at a labour and/or birth and for Anne, her mentor was initially involved with some of her clients as already outlined.

The mentor's role in both groups was overwhelmingly one of providing support and advice although it is acknowledged that the word 'support' has many meanings. Where the mentor was based within the practice, the participants expected their mentor to be available for either discussion of cases or to attend/assist at labours/births. These participants stated that the availability and accessibility of their mentor ensured that support and, for some participants, gave them the confidence to extend their practice even further.

Important qualities and factors wanted in a mentoring relationship

Factors that were significant for these midwives in determining a successful relationship were trust, having a similar philosophy to their mentor, knowing their mentor and choice of mentor. These factors ensured the midwife felt safe, comfortable and secure while they gained further confidence.

The participants stated that knowing the mentor already was a key factor in determining whom to select. 'Knowing your mentor' meant someone they trusted and could feel safe and comfortable to be with. This is supported in the research, which confirms that successful mentoring relationships are naturally set up and based on a partnership of trust and mutual respect of each other (Davidhizar, 1988; Earnshaw, 1995; Levinson et al., 1978; Spouse, 1996).

It was quite difficult really because I wanted someone who I could really trust. That was the big thing for me and feel comfortable with because working in a hospital situation is so completely different definitely- so I knew that I'd need, I wanted someone that was very experienced, well not very, it was more trust was a big thing, it was just someone I could trust that I could go to about any queries or concerns or whatever about particular stuff (Anne, Int:1).

I think it's experience and just I think with my mentor I saw she had a real commitment to her women and I just saw so many qualities in her that I would be able to learn from (Lauren, Int: 3).

She's got a very strong philosophy as normal and that was really, really important for me... she's very politically astute as well and I knew that if I ever got stropky she would support me. And that was really, really important for me. And she's just, philosophically she's very similar (Robyn, Int: 8).

Although most of the participants commented that having an experienced mentor was important, what emerged from this study is that a shared philosophy and a positive attitude towards women and midwives were considered equally valuable attributes. This is consistent with Morton-Cooper and Palmer (2000) describing the mentoring relationship as one based on two people sharing common values and working together to support their philosophies. Similarly, Darling (1984) in her study states a successful mentoring relationship is one where there is a mutual attraction and respect between the mentor and the mentored person. For graduate midwives in New Zealand 'knowing your mentor' and 'trust' were clearly identified as critical factors in achieving a successful mentoring relationship.

Why midwives want supportive mentoring relationships

The midwives interviewed in this study understood autonomy and their responsibility and accountability to women and the profession when they were registered as a midwife. However, making the transition to a confident independent practitioner can be challenging and stressful at times. Often they lacked confidence because clinical experience is valued more by their midwifery colleagues than the comprehensive theoretical and evidence based education they received. Surtees' research (2003) also reported this finding. Midwifery was seen as "essentially a practical profession" and the graduates' lack of practical experience was rated a higher concern than the added value of their theoretical knowledge (Surtees, 2003, p.227).

Midwives stated they wanted a supportive relationship as a transitional process to enable them to gain further confidence and to assist at the times when they felt vulnerable and uncertain.

As Sophie explains:

I don't know what the political situation is like elsewhere but I know at certain shifts at certain times of the day at [the hospital] you might have a group of midwives that are working, that wouldn't necessarily be very supportive of somebody that's gone directly out into independent practice and in a situation like that I needed somebody who would support me, be around me if I was in

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The faces of mentoring in New Zealand: Realities for the new graduate midwife

a situation where I just needed help and I needed assistance or I wanted to bounce advice off somebody (Sophie, Int: 3).

The midwives did not want their mentor to take professional responsibility as was suggested in the Auckland Position Statement but be more in a supportive role.

Zoe appreciated her mentor because:

... if anything it gave me more confidence to be independent and do my own bit and they were never threatening or condescending, never made me feel like I was doing the wrong thing. Or just come and support. One would often just come in and watch and just be there and help like with the little things like changing pads and rubbish and notes and I was always the midwife. And then if something wasn't going properly I could say what do you think and they'd say I think you need to do this now. It wasn't that I was made to feel that I wasn't knowledgeable or anything. It was just somebody to reflect the situation back on what was in the room (Zoe, Int: 5).

