New Zealand College of Midwives (INC)

JOURNAL

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The **National Immunisation Schedule**, the series of free immunisations that protects New Zealand children from serious diseases, has changed from **1 June 2008**.

The changes are:

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- HPV vaccine will be offered to 12-year-old girls from 2009.

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The National Immunisation Schedule*

Age	Diseases covered and vaccines
6 weeks	Diphtheria/Tetanus/Whooping cough/ Polio/Hepatitis B/ *Haemophilus influenzae* type b 1 injection (INFANRIX®-*hexa*) Pneumococcal 1 injection (Prevenar®)
3 months	Diphtheria/Tetanus/Whooping cough/ Polio/Hepatitis B/ *Haemophilus influenzae* type b 1 injection (INFANRIX®-*hexa*) Pneumococcal 1 injection (Prevenar®)
5 months	Diphtheria/Tetanus/Whooping cough/ Polio/Hepatitis B/ *Haemophilus influenzae* type b 1 injection (INFANRIX®-*hexa*) Pneumococcal 1 injection (Prevenar®)
15 months	*Haemophilus influenzae* type b 1 injection (Hiberix™) Measles/Mumps/Rubella 1 injection (M-M-R®II) Pneumococcal 1 injection (Prevenar®)
4 years	Diphtheria/Tetanus/Whooping cough/ Polio 1 injection (INFANRIX-IPV™) Measles/Mumps/Rubella 1 injection (M-M-R®II)
11 years	Diphtheria/Tetanus/Whooping cough 1 injection (Boostrix™)
12 years (girls only)	Human papillomavirus** 3 doses given over 6 months (GARDASIL™)

*from 1 June 2008 ** from 2009

NEW ZEALAND COLLEGE OF MIDWIVES (INC)

JOURNAL 39 **october 2008**

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Koru photograph by Ted Scott.

EDITORIAL

Support for midwifery practice

I have been struck more and more recently about how important it is for midwives to have good solid support for their practice. This is not only because of the challenges that we, as a profession and as individuals, face as we endeavour to function in a 'risk society'; nor is it only to improve the sustainability of practice. Support in practice is, I would contend, fundamentally about maintaining and/or improving the quality of the care that we can and should provide for women and their families, as they prepare for and make the transition to being a new family. Sustainable practice and confident, focused practitioners are the means to the end, not the end itself.

Support for practice is a universal need which was brought home to me on my recent visit to Kiribati where I have been contracted by the World Health Organisation to develop and evaluate a process of supportive supervision for the nurse-midwives working on the Outer Islands. We are talking extreme remoteness and isolation here. There is no medical care and very poor equipment and supplies. For the last three years they have had minimal contact with the main island. The European Union has just begun rebuilding and re-equipping the health centres and I was contracted to set up a process of supportive supervision to ensure that not only were the health centres' equipment and supplies maintained, but that there was ongoing contact and support. The staff would have regular radio telephone contact and would have a visit at least once a year. Ongoing training was also seen as important. Again this process was not seen as necessary for support per se but as necessary to improve and sustain the quality of care.

Support in practice is fundamentally about maintaining and/or improving the quality of the care that we can and should provide for women and their families, as they prepare for and make the transition to being a new family.

Returning to New Zealand always makes me realise how lucky we are with the range of resources that we can access in order to gain support for our practice; support not just in terms of mentoring but also in terms of the skills we need to develop, and the systems that are in place to provide a framework in which we construct our practice. We have a range of ways to ensure that our skills are kept up to date. The institutions in which we work, and our professional organisation both provide ample opportunity for skill development. In New Zealand we also have easy access to up to date information and our educational institutions provide the opportunity to deepen and develop our understanding of midwifery.

A journal such as this can also provide us with such support, principally because it is a venue to share ideas, experiences and research. In this issue we provide such examples. Sue Lennox et al describe the various processes of direct practice support, giving us some background to mentoring, preceptorship and clinical supervision. Liz Smythe and Caroline Young provide us with a lovely example of support in practice, as they share their experiences of professional supervision. Gillian White shares with us her research into postpartum depression scales that she undertook in New Zealand and Margie Duff presents a review of the research into sterile water injections for back pain in labour. Both these articles are also about support in practice - skills and tools we might use to make birth better. In this edition we have also produced an index of the contents of the Journal. This is an important resource for us all as we seek to grow our practice. So I hope that you have a good look at it and go back to any of the articles that may interest you.

And I could not finish this editorial about support in practice without talking about the NZCOM Conference. What a wonderful occasion with a fantastic turnout. Many thanks to Auckland for such a superb conference which was beautifully constructed and so well prepared. It was a joy to attend and I am sure we all agree that we returned home re-energised. And of course, a special acknowledgement for all those who presented. It was so tough trying to make a decision about which presentations to attend. I will be contacting you all over the next wee while to ask if you would be willing to turn your presentations into a publication so we can all share them. Sometimes this can seem daunting but we are happy to provide some assistance for this to happen. It would be a shame if all your hard work was not shared more widely. In sharing what we have learned we can support each other and be better midwives. So please use this Journal as a venue for doing this.

Joan Skinner

Mentorship, preceptorship and clinical supervision: Three key processes for supporting midwives

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Abstract

New Zealand midwives are increasingly seeking and receiving professional support in clinical practice. This support is gaining acceptance within the profession and is now underpinned by government funding. There are a variety of ways in which support can be provided and this review of the literature describes three main approaches: mentoring, preceptorship and clinical supervision. These three key processes may be undertaken by all midwives whether new to practice or new to New Zealand and also by those who wish ongoing support and development. The first government funded support for all new midwifery graduates is called the Midwifery First Year of Practice programme (MFYP) (New Zealand College of Midwives, 2007). The programme commenced in 2007 and includes a mentoring component.

This paper traces the different histories of the terms: mentoring, preceptorship and clinical supervision internationally with reference to their current significance within New Zealand midwifery. These terms have evolved over time, and within different international contexts can manifest quite differently. The array of meanings ascribed to the same concept can cause confusion when midwives begin practice, change from hospital to community practice or change countries. This paper captures the common characteristics of the three terms in the literature. Clarity around the terms is essential if midwives are to gain maximum benefit from the provision of funded support for clinical practice.

Introduction

New Zealand midwives are increasingly seeking and receiving professional support in practice and there are a variety of ways in which this support can be provided. In this paper we focus in particular on the three most common forms: mentoring, preceptoring and clinical supervision. Each of these three processes has different historical roots. For example, Homer wrote in The Odyssey about mentoring which was an ancient Greek practice where older men voluntarily encouraged and supported younger men (Homer, 1945). The term 'preceptorship' originated within religious practices in the 15th and 16th centuries in Europe but re-emerged in nursing in the 1960s in the United States of America to describe the teaching of nurses within a clinical environment (Myrick & Yonge, 2004). The term 'clinical supervision' grew out of the practice of 'supervision' which was first used in the seventeenth century for controlling apothecaries by providing paid advice to them by the emerging, elite, medical class (Grauel, 2002). In this paper we explore these three common terms in an attempt to outline the general features which distinguish them and why their meanings are sometimes confused. Elaborating on the evolution of all three terms with a particular focus on mentoring can provide New Zealand midwives with an understanding of the history and intention of professionally supportive relationships, both for those giving and receiving such support.

Various beliefs coalesce around the terms mentoring, preceptoring and supervision which affect the sorts of support provided by mentors, preceptors and clinical supervisors. Shared understandings within the profession of the commonly held assumptions underlying these support terms could encourage more consistent standards of support. Table 1 summarises the most commonly held assumptions about each of the terms found in the literature – though contrary examples exist for each of the categories. In this article we review each of the terms according to their origins and evolution and look at their most commonly described characteristics such as duration of support, how the relationship is framed and who determines when the support relationship ends.

Mentoring

There are three types of mentoring most commonly described in the literature. Understanding the distinctions made between these types helps not only to clarify mentoring but also illuminates the ways in which mentoring differs from other forms of support.

The first, 'classical mentoring' has its historical and conceptual roots in Homer's Odyssey. Some twenty years after baby Telemarchus was left by his father under the care of Mentor, the Goddess Athena visited the young adult Telemarchus in order to 'embolden him' (Homer, 1945 p.23). She comes disguised as a local to gain admission to his home and provides guidance for him as a voluntary act of kindness and goodwill. These qualities of voluntariness, kindness and goodwill hold the key to the informal type of mentoring, called 'classical mentoring'.