Their vulnerability originated in both the unpredictable and demanding nature of midwifery practice and at times the unsupportive environment of the secondary/tertiary facilities.

When the midwives came into the room they would say ok so we've got meconium liquor yeah, what are the three things we're going to do? To me, you know. And it's sort of like oh no I'm not a student you know I do know the three things we're going to do and you know it's that talking, that patronising talking in front of the client that makes it really difficult to have a client being confident in you. She feels like she's got a student as a midwife (Robyn, Int: 18).

I used to see one of the biggest roles was that I enabled that midwife to enter a facility and that I acted as the buffer between her and the facility in preventing that stress going on her. I managed that stress (Key Informant; No 2).

I'd always worked really, really well with most of them there and had not had any problems throughout as a student and it saddened me to think that I had to do my time to be able to get that although I was exceedingly grateful, just really, really pleased that I'd actually got there. And you know a couple of them made the comment that you know for a new grad you know your boundaries and you've never been unsafe and it was almost like you know you're a new grad so therefore I should have been unsafe? I mean what were they saying? (Jonty, Int: 24).

The midwives' narratives demonstrated that in their first year of practice they were challenged and tested and often felt as if they were 'on trial', hav-

ing to prove themselves and 'do time'. They were not accepted as a 'full' midwife and had to prove their knowledge of clinical skills, use of equipment and that they were efficient practitioners. In this case the mentor's role can be seen as pivotal to the graduate midwife. At times the mentor also took on a protector role when the midwife was with a client in the secondary/tertiary facility and met an unsupportive environment. Although some core midwives were supportive, participants also experienced core staff as lacking generosity and a willingness to help until they had proven themselves. This was also seen with some of the independent midwives.

The culture of maternity services in which the new graduate midwife has to 'do time' and 'prove herself' can be very confrontational and overwhelming for the new independent practitioner. The core midwives, in stating that Jonty had 'never been unsafe'; appear to support the view introduced in Surtees' (2003) research that the concern for safety necessitates close surveillance of graduates. This provides some explanation of why a number of new independent midwives want their mentor also to serve in a protector role.

Recent research (Daellenbach, Kensington, Laurenson & Davies, 2006) that followed-up midwives who had graduated from Christchurch Polytechnic Institute of Technology (CPIT) also suggests many graduates felt challenged by midwives both in the hospital and in independent practice. This research also confirms that graduate midwives want support and especially a supportive relationship to assist them in the transition to a confident practitioner.

What are the implications for midwifery in New Zealand?

Midwives who complete the three-year midwifery degree programme and pass the national examination for midwifery are registered as midwives competent to practice as an autonomous practitioner and are accountable for their practice whether they work as self-employed or in a hospital setting.

The legacy of a maternity service that provided the majority of care from the hospital/institution has meant that midwifery has had to confront a number of issues e.g. understanding autonomy; appreciating and valuing the different roles of the core midwife and independent midwife; debat-

ing and managing the insider (working with the institution) and outsider (with woman) relationships; valuing the evolving education of midwives from the hospital setting to an educational setting and then to an academic undergraduate degree. Midwives who trained prior to the introduction of an undergraduate degree completed courses predominantly on gaining clinical experience, but with limited theoretical and scientific underpinnings. The consequences of this history has seen a higher value placed on clinical experience by many midwives at the expense of the theoretical knowledge of theory and research graduate midwives have gained through the midwifery degree

education. The message seems to be given to new graduates that this intellectual knowledge is devalued by their lack of clinical experience. They are 'disqualified' before they begin practising independently because they have limited clinical experience and their confidence is quickly undermined.

Conclusion

This research has highlighted that the profession needs to debate a number of tensions in an effort to improve relationships between new graduates and experienced midwives, for example: understanding the transition to an independent practitioner, valuing the knowledge base graduate midwives bring to their midwifery practice and the importance of collegial support. The value of collegial support has implications not only for the midwifery profession but also for providers of maternity services. Graduate midwives moving into independent practice are effectively seen as 'outsiders' by the institution and therefore the informal networks of support within the hospital are often not available. In response to this culture, graduate midwives want a supportive mentoring relationship as they move into independent practice.

The narratives from this research indicate that the relationships described fit well within a definition of mentoring. Mentoring is the word that has been chosen in New Zealand to represent the relationship set up to support a midwife to develop professional confidence (NZCOM, 2000). This term signals that value is placed on differing styles of mentoring as a reflection of the relationship being individually negotiated between two registered midwives. This is supported in this research.

The profession needs to support new midwives as they develop confidence as an autonomous

Factors that were significant for these midwives in determining a successful relationship were trust, having a similar philosophy to their mentor, knowing their mentor and choice of mentor.

These factors ensured the midwife felt safe, comfortable and secure while they gained further confidence.

practitioner, and to appreciate that this time is often challenging and stressful. Most professions make an allowance for a new practitioner recognising they will need an initial transitional period and require extra assistance at times and consult more (Morton-Cooper & Palmer, 2000). Midwifery needs to also make this provision for its new practitioners. The challenge for the profession is to review how they support 'their young' and 'nurture' their future midwives. One way to effect change as evidenced in this research is to ensure graduates have a supportive mentoring relationship or an actively supportive practice to assist them as they make the transition to a confident independent practitioner.

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Kensington, M. (2006). *The faces of mentoring in New Zealand: Realities for the new graduate midwife*. *New Zealand College of Midwives Journal*, 35, 22-27.

- 1 Lead Maternity Carer is an authorised practitioner who is a midwife, general practitioner or an obstetrician who has been selected by the woman to provide her maternity care under Section 88 of the New Zealand Public Health & Disability Act 2000.
- 2 Independent midwife or self-employed midwife: provides continuity of care to individual women and their families and is able to claim from the Ministry of Health for their service fees.
- 3 Core midwife: a midwife employed to provide midwifery care in a maternity facility on rostered shifts.
- 4 These are pseudonyms.

BOOK REVIEWS

Midwifery: Preparation for practice

Pairman, S., Pincombe, J., Thorogood, C. & Tracy, S. (Eds). (2006).

Marrickville, NSW: Elsevier.
ISBN: 07-295-3756-0

Reviewers: Rea Daellenbach and Mary Kensington

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The eagerly anticipated midwifery text book for New Zealand and Australia has finally been published. Reading *Midwifery: Preparation for practice* confirms just how essential and invaluable it is to have a midwifery text for Australasia. This book will be useful and inspiring for midwifery students and practising midwives alike. The wealth of local information provided makes this an important resource for all midwives. This includes NZCOM consensus statements, guidelines by the New Zealand Guidelines Group, Australian College of Midwives, RANZCOG, and the legislation pertinent for midwifery practice in

both New Zealand and Australia. This book brings together the latest research, practice guidelines and extensive references including those available on-line.

Midwifery: Preparation for practice has been developed by one editor from New Zealand, Sally Pairman, and three editors from Australia. It brings together work from 41 authors with a wide range of backgrounds. Contributors are from both New Zealand and Australia and include midwives who work within education and policy as well as practising midwives from a variety of settings. Two chapters are written by scientists and one by

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Midwifery: Preparation for practice

a sociologist. A range of authors brings a diversity of styles amongst the chapters which means there is something in here to please everyone. Most of the practice oriented chapters have been written by practising midwives. This has enabled the editors to strike a balance between theoretical and practical midwifery knowledge.

The differences between the New Zealand and Australian maternity and health systems are highlighted in this book. The way systems are set up in each country has a major impact on how midwifery care is offered. This comparative approach demonstrates that there are a number of ways of providing maternity care which encourages questioning and reflection.

The concept of midwifery as a partnership between women and midwives is integrated throughout the book, not only in chapter content but also in the structure of the book. At different points in the book there is recognition of the variety of choices women might make with suggestions on how a midwife can support these decisions, for example: for women choosing not to use intrapartum antibiotics to reduce the risk of early onset neonatal Group B Streptococcus infection (Grigg, as cited in Tracy 2006, p. 607- 608), or women who decline to have a blood transfusion (Thorogood & Hendy, 2006, p. 790).