The second type of mentoring is 'institutional' or 'business mentoring' which began in the 1970s and is a phenomenon commonly associated with corporations (Hagerty, 1986). This first began as a form of career support within the business world in the United States of America. The informal classical conception of the mentor prototype as a guardian or a personal helper for a less experienced colleague became incorporated into business practice. One example is characterised in the support provided to Richard Branson by Freddie Laker (Levinson, Darrow, Klein, Levinson, & McKee, 1978). This type of mentoring is characterised by grooming new and talented employees for career advancement. Evidence showed those who were singled out and given personal support did indeed flourish (Kram, 1983; Levinson, Darrow, Klein, Levinson, & McKee, 1978). The effectiveness of the idea of providing individual support for career transitions was developed as a generalised professional support term outside the business world.

The third type of mentoring called 'formal mentoring' is characterised by the mentoring component of New Zealand's government funded Midwifery First Year of Practice programme (MFYP) (New Zealand College of Midwives, 2007). This formal model encourages the qualities of classical mentoring in that the new graduates choose their own mentor. However the MFYP also has formal specifications in that mentors have to opt onto the programme and to attend training workshops as well as monitoring the number and hours of contact time. This is a structured process where the focus is on planned goals and expectations. There is evidence that formal mentoring programmes are more effective than informal or 'classical' mentoring relationships (Clutterbuck, 2001).

Mentoring began appearing in the nursing literature as early as 1977 when Vance systematically defined the mentor concept for the nursing profession (Vance, 1991). In the 1980s a nurse consultant in leadership and organisational development interviewed 150 people of whom 50 were nurses, and found that for all those studied; the essential components of "an important major mentor relationship" are attraction, action and affect which correspond to mentoring roles as inspirer, investor and supporter (Darling, 1984 p.42). Informal mentoring began to appear in the UK in the 1980s but attempts to grapple with defining the concepts and roles did not appear until the 1990s when there was a burgeoning of nursing publications about

the subject (Andrews & Wallis, 1999; Anforth, 1992; Armitage & Burnard, 1991; Donovan, 1990). The idea of mentoring was attractive to health professionals because of a focus on the learner's needs.

Mentoring captured the imagination of nurses (which included midwives) internationally. The dialogue about mentoring was vigorously argued using the adult education rhetoric. Educational theory had shifted in the recent decades from a pedagogical approach of teacher being the driver of learning to one where the student became responsible for their learning. This approach was based on changing theories about adult learning. This focus on the individual student learner also paralleled a shift from task orientated nursing practice to more person-centred patient care. The initial debate focused around the difficulties of students choosing a mentor, the need for a clear understanding about what being a mentor entailed and whether assessment would be a feature when the role was clearly about befriending, assisting and guiding (Anforth, 1992; Armitage & Burnard, 1991).

The emergence of and debates about mentoring in New Zealand were stimulated by midwifery autonomy in New Zealand (Holland, 2001). The 1992 newly convened Maternity Access Agreement Committee (MAAC) which replaced the Obstetric Standards Review Committee (OSRC) of the Auckland Area Health Board had concerns about the competency of newly graduated midwives emerging from the newly established direct entry programmes of a newly autonomous profession (Holland, 2001; Kensington, 2005). The term 'direct entry' refers to the separation of midwifery from nursing. Instead of a postgraduate nursing qualification 'Midwifery' became recognised under the law as a profession in its own right. Midwifery registration was now based on successful completion of a bachelor's degree in midwifery. The first direct entry programme commenced in Dunedin in 1992 and the first new graduates qualified at the end of 1994 (Pairman, 2006). Hospital obstetrical committees in Dunedin and Lower Hutt as well as Auckland were concerned that graduates from these courses might not be safe and made oversight by another experienced midwife-mentor a mandatory requirement before issuing access agreements to new graduate midwives (Kensington, 2005, 2006). Experienced midwives rose to the challenge voluntarily and mentored new graduate midwives. The professional body of the New Zealand College of Midwives responded with a consensus statement in 1996 which supported mentoring as an appropriate professional activity and with minor changes this statement still remains current (New Zealand College of Midwives, 2000). Processes of support and recompense were individually negotiated around the country.

From 2007 mentoring of new graduate midwives has changed from an informal relationship negotiated by the mentor and mentee to a funded and formally contracted relationship. However within this formal model strong voluntary and generous aspects of classical mentoring were retained where: "…the relationship is focussed on individual needs and maintained by self selection of the mentor and mentee" (Palmer, 2000 p.85). Having the mentees select their mentors is an important part of any mentoring arrangement whether formal or informal, since a successful relationship requires a dynamic mutuality (Morton-Cooper & Palmer, 2005). Ensuring that the individual with the primary learning need is the active part of the relationship is important if a sense of security and ease is to exist within the mentoring relationship.

Appreciating, supporting and enabling the learner to function as the active partner arose out of changes in educational theory about how adults learn best. The development of the concept of adult learning emerged from the work of Knowles (1973). His adult learning theory is based on four assumptions which differ from theories about how children learn and what had been until then the standard understanding about how learners learn. He believes adult learning is based on: changes in self-concept, the role of experience, readiness to learn and orientation to learning (Knowles, 1973). Research has also confirmed that the adult learner knows what and who they need to support their learning (Clutterbuck, 2001). This change in understanding about teachers and learners has crucial implications for mentoring. Clutterbuck found that "the relationships that worked best and most often were generally those where the mentees themselves selected their mentors" (Clutterbuck, 2001 p.27). Adult learning principles encourage the learner to take responsibility for their own learning by actively pursuing their own answers by critical reflection and problem solving (Morton-Cooper & Palmer, 2000). The mentor is framed as the conscious, experienced and professional supporter who listens, expands and supports learning.

Integral to mentoring is the notion of confidence-building by the mentor rather than competence assessment. The mentor though has a responsibility within this encounter to challenge and critique the thoughts and actions of the mentee, but in a way which enables rather than disables the new graduate's confidence (Morton-Cooper & Palmer, 2000; Surtees, 2008).

The clinical component of mentoring is subsumed within "a closer and more personal relationship" between a mentor and mentee (Armitage & Burnard, 1991; Levinson, Darrow, Klein, Levinson, & McKee, 1978; Morle, 1990). Though both mentor and mentee may gain satisfaction from the partnership, the intention of the relationship is primarily to support the mentee's interests. These interests mean that the mentee is in general the more active member, choosing the mentor, negotiating a relationship that suits her needs and taking responsibility for her own learning.

The relationship needs time to achieve the objectives of a mentoring relationship. Mentorships are generally considered long term relationships; times vary but they are generally assumed to be a year if not longer (Andrews & Wallis, 1999; Armitage & Burnard, 1991; Firtko, Stewart, & Knox, 2005; Morton-Cooper & Palmer, 2005; Shaw, 2007).

There are very few research studies about mentoring of midwives in general but even fewer about mentoring new graduate midwives. In New Zealand there are two research studies about mentoring in midwifery. Kensington (2005) focused on nine new graduates reflecting on their experiences of mentoring and of their first year of practice and Stewart & Wootton, (2005) surveyed all registered midwives for their views on mentoring. The findings from both studies showed a great variety of beliefs about both what constitutes mentoring and also about the vastly different range of support those new graduates actually needed from their mentors.

Kensington (2005) interviewed nine new graduates. These in-depth interviews exposed wide variations in the new graduate midwives' felt needs for mentoring. Five of the nine new graduates and their mentors were within the same practice and mentors were available 24 hours a day, seven days a week. Another three new graduates chose their mentors from outside of their practice with one having minimal contact with her mentor "twice for about an hour" and "talked on the phone about five or six times" in the year (Kensington, 2005 p.109). Another new graduate chose not to have a named mentor and instead joined an established practice. The transition from student to autonomous midwife practitioner was shown through the new graduates' stories. This was achieved through their mentors, "supporting and investing time into the relationship and offering advice and strategies to the mentored person" (Kensington, 2005 p.85). This occurred both on the job, in practice and, for some, later during times set aside for reflection.