The book is divided into two parts, entitled 'Part A: Partners' and 'Part B: Practice'. The first

part of the book sets the scene for midwifery in New Zealand and Australia providing an overview of the historical context in which each maternity system was developed. This section also includes chapters on the significant contemporary influences on midwifery such as world views, evidence based health practice and the impact that place of birth has for women and midwives. The next section covers issues for women. The chapters on 'Challenges to women's health' and 'Making decisions about fertility' are descriptive and practically oriented providing up to date information to enable midwives to work with women. The last section focuses on the professional, legal and ethical frameworks for midwifery practice in New Zealand and Australia. This is one of the things that make this book so relevant for New Zealand midwifery.

Part B encompasses the bulk of the book and is divided into three sections: partnership, autonomous practice and collaborative practice. The partnership section is based on the New Zealand model and reflects the way that partnership and cultural safety are integral to midwifery practice. The autonomous practice section covers the midwifery scope of practice as defined by the Midwifery Council of New Zealand whereas the collaborative practice section addresses the areas of midwifery practice where midwives work with women who also require care from other health professionals. These chapters all emphasise the importance of understanding the physiology of

childbirth. However, for completeness inclusion of anatomy of the pelvis and fetal skull would have been beneficial.

The text book is brought to life by the inclusion of stories from women's and midwives' experiences. The practice chapters all have learning outcomes, critical thinking exercises and review questions as well as extensive referencing and further reading recommendations. Many practice chapters also link information to the NZCOM decision points identified in the Standards for Practice. Critical thinking exercises and review questions are interspersed throughout the chapters which assist student learning. These are also relevant for practising midwives to support the development of reflection skills.

As educators, we recommend this textbook as required reading for all midwifery students. The multi layered nature of this text makes it a valuable resource for first, second and third year midwifery students. For students a textbook that is able to contextualise midwifery practice within the partnership model and the realities of autonomous practice is a welcome innovation that has not been seen before. This text will make a useful addition to all midwives' libraries in New Zealand, Australia and any country in which midwifery is practised.

Further reviews of this book will be included in the December Midwifery News.

Facilitating reflective learning through mentoring and coaching

Brockbank, A., & McGill, I. (2006).

London: Kogan Page Ltd.

ISBN: 0 74944448 7

*Reviewer: Sarah Stewart
PhD candidate
Senior Lecturer, School of Midwifery,
Otago Polytechnic*

Mentoring is currently a hot topic being debated up and down the country. This increased awareness is encouraging midwives to think about the meaning of mentoring; what the role of the mentor is and how to carry out that role in a way that benefits both mentee and mentor. This book is an excellent resource for midwives who want to know more about mentoring and how to develop the skills required by an effective mentor.

Brockbank and McGill are educationalists who write in an easy manner which is not too high-brow, and combines theory with useful information that can be utilised in practice. The authors

begin the book by describing the different approaches to mentoring and coaching and discussing the theories of learning which gives the reader a foundation on which to build their understanding of mentoring. The chapter on reflective learning explains what reflective dialogue is and how to ask questions that facilitate critical thinking which is an essential element of mentoring. Alongside the learning theories is an exploration of mentoring and coaching theory. Whilst midwives may not think that coaching is of relevance, there are elements of coaching that may be incorporated into mentoring practice.

Once the theoretical perspectives of mentoring are dealt with, the authors get into the practicalities of mentoring. They look at the mentor's role and investigate the barriers to being a mentor. Practical advice and information is given on issues such as developing listening skills, giving feedback

and managing conflict. One section explores what mentoring means for the mentee or person being mentored, including the management of disclosure and dealing with receiving feedback. The section of the book that I found especially valuable were the appendices which included a template for a mentoring contract; suggested format for a learning journal; questions for reflective dialogue and ground rules for a mentoring relationship.

I would highly recommend this book for any midwife who is thinking about being a mentor or receiving mentoring. However, for midwives who are more interested in learning about working in the clinical environment with students; teaching clinical skills and assessing practice, I would recommend: *Assessment, supervision and support in clinical practice: a guide for nurses, midwives, and other health professionals*

Ci Ci Stuart, 2004

Churchill Livingstone, London



Impact of birthing practices on breastfeeding: Protecting the mother and baby continuum

Kroeger, M., & Smith, L. (2003).

USA: Jones and Bartlett
ISBN: 0763724815

Reviewer: Ann Johnson
Self-Employed Midwife

'Impact of Birthing Practices on Breastfeeding' focuses on events and interventions surrounding childbirth and breastfeeding both in developed and developing nations worldwide. Mary Kroeger and Linda Smith examine the bond between the mother and baby from the perspective of labour, birth, and breastfeeding.

This text is composed of a collection of experience, research and stories throughout the twelve chapters and is extensively referenced. It finishes with six appendices outlining various movements and initiatives in the US and developing nations that promote and support breastfeeding.

Kroeger focuses on the failure in both developed and developing nations to link the impact of certain childbirth interventions on the readiness of mother or newborn to breastfeed. Smiths' contribution to this text is chapter seven entitled, "Physics, Forces, and Mechanical Effects of Birth on Breastfeeding".

The first chapter is an interesting overview of birth cultures and practices during, largely, the twentieth century, including the birth of La Leche League and the global Baby Friendly Hospital Initiative. Chapter Two entitled "Evidence-based Practice in Perinatal Care" is headed by a succinct quote from Albert Einstein, "Not everything that counts can be counted and not everything that can be counted, counts", which is exactly what Mary Kroeger strives to demonstrate. She examines both the gap in research on the impact of birthing practices on breastfeeding outcomes and the lack of change in practice when there is evidence that supports change.

Chapters Three and Nine entitled "Laboring with a Support Person" and "Fear and Stress in Childbirth and Breastfeeding" respectively could have been combined however the author has presented research and findings that are specific to the titles. "Laboring with a Support Person" focuses on research and evidence that supports this with compelling evidence that support in labour not only reduces the need for intervention and improves birth outcomes, but also impacts positively on breastfeeding and mothering. "Fear and Stress in Childbirth and Breastfeeding" de-

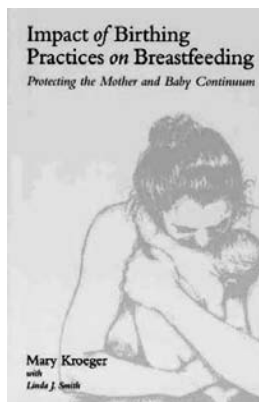
scribes the physiological effects of labour, without analgesia, allowing the body to rely on its own inbuilt mechanism to modulate the pain and how this mechanism can be switched off with labour medications and interventions. The effects of high stress hormones on labour progress and thus birth outcomes are examined as are the effects of those hormones on the newborn, both positively and negatively particularly in regard to bonding and suckling behaviours.

In Chapter Seven Smith looks more closely at the mechanics of labour and labour interventions, and how these affect mother and newborn. She presents a convincing case to explain the relationships between disorganised feeding and birth practices, events and interventions. However she acknowledges the scarcity of supportive research making the connection difficult to prove. It is disappointing though, that osteopathic treatment of infants with sucking dysfunction is not examined. Only a reference to Peter Hartman and Maxwell Flavell's research into results of osteopathic treatment in infants who underwent osteopathic treatment is made.

The remaining chapters examine childbirth practices and interventions alone and in combination that contribute to the 'cascade' of events that the authors attribute to poor breastfeeding outcome both in initiation and duration. This "cascade" can be triggered for example by a lack of continuous support in labour, creating poor coping particularly in primigravid women. Anxiety and pain have been shown to slow labour which may then lead to interventions such as augmentation of labour, more fear and loss of control and the ever increasing medicalisation of labour and birth, including administration of narcotic or epidural analgesia / anaesthesia. This leads to confinement to bed and even decreasing the woman's ability to change position. Ultimately this cascade of events and interventions may progress to surgical or instrumental birth with increased likelihood of interruption of that valuable initial skin to skin contact and potential separation of mother and baby. Often the mother and or baby are in poor condition for bonding, with the mother in pain, exhausted, medicated or all three. The author acknowledges the difficulty to know which factors may be linked to disruption of the breastfeeding dyad as the interventions may precede assisted or surgical birth that are performed for varied

reasons. However there is a host of research and literature that supports the knowledge regarding factors that delay lactogenesis including prolonged labour (first and second stages) and caesarean section (Riordan, 2005).