The range of activities that have been associated with mentoring in midwifery causes confusion around the question of what constitutes mentoring – is it about reflection on experiences or might it also involve clinical support as well as many other teaching moments? However, this confusion is based on thinking mentorship is about what mentors 'do' rather

than how mentors are 'being' in their role. Just as the job of a midwife is to 'be responsive' to the woman's concerns and interests, the job of a mentor is to put the mentees' interest in the foreground of the relationship. The ability to both negotiate and be responsive to the mentees' needs and concerns is the work of mentoring and parallels our role with childbearing clients.

At the time of Stewart and Wootton's, (2005) New Zealand study, mentoring of new graduate midwives could be regarded as 'ad hoc'. Their descriptive survey of 684 or 44 percent of New Zealand's registered midwives questioned the understandings of practising midwives about the concept of mentoring. The results of their survey show the barriers to being a mentor were "time constraints and financial obligations" (p. 41) which resulted from midwives offering and providing time for both clinical support and for reflection about the new graduates' experience. Their solution was to suggest; "…if midwives receive clinical support from the midwives they work with in every day practice, the mentor can concentrate on providing opportunities for reflection and development away from the clinical environment…" (Stewart & Wootton, 2005, p. 41).

Financial support is now forthcoming within the MFYP programme which commenced in 2007 following the Minister of Health's 2006 announcement of funding for a pilot Midwifery First Year of Practice programme (Ministry of Health, 2007). The mentoring associated with MFYP fits closely with a formally structured model of mentoring with regulations, a professional framework, mentor training and monitoring. This model differs in quite concrete ways from preceptorship by being designed to meet the mentees' needs and purposes rather than those of the institutions in which midwives may be employed. Mentoring in general is characterised by being a voluntary long term commitment relationship supporting the learner through a professional transition and maintained through mutual and negotiated consent. The next section of this paper explores the differences and similarities between the professional support terms 'preceptorship' and 'clinical supervision' in relation to mentoring.

Preceptorship

Preceptorship is somewhat easier to differentiate from both mentoring and clinical supervision because it is framed within a hospital setting and is instituted for specific purposes and periods of time. In New Zealand nursing and midwifery became separate professions when in 1990 the Nurses Act was amended (New Zealand Statute, 1990). The separation was completed in 2004 when the Health Practitioners Competency Assurance Act established the New Zealand Midwifery Council (New Zealand Statute, 2003). However the influences of the professions' shared histories has profoundly shaped the expectations, understandings and provision of support for midwifery practitioners until very recently and much of the literature related to preceptorship in nursing refers also to midwifery.

Nurses and midwives are now educated in institutions of higher learning but up until the late twentieth century they trained and worked predominantly in hospitals. The history and emergence of preceptorship can be traced to Florence Nightingale who wrote in 1882 that first year nurses' "…practical and technical education [needs to] be supported by nurses who [have] been 'trained to train'" (cited in Palmer, 1983, p.17). Preceptorship arose out of the need to teach junior or newly engaged staff the conventions and processes of that particular hospital. This apprenticeship-style of support favoured the hospitals' needs rather than the educational needs of individual nurses (Myrick, 1988). As the education of nurses changed from hospital based training to educational institutes of higher learning, so too did the needs of the transitioning students when they entered the hospital workforce.

Nursing education in the USA was transferred from a hospital base into a variety of academic pathways to registration from the 1960s (Greenwood, 2000; Myrick, 1988). These changes to a more theoretically based nursing education occurred in New Zealand in 1973 and in Australia over a period from 1984-1993 and similarly over a period of time in the UK beginning in 1989 and completed by 2000 at the same time as Canada (Greenwood, 2000; Reid, 1994).

This change in education and practice experience for undergraduates exacerbated the sense of what Kramer (1974) called 'reality shock' for new graduates. New staff nurses who were unused to hospital practice were shocked by the experience of everyday hospital reality on entering the profession in their first year of practice. The experience of reality shock is still felt by new graduate nurses and midwives thirty years later (Cowin & Hengstberger-Sims, 2006; Kensington, 2005). The need for support for new graduates has always been present but even more so once nurses and midwives were educated outside of hospitals and on graduation needed socialisation into hospitals and their processes.

The concept of preceptorship is clearer than that of mentoring and there is little international confusion over the meaning of the term. According to the author of a recent New Zealand study (Turner, 2007) the concept of preceptorship in New Zealand is similar to that found in Australia, North America and the United Kingdom.

An Australian midwife, McKenna (2003) writes "unlike mentoring, preceptorships are primarily clinical teaching roles that are used to support the transition of mentees and graduates into new clinical environments" (p. 8). In relation to midwifery in the UK, Hobbs (2003) supports McKenna's view that preceptors "should focus upon both socialisation and the clinical development of the preceptee" (p. 6). Though Turner (2007) argues that preceptees should be able to choose their preceptor as happens in mentoring, in practice this would be unusual. Midwife preceptors unlike mentors are often appointed by a ward co-ordinator who attempts to match the pairs appropriately (Cooper, Stainsby, & Andrzejowsha, 2000).

Preceptorships tend to be of short duration from a few weeks or three to six months (Ashton & Richardson, 1992; Firtko, 2005). The length of support varies but some evidence points to the first three months as critical for successful skill acquisition and commitment to continue nursing (Dufault, 1990). The same time frame seems also to have been borne out in preceptorship in midwifery (Kensington, 2005). The relationship generally has either a predetermined length or associated with the preceptee fulfilling pre-set assessed criteria.

In summary, preceptorship is unlike mentorship in a number of significant ways: the support is for shorter periods of time, the preceptors are selected by senior nurses or midwives and not by the preceptee, and the purposes are in general predetermined by the institution which focuses on what needs to be learned rather than on the learner's needs.

Clinical Supervision

'Supervision' cannot be as easily categorised as preceptorship. It may be an institutional 'support' system which is imposed unasked, or a private support relationship which provides access to individual self governance (Fowler & Chevannes, 1998; Wickham, 2005). The latter relationship, sometimes called clinical supervision, "is complementary to, yet separate from, other forms of supervision" (Winstanley, 2000 p.31). Burrow warns us about confusing managerial supervision with clinical supervision (Burrow, 1995). Managerial supervision is primarily concerned with the needs of the institution and cannot logically prioritise individual supervisee's needs above those of an employer. What follows is a discussion about the emergence of the idea of clinical supervision from the umbrella term, 'supervision', a term which encompasses a collection of different purposes.

The history and meaning of the broad concept of supervision changes with each telling but for Grauel (2002) the pre-history emerged in the 17th and 18th Centuries within medicine in England. This use of the term 'supervision' was about power and control of one group over another's practice. However the term also has other connotations. Kelly et al (2001) describe 'supervision' as a 'bi-polar' issue because the term describes practices that are at one end enabling,

educative and encouraging and at the other end describes practices that are predominantly about controlling and assessing practitioners (Cutcliffe, Butterworth, & Proctor, 2001; Kelly, Long, & McKenna, 2001). The term has a history of clinical practice surveillance and assessment with instances of misuse of power which cast a shadow over its general understanding. The historical and theoretical foundations for mentoring are far less burdened than those of supervision and as a result the practice of clinical supervision remains confused with so many competing forms.

In Britain, regulations which included supervision of midwives have been mandated since 1902 (Day-Stirk, 2002) and supervision of midwives has served an overtly disciplinary function. Now, more than a century after the regulation was put in place, supervision is becoming more enabling (Osbourne, 2007; Winship, 1996) but some midwives in the UK still distrust the process and remain sceptical of supervision and supervisors (Osbourne, 2007). Kirkham (2000) describes a unit where both statutory supervision and clinical supervision were practised side by side and midwives viewed clinical supervision "very positively" (Kirkham & Stapleton, 2000 p.470). Research by Deery (2005) explored the views of midwives within clinical practice in the UK about their view of their support needs and how they would like these needs addressed. The midwives identified clinical supervision as a potential support for working with the complex changes within their practices (Deery, 2005).

There are many models and definitions of clinical supervision. Proctor's three-function model has consistently provided an easily understood interactive model (Proctor, 1986). The components of the model are a useful guide for both supervisor and supervisee. Clinical supervision according to Proctor should serve three categories of functions: normative (organisational responsibility, quality control), formative (development of skills and knowledge) and restorative (supporting personal well-being). Later models have explored the means by which these functions are facilitated. For example Bond and Holland have shown how the normative function (quality, standards and accountability) might be enhanced by using the restorative and formative functions within the context of clinical supervision (Bond & Holland, 1998). In Proctor's model there is an assumption of an enabling and cooperative relationship which has no formal assessment or managerial function (Morton-Cooper & Palmer, 2005). The functions outlined in this model fit the aims of the mentoring component of the New Zealand MYFP programme.

The University of Manchester can lay claim to raising the value of clinical supervision in community nursing in 1988 (Butterworth, Faugier, & Burnard, 1998) when researchers used Proctor's functions model as one of three models in developing the Manchester Clinical Supervision scale, a validated assessment tool for research on clinical supervision (Winstanley, 2000). The scale

Table 1: Broad differences between mentoring, precepting and clinical supervision

	Mentoring	Preceptoring	Clinical Supervision
Duration	Long term commitment (Andrews & Wallis, 1999; Armitage & Burnard, 1991; Firtko et al, 2005)	Short term commitment (Firtko et al, 2005)	Variable and dependent on supervisee. Tends to be ongoing.
Choice of supporter	Mentee chooses mentor A voluntary relationship between registered professionals where the inexperienced or novice practitioner chooses the experienced practitioner as an appropriate guide through a process of attaining confidence.	Preceptor appointed not chosen Preceptorship differs conceptually from mentoring particularly in regard to the preceptor being allocated to, rather than chosen by, the new graduate.	Chosen in independent supervision: a relationship which has no formal assessment or managerial oversight. (Other types of 'supervision' differ)
Purpose	Enable or develop professional confidence A mentoring relationship is one of supporting professional transition through new environments and/or experiences. This relationship may not be established or maintained by an employer.	Fitness to practice; clinical development The preceptor role is described differently to mentoring focusing on the content to be covered rather than on the new graduate's experience of practice.	Process of reflective self assessment may include both high support and high challenge (Johns & Freshwater, 1998)
Beginning	Negotiated between the parties	Ascribed	Negotiated
Ending	By mutual and negotiated consent	When term of preceptorship finishes, may be one or two weeks up to a couple of months	Ends when supervisee decides
Reason for Govt support	Response to workforce concerns both at the recruitment and the retention ends. Transition to practice is one of the key concepts attached to mentoring (Passant, 2002; Theobald, 2002).	Response to reality shock in UK and US. Support transition; role mastery and socialisation	Change from task orientation to nursing process and professional governance

has the largest data set on clinical supervision and shows that "effective clinical supervision can contribute to an improvement in skills, encouragement of reflective practice and an increase in job satisfaction" (Winstanley, 2000 p.32). The scale was used in a trial that was specifically designed to measure the effectiveness of clinical supervision on supervisees, supervisors and the quality of the care they provided. The results showed that "clinical supervision was experienced as useful and was perceived as a benefit to improve practice" (Cutcliffe et al 2001, p. 122). Evidence showed that at the very least clinical supervision operates as a means for safeguarding minimum clinical standards and at best sustains and develops excellence in practice (Bishop, 2007, 2008; Carson, 2007). Major research findings about clinical supervision for UK midwives, nurses and health visitors showed that meeting monthly for at least one hour was best and the recipients reported improvements in their care, skill and job satisfaction (Hrykas, 2001; Winstanley, 2000). Unlike mentoring, clinical supervision is well researched and comes highly recommended for use in improving the quality of clinical practice.

Anecdotally there are an increasing number of self employed midwives accessing clinical supervision in New Zealand. Clinical supervision may be funded for members of staff within hospitals but self employed Lead Maternity Carer (LMC) midwives pay as they would for other private services. Clinical supervision within midwifery is not legislated or regulated and so long as that situation remains the case the choice remains in the hands of the practitioner to commence and cease attending sessions.

There seems little difference between the values, functions and practices in independent clinical supervision and those encouraged in mentoring. In time perhaps the theoretical frameworks for both will merge and the historical differences may be left behind, along with the confusion which surrounds the terms. This confusion is as a result of the historical development of professional support and the dynamic ways in which terms change over time and within different contexts. Preceptorship has far more clarity than either of the other terms and serves an important function within hospital settings. There can be little basis for confusion between preceptoring and the other two terms, mentoring and clinical supervision. The differences in purpose and process between preceptorship and either mentorship or clinical supervision are quite marked.

Conclusion

There will always be a need for professional support in the clinical environment. The naming and understanding of the breadth and depth of the function of mentoring, precepting and supervision are important. The important issue is one of clarifying the concept attached to the roles before they become part of any system of professional support. This has been done in New Zealand with the publication of the mentoring framework (Gray, 2006). This framework outlines the New Zealand College of Midwives' concept of mentoring for the whole of the midwifery profession at any stage of a midwife's career. The formal mentoring pilot programme funded by the Clinical Training Agency arm of the Ministry of Health is focused on professional role development of the new graduate midwife and managing the formal aspects of the mentoring partnership.

Internationally terms, titles and concepts vary in their definitions and understandings 'on the ground' and this is an important feature of trying to make sense of these three terms. Many commentators agree that there is a bit of preceptoring in mentoring and vice versa and a bit of clinical supervision or reflective self development in the practice of both mentoring and preceptorship. Mentoring, preceptorship and clinical supervision despite historically different beginnings share some common features and acknowledge, at least in theory, adult learning principles. These principles support the learner's process and acknowledge the individual as the active partner in the relationship. Preceptorship has some fundamental differences based on the active partner being the preceptor with a focus on the content to be taught rather than the needs of the learner. What is important is that we have some notion of the history and concept development attached to the terms mentoring, preceptorship and clinical supervision. Eliminating confusion may benefit both nursing and midwifery practices.

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Professional supervision: reflections on experience

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Abstract

The authors of this paper engaged in the process of 'Professional supervision'. Liz was required to 'supervise' as part of a postgraduate learning experience and Carolyn offered to be supervised. Our experience revealed the value for the midwife of 'being listened to'. Transcripts from the sessions revealed how Carolyn kept articulating her practice values, using them as benchmarks on which to judge her own practice. Gentle challenge from the supervisor opened thinking space. The thinking went on between the supervision sessions. The process offered a 'mirror' to Carolyn whereby she could see afresh the calibre of her practice. From our experience we argue professional supervision is a valuable strategy towards preventing burnout.

Professional supervision: reflections on the experience

The notion of 'professional supervision' has flirted around the edge of midwives conversations for some years. It is not about accountability, for the midwifery standards review process deals with that. It is more about an outlet, a safe space to let go of the stress of the month and to take time to ponder. There have been midwives-turned-counsellors who have offered such services, yet our hunch is the up-take has been slow. It is often difficult to make and keep appointments, and it costs money; besides which, to step into something which feels like 'counselling' has a sense of 'not coping'.

When the data started emerging from Carolyn's thesis on 'burnout in independent midwifery practice' there was a strong sense for us both of "if only these midwives had been able to talk to someone before it got that bad". Carolyn, who has been practising homebirth/independent midwifery since 1975, had never had professional supervision herself. Liz (Carolyn's thesis supervisor) then, as part of her sabbatical, enrolled in a paper to learn how to do professional supervision. She needed to practice on someone and Carolyn was keen to experience what professional supervision was like. We recognised the possible danger of the duel relationship (Bogard, 1992) but by meeting for professional supervision at a different time and place kept the two ventures separate. We agreed on a four session contract, over which period Liz also had professional supervision to reflect on her own process. This paper is an initial reaction to open the conversation of professional supervision for on-going discussion amongst the midwifery community.

What is professional supervision?

There is a wide variety of definitions related to professional supervision: to offer protection to both clients and health professionals (Barker, 1992); to enhance clinical practice (Butterworth & Faugier, 1992); to ensure safe practice, develop skills, encourage personal and professional growth and offer support (Brocklehurst, 1999). Van Ooijen (2003) talks of the triad of ends, restorative (to counsel), normative (to teach) and formative (to monitor), pointing to a range of possibilities. Gazzola and Theriault (2007) talk of skill acquisition, development of professional identity and helping the supervisee attain competence. But for Carolyn and Liz the one definition that called us into this experience of supervision was to prevent and manage burnout (Freudenburger, in Butterworth & Faugier, 1992). We believe the type of professional supervision that might facilitate this is one of a regular on-going relationship with a person skilled in communication who is there to listen, support and when necessary sensitively challenge the midwife, enabling her to take stock of the impact of practice on her personal life, and ensure her ongoing practice is safe. Though our experience has been brief, we believe there is a strong likelihood that professional supervision would make a significant difference to descent into burnout territory.