Kroeger presents all this information with the aim to keep childbirth as natural as possible by providing a holistic and non-invasive approach to labour and childbirth, which will enhance both bonding and the mother - infant readiness to breastfeed.



Photos, drawings, tables and graphs throughout the book enhance the information as do the anecdotal stories such as the one of the man who handcuffed himself to his labouring wife to ensure he stayed with her, as the hospital only permitted 'approved labour coaches to support women!'

The author Mary Kroeger was a nurse, midwife and international maternal and child health consultant with over 20 years of experience in North America, South America, Asia and Africa. She held a Masters degree in Public Health and specialised in safe motherhood, child survival, birth spacing, lactation management, and prevention of mother-to-child transmission of HIV. She passed away last year after more than a year battling cancer.

Linda Smith has been a Lactation Consultant in private practice in the U.S for twenty five years. She is a founding member of the International Lactation Consultants Association and also serves on a number of committees promoting and supporting breastfeeding. She has also been a childbirth educator. She has written a number of books on the subject of breastfeeding including 'Comprehensive Lactation Consultant: Exam Review' (Smith 2005).

Kroeger and Smith's text is a well researched resource for all who work with expectant mothers, mothers and their babies as well as obstetricians, anaesthetists and midwifery students. Whatever your views it will stimulate thought and a better understanding of protecting the delicate and precious breastfeeding dyad.

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Gentle birth, gentle mothering. The wisdom and science of gentle choices in pregnancy, birth and parenting.

Buckley, S. (2005).

Brisbane: One Moon Press. ISBN 0975-8077-0-6

Reviewer: Debbie Payne

Centre for Midwifery & Women's Health
Research, Auckland University of Technology

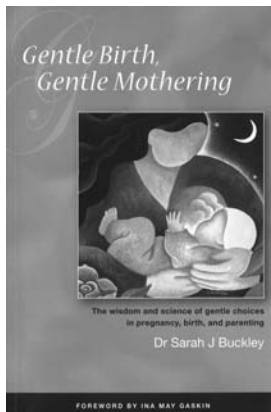
Sarah Buckley is an Australian General Practitioner who has published articles based on both her own experiences as a mother, and her wide, critical reading of medical and other literature, in a variety of journals since 1996. These articles form the basis of her book.

There are three sections to the book. The first consists of relatively short chapters that draw predominantly on Buckley's own four birthing experiences, all of which were homebirths. The middle section

of the book is a critical and well referenced analysis of practices and issues such as prenatal diagnosis, ultrasounds, epidurals, caesarean sections, third stage and breech births. The last section focuses on mothering and considers practices such as breastfeeding, attachment parenting, co-sleeping and gentle discipline.

That the foreword is written by American midwife and author of Spiritual Midwifery, Ina May Gaskin, indicates the author's perspective on pregnancy, birth and mothering: that birth is a normal physiological process. It has the potential to be a rich, spiritual and empowering experience for

women. However, for women to achieve their full potential they must be well informed and involved in decision-making. Buckley aims to provide such information.



Midwives practice in a world where there are multiple and conflicting perspectives regarding pregnancy, birth and parenting. This book presents a perspective that they and midwifery students should know of to be able to provide information and support to women who view pregnancy and birth as a normal process. In summary it is a useful resource for both women and midwives.

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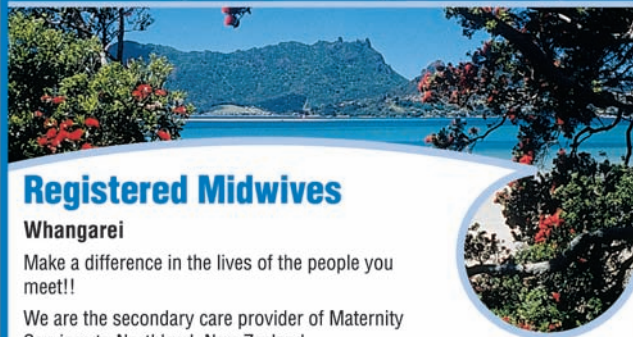
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NORTHLAND DISTRICT HEALTH BOARD

Te Pouari Hauora A Rohe O Te Tai Tokerau



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*References: 1. Wordwood M et al. Iron absorption from a natural mineral water (Spatone Iron-Plus). *Clin Lab Haem* 1996; 18:23-27. 2. McKenna D et al. A randomised trial investigating an iron-rich natural mineral water as a prophylaxis against iron deficiency in pregnancy. *Clin Lab Haem* 2003; 25: 99-103. 3. Halksworth G et al. Iron absorption from Spatone (a natural mineral water) for prevention of iron deficiency in pregnancy. *Clin Lab Haem* 2003; 25: 227-231.