A recent book drawing on New Zealand experience uses the term 'clinical supervision' akin to 'professional supervision' (Wepa, 2007). It draws on experiences from social work, mental health nursing, counselling, Plunket nursing, and nursing and allied health professionals within the District Health Board setting. The midwifery perspective is not surprisingly absent, for anecdotally it seems few midwives routinely have professional supervision. Yet, amongst other professions it is midwives who are on call twenty four hours a day, sometimes for weeks on end; midwives who hold the responsibilities of the well being of mother and baby knowing death is a possibility; midwives who need to find their way through a health system that is sometimes less than welcoming; midwives who are drawn away from their families with no advanced warning. The role and life of an independent midwife oozes with possibilities of stress. We believe it is time for the profession to proactively address the cost of such stress to committed midwives who have a passion to offer the best midwifery practice possible to the women in their care. How often do they go beyond the call of duty? How often do they make personal sacrifices that wound self and others?

How does supervision work?

There are models of how to do supervision. Liz went to meet Carolyn for our first session armed with a set of questions following a three step method (van Ooijien, 2003): of what? (focus on facts) how? (focus on feelings) and what now? (focus on action). Carolyn had been asked to have something ready to 'bring' to supervision. Within minutes of initiating the session Carolyn was already telling her story. It was an incident that was bugging her. She'd initially got stirred up when the event happened but had since had time to start thinking it through. Liz heard the 'thinking through'. Throughout it all Carolyn asked: 'What could I have done differently? What did I miss? What do I need to learn from this situation?' On listening to the tape we made, Liz did a lot of 'mmmming' but otherwise simply listened. The three step method was never consulted; we seemed to know the way this conversation needed to unfold, drawing on our lifetime's experience of listening and responding. To Liz it was clear from the outset that

there had been no 'poor' practice on Carolyn's part but to simply have said that would have left Carolyn still with unresolved feelings. Rather Carolyn was able to work through the incident for herself, view it from different angles, consider what underpinned her vulnerability, and bring herself to an assurance that while there was valuable learning from the reflections that had emerged, the issue really was about 'them' rather than 'her'. Liz could affirm that with enthusiastic approval. Maybe an issue that could have niggled on for weeks was now resolved. Maybe it would no longer creep back into her mind to haunt and bother.

Being listened to

Throughout our next three sessions a similar pattern emerged. Carolyn would find herself ready with several stories from practice to 'work through'. Liz would listen attentively. We both recognised this was a different style of listening to what happens when midwives tell stories to each other over coffee. This was a privileging of Carolyn's right to speak and hold the conversation with her own stories. There were times when Liz briefly shared a story of her own to show she too was 'only human'. But it was Carolyn's stories that mattered. For Carolyn this was a unique and unusual experience. As an experienced midwife she recognised she was most often listening to the stories of others. Fiumara, a philosopher who draws on the metaphor of midwifery to describe the attentiveness by which a listener must await the birth of that which is not yet spoken says: "there are not always words for what we have in hand (in mind, in the soul)…And remaining in search of that treasure – undescribed and undescribable – is indeed assent to a revelation of something 'rich and frail'" (Fiumara, 1990, p. 153). To listen, to keep on listening, and to be willing to trust the awaiting is to hold open the hope for the tentative speaking from the soul. Fiumara warns: "In a non-listening culture, one may be rewarded without being understood, satisfied without being heard, and well-cared for without maturing". (ibid. p.156). To listen to a midwife speak of her experiences is not for the purpose of the supervisor 'hearing' but rather to bring the speaking into the open. There the midwife can see afresh the wisdom, sorrow, burden and concerns she is carrying in her soul. The listener can share such emotions. Heron (2001) describes the empathy that arises from such listening as "participative communion" (Heron, 2001, p. 23). Many times we came to share a sacred space of knowing the 'unspoken' had been said, heard and understood for its precious fragility.

Living values

As Liz listened to Carolyn recounting experiences from practice, some still unfolding and others from years ago but still fresh in her memory she came to see how often Carolyn would measure what she had done alongside a value statement. We both might have missed this but for the transcript which later revealed a recurring pattern that kept saying "this is how I would hope to practice". Examples of such values were:

- Women need to leave my care without unresolved feelings about how things went
- I respect the woman's right to make informed decisions
- I learn from tough experiences and build that learning into being better
- I need to keep my commitments to women, or let them know if I am unavoidably detained
- I strive to keep women calm during labour
- I listen to my intuitive voice
- Being a midwife is about working with families in a way that impacts on their future
- When doctors do not seem to 'hear' you just keep on telling/showing until they do
- You cannot always believe 'normal' in what is there to see
- You need to forgive yourself for what just 'is'
- Midwives have a responsibility to share experiential learning with each other
- It is important for me to work through experiences that impact on me
- There has to be a point where you can turn the phone off if you get tired
- Most people already know the answers

This does not pretend to be an exhaustive list of the values that underpin Carolyn's practice. Rather it demonstrates how clear she is about what constitutes good practice. Thus in her reflections she is able to recognise she met her own standards (or not) and move on from that point. We believe when a midwife is clear about their personal meaning of 'good practice' then it is likely that

a. It is much easier for them to meet those expectations in an almost unthinking way because it becomes who they are
b. It gives them something to bring to their reflection: "did I do xxx?"
c. It lets them move on when they can say, 'yes' I did the best I could in those circumstances
d. It is likely that such reflective processes reduce the potential for burnout.

Offering challenge

At the end of our first session when I asked Carolyn for feedback she made it clear that she expected to be challenged. Gazzola and Theriault (2007) suggest that good supervision requires a crucial balance between "being supportive and being challenging". (Gazzola and Theriault, 2007, p. 190). Yet more often than not the challenge seemed to come from Carolyn herself. She was the one asking herself tough questions about finding a different mode of practising that would allow her regular time off-call. She was the one who came back to the tough issues session after session to report progress. At times Liz would raise a question such as, "Is there a better way of coming back from leave than 'it feeling like walking into a swamp?" The role of challenge is to identify where the tensions lie and to address them in a climate of emotional support whereby together there is attention paid to how the supervisee could "think and act in creative, new ways" (Gazzola & Theriault, 2007, p.191). Thus challenge is not to say "you are wrong" or "that was bad" but rather to open a thinking space whereby the supervisee may work through how a situation could be improved.

Being always there

After having fallen into the pattern of professional supervision Carolyn noticed how it was about more than meeting once a month:

I sent you an email after our last session saying how the process had a lot more hidden things in it than we had actually appreciated. What I found is that when I went to the birth I was really thinking, now if I am talking this through with Liz, what am I going to say about this? And I know what I'm doing here but are the decisions justifiable, and how would I justify it to another person. So I felt that it is more than a reflective process. It actually starts to influence the decision that you make at the time. If you are going to be upfront and honest and fully disclose your working experience then it really makes you evaluate what you are doing even more carefully at the time.

Professional supervision brings a sense of being under the gaze of the ever watchful eye. This reinforces how important it is that the relationship is based on trust and integrity. It is vital that both supervisor and supervisee feel safe in the relationship (Gazzola & Theriault, 2007). Liz reflected on how challenging it would be to supervise a midwife who she did not believe was practising to appropriate standards. Similarly, it would have created additional tensions for Carolyn if she had felt judged and disrespected. Clearly she was the expert midwife in this relationship. Liz was the person who opened a space for her to reflect and learn from her own speaking and thinking. And curiously, that space extended to the in-practice experience when time and

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again she was called to think about practice differently because of being in professional supervision. A heightened sense of personal accountability both to clients and to her own well being emerged.

Being 'mirror'

As a student learning to be a professional supervisor Liz watched the teacher, Tony MacCulloch, supervising a fellow student in front of the class to show what the books never quite seem able to say. One of the things that struck her was the very thoughtful way he offered a summary back to the supervisee. There is a sense that as experienced midwives, teachers and human beings we are already skilled listeners. In other words, we already know how to do professional supervision. Yet, there are strategies that are more than one does in normal communication. At our next session Liz made a deliberate effort to summarise what she had heard Carolyn say:

Me: What I am aware that I don't do particularly well, and what Tony the teacher does, is summarise at the end.

C: Well off you go

Me: [laughing] I am just always in awe of how reflective you are. You so often say: 'what I can learn from the things that go wrong'. That's an amazing gift. While I hear you say 'I'm a bit angsted about this' the fact that you have worked out the little things that could have made a difference, that's a wonderful gift.

C: I can't imagine any one not doing that

Me: I can. They might be more interested in excusing themselves than learning from it. Because both those situations you talked about are very excusable. There are a hundred reasons to say 'heh, this was normal practice, in fact this was very good practice', but you always try to find the one little thing that would make it even better practice. And I think that's what sustains you. You see it as a calling, a vocation. The story of the child who died, you know you made a significant difference. And that's something that you cherish.

C: Oh yes, but I do that as a gift to me, to be able to help a family through such a critical event.

Me: So while you give a huge amount of yourself you are also nurtured by those experiences, so it is very reciprocal.

C: Yes, it feels like that.

Me: It's just amazing and wonderful and great!

C: [Shared laughter]

Me: I just love hearing your stories

C: Good. And there always seems like there are some. But if I wasn't doing this process I'd just see it as another working month. It's by stopping and thinking- then you think there have been some big events in this month.

Professional supervision offers an opportunity to help the midwife see that working through the angst of a troublesome situation is in fact what lies at the heart of her expertise. It is to turn frowns to laughter. It is to remember and celebrate the difference a midwife can make to the joys and sorrows of the childbirth experience. It is to transform just another working month into the dynamic, rich tapestry of events that reveal a picture of committed competent practice. In the to and fro of everyday conversations we rarely pause to gift other the mirror of 'how she has been in the month'. The tough points are likely to stay quietly niggling away, and the moment of insightful practice uncelebrated.

To be a mirror to another is not to tell them who they are but rather to let them see their own self portrait. Merton says:

> *The individual person is responsible for living his own life and for 'finding himself'. If he persists in shifting this responsibility to somebody else, he fails to find out the meaning of his existence. You cannot tell me who I am, and I cannot tell you who you are. If you do not know your own identity, who is going to identify you? Others can give you a name or a number, but they can never tell you who you really are. That is something you yourself can only discover from within (Merton, 1955, p.xi-xii).*

A supervisee who feels safe enough to reveal the person within comes to know what it means to be a midwife in a uniquely personal contextual way. It is her own self that comes into view, and from that view the picture can be considered and at times perhaps changed.

Conclusion

Carolyn and Liz have both come to appreciate the gift of professional supervision (Liz being also required to receive professional supervision as part of her course). It does not pretend to be counselling. The skills required are fundamentally about creating a safe space for a midwife to reflect on her practice and her own well being within it. Such a strategy has the potential to reveal the early warning signs of burn out and to allow for strategies to be put in place before the midwife is so caught up in exhaustion that she can no longer see a way forward. It is to nurture and value the midwife-as-person, affirming her own rights to personal space and care. It is to celebrate 'great practice' that may go quite unnoticed by anybody else. It is to forgive the lapses that while they may have had minimal consequence still can burden the midwife with a sense of guilt. It is to problem solve tricky situations that are on-going, or being ready with a plan for the next time a similar set of circumstances arises. It is to let off steam about the thoughtless people who wound and create havoc. It is to laugh together, and cry together. It is to affirm that as midwives we are worthy of care.

We encourage midwives to expect to have professional supervision, or an alternative process that meets similar ends. Perhaps there are some willing to enrol in the postgraduate paper on Professional Supervision at Auckland University of Technology (as two other midwives from National Women's and Middlemore Hospital did with Liz) to be ready to take on the role of supervisor. Already there are counsellors who offer professional supervision as a service. The biggest change is simply recognising that such a service is one midwives deserve to have access to in helping them to sustain their passion for midwifery practice and their personal wellness to cope with the demands. To listen to the life of another person is to honour their humanity; to be listened to is to equip one to enact one's own humanity to its full, rich potential.

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A comparison of the Postpartum Depression Screening Scale (PDSS) with the Edinburgh Postnatal Depression Scale (EPDS)

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Abstract

The reliability and validity of the Postpartum Depression Screening Scale (PDSS) was determined and compared with the Edinburgh Depression Screening Scale (EPDS), and a structured clinical interview, on a sample of 60 New Zealand women of European origin. Even though the sample was small the PDSS had good validity when compared with the EPDS, and the structured clinical interview. Additionally the result compared well with larger studies undertaken in the USA. Both the PDSS and EPDS are reliable and valid screening tools for New Zealand women of European origin. The use of the PDSS by mental health clinicians and the EPDS or short version PDSS by midwives is supported.

Introduction

Postnatal depression (PND) is a mood disorder meeting standardised criteria (American Psychological Association, 1994; Cox, Murray & Chapman, 1993) for a mild or major depression that occurs following childbirth and has a substantial impact on mother, infant and family (O'Hara, 1997). The condition is relatively common. A meta-analysis of 59 studies undertaken by O'Hara and Swain (1996) involving 12,810 women, and using a mix of both diagnostic interview and psychometric screening measures, found an overall prevalence rate for PND of 13%.

A difficulty for researchers and clinicians has been a lack of consensus over a conceptual definition of PND and what measure should be used to screen for it. No explicit definition of PND is provided in the Diagnostic Statistics Manual [DSM IV - TR] (American Psychological Association, 1994) and the distinction between PND and general depression in terms of clinical symptoms remains unclear. A number of psychometric scales have been used to screen for PND each with somewhat different diagnostic criteria and open to cultural variation in interpretation. The best-known scale, the Edinburgh Postnatal Depression Screening Scale (EPDS) was developed by Cox, Holden and Sagovsky (1987) and is now used worldwide. It is a screening tool that can be used by midwives and has thus been useful for referral purposes. Following extensive qualitative research, involving women with a history of postnatal depression, over a period of 10 years, Beck and Gable (2000, 2001a, 2001b, 2002) developed a screening scale, entitled the Postnatal Depression Screening Scale (PDDS), that reflected the actual experiences of postnatal mothers.

The authors of the PDSS in their manual (Beck & Gable, 2002) and in a direct comparison study with the EPDS (Beck & Gable, 2001) have indicated that their scale may have superior combinations of sensitivity and specificity, and as such it may be better for detecting major postnatal depression. The full scale has received criticism from the UK National Screening Committee (2001) because of its length, which they claimed is inconvenient for routine clinical practice such as that undertaken by midwives. A short form of the PDSS (PDSS - SF) however, has been validated (Beck & Gable, 2002).

To suggest that one third of women are depressed following childbirth is alarming and again raises the question of how much is known about normal postnatal emotional adjustment, and how much of that adjustment mimics the measured symptoms of mild depression.

In this paper the results of a study comparing the Postpartum Depression Screening Scale (PDSS) with the Edinburgh Postnatal Depression Scale (EPDS) among a cohort of women in New Zealand is presented. The aims of the study were to test the PDSS and the EPDS with a sample of women in New Zealand and to determine if the PDSS Short Form (PDSS-SF) provides adequate screening in comparison to the full-scale measure

Participants

Because validation of screening scales is subject to cultural sensitivities and semantics the target population for this study was specific. Inclusion factors necessitated English had to be the predominant language and the women had to identify as of European origin because these women feature as the most common ethnic group of postnatal women in New Zealand (Statistics New Zealand, retrieved 10/4/06). Other factors were childbearing women over the age of 18 years with at least two weeks postnatal experience, with or without feelings of depression (but did not have to be feeling depressed). Women were recruited from the community through wide-scale advertising.