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177.701

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Semester 2
177.702

Evidence-based Midwifery Practice, offered on Palmerston North campus, 30 July - 2 August.

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Safety Items	✓	Comments/Actions
Emergency Readiness		
Awareness of 111 operation		Phone book inside cover.
Torch near bed		Spare batteries.
Address clearly identified		Large street or R.A.P.I.D. numbers.
Phone accessible from floor		Emergency numbers by phone.
First aid kit		St John Ambulance (clean sealed water should be included in the kit).
Emergency help arranged		Contact Neighbourhood Watch co-ordinator if needed.
Fire Safety		
Smoke alarms installed		Minimum 1 per sleeping room, each level, and living area.
Escape plan in place		Plan to get out alive, check doors are easy to unlock from the inside
Fire extinguisher/Fire blanket		Recommended.
Garden hose		Permanently connected to outside tap.
Chimney safety		Clean/inspected, mesh screen, metal ash container.
In and Around Your Home		
Heaters		The heater metre rule – everything one meter away.
LPG Cylinders – BBQ's etc...		Remember to store, maintain and use gas bottles safely.
Matches, lighters and candles		Keep out of sight and reach of children.
Incinerators		Well maintained and away from trees, fences, buildings etc... Always watch while alight.
Garden		Keep all dead wood etc away from the house.
Taps		Outside taps in working order.
General Home Safety		
Hot water		Temperature at tap no more than 50°C.
Use wheat bag		Safer than hot water bottle, remember to put a glass of water in the microwave when heating.
Safe house keeping		Check structural integrity of balconies and wooden fire escapes etc... Don't let rubbish pile up.
Poison storage		Out of reach and locked (medicines & chemicals).
Electricity		Check electric blankets annually, check switch gear is accessible and child safe. Ensure it is properly secured to the mattress.



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SITUATIONS VACANT

Midwife Educator

The prime function of this role is to support the NZCOM Education and Midwifery Advisors in the development and facilitation of our National programmes that support midwifery practice. The role involves teaching within technical skills and mentoring programmes and co ordination of NZCOM education contracts.

The position would suit an experienced midwife who has additional skills in the education of midwives. Post graduate qualifications would be advantageous. The role is based in Christchurch but involves travel throughout New Zealand.

If you would like to join our small, friendly and enthusiastic team here at National Office. Please apply with a copy of your CV to:

Karen Guilliland
CEO
New Zealand College of Midwives
PO Box 21 106, Christchurch
Or by email: nzcom@nzcom.org.nz

Closing date for applications:
1 November 2006



Come to Conference – Registrations will be accepted up to and including the start of conference on the 18th September.

Don't miss this fabulous opportunity to meet with Midwifery colleagues from throughout New Zealand and keynote speakers Jane Thomas, Sharron Cole, Rae Daellenbach, Sarah Buckley, Mina Timutimu and Judith McAra-Couper.

The Inaugural Joan Donley Memorial Address will be presented at the 9th Biennial National Conference of the New Zealand College of Midwives by Carolyn Young.



JOURNAL guidelines for contributors

The NZCOM journal is published in April and October each year. It focuses on midwifery issues and has a readership of midwives and other people involved in pregnancy and childbearing, both in New Zealand and overseas. The journal welcomes original articles which have not previously been published in any form. In general, articles should be between 500-4000 words.

Format

Please ensure that the following requirements are followed.

- **Four** copies of article supplied – typed on A4 paper with doublespacing **OR**
- Article supplied as WORD document or RTF file
- Word count included
- Abstract of 100 words maximum included
- Diagrams, tables or photographs supplied in computer generated form
- Separate sheet containing biographical details of all authors (name, occupation, current area of expertise/practice, qualifications, contact address including phone and / or email details).
- Letter signed by all authors stating that they submit the article for publication
- All referencing in American Psychological Association (APA) 5th edition format.