Measures

Postpartum Depression Screening Scale

The PDSS is a 35-item 5-point Likert type self-report scale comprising seven subscales or dimensions (Beck & Gable, 2000) to specifically screen for PND. The seven subscales are sleeping/eating disturbances; anxiety and insecurity; emotional lability; cognitive impairment; loss of self; guilt and shame; and contemplating harming oneself. Each subscale is composed of five identifying symptoms that the mothers can present with in the period after the childbirth. These are itemized in degree of intensity that can vary from full disagreement to full agreement thus scores range from 35 to 175. The PDSS is copyrighted to the Western Psychological Society and cannot be reproduced in full within this paper although it can be purchased for clinical or research purposes. In this study the PDSS was administered according to the standard PDSS manual instructions (Beck & Gable, 2002). Additionally the first seven questions (representing each subscale) can be used as short version (PDSS – SF).

The Edinburgh Postnatal Depression Scale

The EPDS is a 10-item self-report scale, with satisfactory internal consistency that was developed to specifically screen for PND in community samples (Boyce, Stubbs, Todd, 1993; Cox, Holden, Sagovsky, 1987; Eberhard-Gran, Eskild, Tambs, Opjordsmoen, Samuelson, 2001; Lawrie, Hofmeyr, de Jager, Berk, 1998; Milgrom, Ericksen, Negri, Gemmill, 2005; Pop, Komproe, Van Son, 1992; Shakespeare, Blake, Garcia, 2003). Possible responses are scored from 0 to 3, in growing order of gravity, creating a minimum score of 0 and a maximum score of 30. In this study the EPDS was administered along with the PDSS.

Structured Clinical Interview

An adapted structured clinical interview [SCID-I] (First, Spitzer, Williams, 2002) for DSM IV (American Psychological Association, 1994) mood disorders was used (White, 2005). The interview modifications were made in order to contextualise the clinical interview for the postnatal situation and consisted of general questions about the birth experience such as: How were pregnancy and the birth for you? Was the birth process how you expected it would be? Have your reactions to be a new mum been as you expected? Following these

general questions responses to questions about mood change associated with DSM IV-TR Axis I (American Psychological Association, 1994) mood disorders, mental state, relationships, thoughts of harming self or baby, and self assessment of management related to "since you have had the baby…" were sought. On the basis of the clinical interview participants were classified as having mild depression, major depression or normal adjustment.

Procedure

Advertisements about the research were placed in appropriate shopping centres, doctors' waiting rooms, antenatal classrooms, local magazines/newspapers, and by word of mouth. The nature of the research was explained in that the women did not have to be feeling depressed. This explanation was to avoid bias of having only women with diagnosed postpartum depression volunteer, and to provide a sample that reflects the general population of postnatal women.

Following initial contact volunteers were sent a letter of information. Having established their willingness to participate in the study most of the women (90%) were interviewed by the principal investigator face to face in their own home. Two women who were very keen to undertake the study were sent the screening tools and interviewed by telephone.

The EPDS and PDSS were presented in random order and the interview took place before an analysis of the responses was made. Before the visit concluded a check was made to ensure there were no high responses on the suicidal ideation dimension. Where scores were high the women were advised to discuss the findings with their family doctor, Plunket (child health) nurse, or midwife, and a copy of the response sheet was included. A follow up telephone call was made a few days later to these women to ensure their understanding of the meaning of the results, and that they were simply being screened. Their emotional safety was also checked. Ethics approval for the study was gained from the Massey University Human Ethics Committee, the regional District Health Board Ethics Committee and the Plunket Society Ethics Committee.

Results

All data were analysed with SPSS 13, a statistical programme. The PDSS and EPDS were administered to 62 postnatal women volunteers. Two were excluded from the sample because they were already undergoing treatment for a condition other than PND, leaving a sample of 60 women. While it is recognised that the sample was small this number met the assumptions required for the statistical analyses and the demographic profile was similar to those in the large scale Beck and Gable studies (2000, 2001a, 2001b) although the level of education was substantially higher in the present study. Thus the researcher was confident the findings compared well with Beck and Gable's results.

Demographics

The demographic data describing this purposive sample are presented in Table 1. The participant ages were representative of New Zealand postnatal women as indicated by Statistics New Zealand (retrieved, 10/4/06). Typically the women in the study were white, married or in a stable partnership, in their early thirties with higher education, first child, four to seven weeks postnatal with no history of a previous depression. The 30–34 year age group is the most common age group for childbearing (111 births per 1,000 women). The median age of New Zealand women giving birth during the year ending December 2002 was 30.1 years and 52% of those new mothers were of European extraction only (i.e. white, non-mixed ethnicity).

Total Scores

The PDSS total scores ranged from 37 to 151 with a mean of 66 (SD = 26.7), median 56.5, while the EPDS total scores ranged from 0 to 20 with a mean of 7.26 (SD = 4.8) and a median of 7.

Table 1: Demographic characteristics of the postpartum sample. (N=60).

Number of times pregnant:

1: 31 (51.7%)
2: 17 (28.3%)
3: 8 (13.3%)
4: 1 (1.7%)
5: 2 (3.3%)
10: 1 (1.7%)

Mean: 1.88
SD: 1.00

Age:

Range: 21 - 44 Mean: 33.0 SD: 4.6

Previous history of depression:

Yes: 19 (31.7%) No: 41 (68.3%)

Number of weeks since birth:

Range: 2 - 29 Mean: 7.92 SD: 5.12

Highest Education:

Less than High School: 1 (6.8%)
High School: 5 (8.5%)
College: 8 (13.6%)
Degree: 42 (71.2%)

Marital Status:

Single: 4 (6.7%)
Married: 38 (63.3%)
Partnered: 17 (28.3%)

Table 2: Internal consistency for the PDSS total scale and seven subscales.

Scale	Sleeping / eating disturbances (SLP)	Anxiety / insecurity (ANX)	Emotional liability (ELB)	Mental confusion (MNT)	Loss of self (LOS)	Guilt / shame (GLT)	Suicidal thoughts (SUI)	PDSS total scale
Cronbach's Alpha	0.79	0.81	0.83	0.89	0.93	0.87	0.94	0.97

Reliability

Internal consistency of the PDSS 35-item total scale, including the seven subscales was measured by Cronbach's alpha and is presented in Table 2. Reliability was very high for the total scale and satisfactory for the seven subscales. Cronbach's alpha was also used to compare the items on the EPDS with a reliability coefficient of 0.87. All these results were similar to those obtained by Beck and Gable (2000, 2001a, 2001b) in their studies of 525 and 150 women respectively.

Validity

The PDSS total score correlated strongly with the EPDS total score (r = 0.87, p <0.001) again demonstrating comparability with the Beck and Gable (2001a) study where a value of 0.79 was obtained. This finding shows a good level of association between these two measures.

The PDSS and EPDS scores were also compared with the clinical diagnostic status, the women being classified as having mild depression, major depression or normal adjustment. In this study 40 women (66.7%) were not depressed, 15 (25%) were formally diagnosed as having mild depression and 5 (8.3%) were found to have a major depression following referral. A strong correlation was obtained between the PDSS total score and the clinical interview diagnostic classifications (Spearman's rho = 0.70) and the EPDS also correlated strongly with the clinical diagnosis (Spearman's rho = 0.67).

Overall 83.3% of cases were correctly classified by the EPDS, less than the correct classifications using the PDSS. One clinically diagnosed case of major depression was classified as normal on the basis of the EPDS screening (the EPDS score of this participant was 7). In contrast that person scored 94 on the PDSS with the three highest symptom content domains being Anxiety/Insecurity, Guilt/Shame and Loss of Self. The EPDS does not directly measure loss of self, or guilt/shame on its two anxiety measures items 4 and 5. For Item 4 "I have been anxious or worried for no good reason" and Item 5 "I have felt scared or panicky for no very good reason" the participant responded "No, not at all".

Sensitivity and Specificity

A receiver operating characteristic (ROC) analysis was performed on both the PDSS and the EPDS to obtain the sensitivity, specificity, and positive predictive value and negative predictive values, as well as to determine how the established cut-off scores (Beck & Gable, 2001a) apply to a New Zealand sample. The first analysis was based on the diagnostic classification with the sample dichotomised as normal adjustment (n = 40) versus depression (mild and major, n = 20). The recommended PDSS cut-off score of 60 for minor depression suggested by Beck and Gable (2001a, 2001b) is confirmed by the data in Table 3, resulting in a sensitivity of 95% and a specificity of 78%. A recommended cut-off score of 9 on the EPDS (Cox, Murray, Chapman, 1993) along with its sensitivity, specificity, positive and negative predictive values are also highlighted in Table 3. The area under the ROC curve (0.90, SE = 0.05) was similar to the PDSS. A cut-off of 8 for EPDS however would have substantially increased the sensitivity while maintaining an adequate level of specificity.