Ethics

Any article which reports a piece of research needs to note the processes undertaken for ethical approval.

References

Authors are responsible for providing accurate and complete references. The journal uses the American Psychological Association (APA) format. Some details of this format are available on the APA website at www.apastyle.org. The 5th edition of the APA

Publication Manual was published in 2001. In the text, authors' names are followed by the date of publication such as "Bain (1999) noted" or "this was an issue in *Irish midwifery practice* (Mary, 2000)". Where there are three or more authors, all the names should appear in the first citation such as "(Stoddart, Mews, Neill & Finn, 2001)" and then the abbreviation "(Stoddart et al., 2000)" can be used. Where there are more than 6 authors then "et al." can be used throughout.

The reference list at the end of the article should contain a complete alphabetical list of all citations in the article. It is the responsibility of the author to ensure that the reference list is complete. A comprehensive range of examples are provided on the APA website. Two examples are included here.

Journal article

Pairman, S. (1999). Partnership revisited: Towards a midwifery theory. *New Zealand College of Midwives Journal*, 21 (4), 6-12.

Book

Page, L. (Ed.). (2000). *The new midwifery*. London: Churchill Livingstone.

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It is the responsibility of authors to ensure that any necessary permission is sought for copyright material. This relates to articles which include substantial quotations, diagrams, artwork and other items which are owned by other authors. Further details and examples are included in the APA *Publication Manual*. Written evidence of copyright permission must be sent to the journal if the article is accepted for publication. Please contact the Editorial Board if you wish to have clarification of copyright material.

Review process

External review is undertaken by two reviewers who have expertise relevant to the article content. In addition, two members of the Editorial Board act as reviewers and collate feedback from the two external reviewers. The process of review is outlined in the October 2001 issue.

Other items for publication

Items other than articles are welcomed for publication. These include:

- Exemplars/ stories of practice for the practice wisdom column
- Book reviews
- Abstracts of Masters or doctoral theses
- Letters to the editor

The expectation regarding publication of any of these items is that they preserve confidentiality where necessary (e.g. in exemplars) and seek any necessary copyright permission of quoted materials (see earlier section on copyright). Items other than articles are not generally sent out for a review. Instead the Editorial Board reserve the right to make a final decision regarding inclusion in a journal issue. Such decisions take into account the length of the journal and the nature of other articles.

Acceptance

On acceptance of an article or other item for publication authors will be requested to submit the material with any necessary amendments by a specified date as either a Word document or a RTF file for a PC. Articles which are accepted and published become the copyright of the journal. In the future this may include placing articles as part of an on-line publication of the journal. As part of the electronic process of printing the journal, the Editorial board reserves the right to modify any article which is accepted with regard to formatting and layout.

Contacts for the Editorial Board:

- Alison Stewart, Convenor of the Editorial Board, alisons@tekatago.ac.nz

Reference

American Psychological Association. (2001). *Publication manual of the American Psychological Association* (5th ed.). Washington, DC: American Psychological Association.

Last updated March 2005



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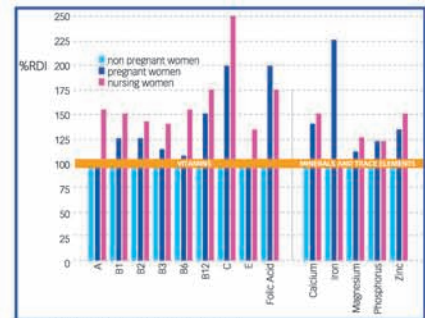
⁷A.E. Czeizel, et al. Preterm birth reduction after Clotrimazole treatment during pregnancy, EU J ObsGyn and Reproductive Biology 116 (2004) 157-163, 2004.

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1. Aztec Pharmacy data MAT 1/05, 2. IMS data MAT 12/04, 3. Czeizel et al, Prevention of the first occurrence of neural-tube defects by periconceptional vitamin supplementation, New England Journal of Medicine (NEJM), 1992



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