Table 3. Validity of the PDSS and EPDS as a screening measure over a range of cutoff scores using the clinical interview criteria of normal adjustment versus depression (mild and major).

PDSS cutoff score	Sensitivity (%)	Specificity (%)	Positive predictive value (%)	Negative predictive value (%)
50	95	46	48	95
55	95	70	59	96
60	**95**	**78**	**70**	**97**
65	90	83	72	94
70	85	90	81	92

EPDS cutoff score	Sensitivity (%)	Specificity (%)	Positive predictive value (%)	Negative predictive value (%)
7	87	76	58	93
8	80	89	74	92
9	**70**	**93**	**83**	**88**
10	60	95	81	84
11	53	99	92	81

PDSS Subscales.

As in the Beck and Gable (2001a) study all seven subscales or dimensions of the PDSS in the present study correlated substantially. The highest correlation was for the Anxiety/Insecurity scale, was also consistent with the findings of Beck and Gable. The central role of the Anxiety/Insecurity scale in contributing to PND is thus emphasised in all these studies.

PDSS Short Form (PDSS-SF)

In the present study the PDSS-SF total scores had a mean of 14.43 (SD = 5.91), with a median value of 13.0 and a range of 7 to 32. The coefficient alpha was 0.86, indicating good internal consistency. These results were again similar to the values obtained by Beck and Gable (2001a).

The high correlations between the PDSS-SF and the full scale PDSS (r = 0.94) and with the EPDS (r = 0.86) supports the validity of the Short Form measure, and the high correlation with the clinical interview diagnostic classification (r = 0.79) further supports the validity of the short form measure.

The ROC analysis conducted on the PDSS was repeated with the PDSS-SF. The recommended Short Form cut-off score of 14 for screening for mild or major depression (2002) is highlighted in Table 4. The results confirm the decision of Beck and Gable in using a cut-off score of 14 in order to maximize sensitivity while retaining adequate levels of specificity. The area under the PDSS-SF ROC curve (0.93, SE = 0.04) was the same as for the PDSS full scale ROC analysis. Collectively all results indicate that the PDSS-SF may be an efficient method of screening.

Discussion

Despite the small, select sample in the present study a number of conclusions can be drawn. On a New Zealand cohort of women with European origins the PDSS has good reliability and validity in comparison to the more commonly used measure,

Table 4. Validity of the PDSS Short Form as a screening measure over a range of cut-off scores using the SCID criteria of normal adjustment versus depression (mild and major).

PDSS short form cutoff score	Sensitivity (%)	Specificity (%)	Positive predictive value (%)	Negative predictive value (%)
12	95	67	58	96
13	95	75	61	97
14	**93**	**81**	**70**	**97**
15	85	87	72	94
16	78	95	84	90

the EPDS. All the women found the PDSS culturally and conceptually relevant, semantically meaningful, and sensitive to the postnatal period. Many women (including those not depressed) expressed how much better they felt after the interview having had a chance to be heard. Where scores on the PDSS or EPDS were high the women were sent a letter suggesting they may like to follow up with their general practitioner or midwife and the women were also contacted by phone. A common response was " I felt so much better after I had talked to you." This finding supports the idea of the value of the "listening visit" (Clement, 1995) and the importance of encouraging women to talk about the birth and how they are feeling about being a new mother (White, 2005). The PDSS was favoured over the EPDS because the women considered the statements more comprehensively captured their feelings.

There are a number of indicators that the PDSS is a more comprehensive measure of PND than the EPDS. The PDSS has a higher sensitivity (95%) compared to the EPDS (70%) and this is reflected in the analysis where the PDSS correctly identified 80% of women as having PND compared to 70% for the EPDS. The relatively lower sensitivity of the EPDS in the present study is of concern for a screening instrument. This difference may be due to the broader item content of the PDSS, where the five initial symptoms of PND are considered to be anxiety, insomnia, agitation, irritability and confusion and the PDSS, unlike the EPDS, assesses all five of these symptom domains (Beck & Gable, 2001b). Dalton (1996) has noted that PND is not the same as typical depression and that a limitation of the EPDS is that it does not measure key symptoms associated with PND.

Interestingly, a participant classified as having major depression by the PDSS and the clinical interview was classified as normal by the EPDS. This result is consistent with the claim that the PDSS more reliably detects major depression compared to the EPDS (source 2001a). This may be due to the fact that the EPDS does not contain items that directly measure loss of self or guilt/shame.

One could also contend that on Item 4 ("I have been worried or anxious for no good reason") and Item 5 ("I have felt scared or panicky for no very good reason") a person with high levels of anxiety could nevertheless respond "No, not at all" if they should perceive a reason for their anxiety using the EPDS. Given the central role of the Anxiety/Insecurity scale in discriminating PND it is of particular concern that there may be validity issues with these items in the EPDS. There are also the wider issues of the relationship between anxiety disorders and depressive disorders and how they may influence each other (Donahue, 2005; Wetherell, Gatz, Pederson, 2001). If anxiety is an antecedent of, or co-morbid with, depression then it makes sense to include it in a screening test for depression. Although this may lead to some construct confusion in a screening scale for PND where "Depression is not necessarily the first or most important symptom of women suffering from postpartum depression" (Beck & Gable 2001a, p244), the recognition that anxiety may be the first or most important symptom in postnatal women is of clinical significance to maternity caregivers.

The prevalence rate for mild and major depression of 33.3% is higher in this small group of New Zealand women than that typically reported for PND. The high prevalence rate of mild depression in the present study could reflect a biased sample in that women with mild symptoms were more motivated to volunteer. However, similar high prevalence rates have been reported in other studies (Gotlib, Whiffen, Mount, Mine, Cordy, 1989; O'Hara & Swain, 1996). In their study of 150 women Beck and Gable (2001a) report 19% as having mild depression and 12% as having major depression (total 31%).

To suggest that one third of women are depressed following childbirth is alarming and again raises the question of how much is known about normal postnatal emotional adjustment, and how much of that adjustment mimics the measured symptoms of mild depression. This misattribution would be most likely to occur for people assigned to the borderline mild depression category, the most common depression category in the present study.

The structured clinical interview used was an adaptation of the SCID-1 taking into account the context of the postnatal experience. These clinical interviews again stress the issue previously raised that not enough is known about normal emotional adjustment following childbirth and that many postnatal women have clusters of symptoms that could be labelled depression but are actually something else. For example, in some instances the women were away from family having recently settled in New Zealand and were desperately homesick, or were extremely fatigued from dealing with a crying baby. In many cases the fundamental issue was anxiety/insecurity about breastfeeding or parenting skills. The role of guilt and shame also requires further investigation as this can be linked to anxiety and insecurity.

The danger of misclassifying a mental condition using screening tools developed in one language/culture as diagnostic tools in other languages and cultures, without taking into account cultural and social beliefs about childbirth and what is considered normal, is always present. On the other hand undetected or untreated mild depression can lead to major depression as it is not clear which women manifesting 'mild depression' may be experiencing a normal adjustment with some anxieties or which women may spiral into a major depression.

Conclusion

In terms of the aims of the present study both the PDSS and the EPDS had satisfactory reliability and validity when used with the specific group of women tested (some of whom volunteered as they 'felt' unhappy and some who volunteered because, although they 'felt' fine, they simply wanted to assist other women in research about PND). The results also indicate that the PDSS short form may be an efficient method of screening for normal adjustment versus symptoms of PND, thus addressing critics of the full scale PDSS who suggest that it is too long. While the small sample size may appear limiting, confidence in the findings is increased as the findings are consistent with the results of previous larger studies by Beck and Gable (2001a, 2001b, 2002).

A key feature for clinical practice was the superior sensitivity of the PDSS compared to the EPDS. However a limitation is the cost of the PDSS for use in clinical practice as the tool is copyrighted compared to the EPDS which is free. Further validation studies

are required to include women of other ethnicities (Schumacher et al, 2008). Discussions with Maori concerning undertaking a back-translation of the PDSS and EPDS revealed the general mistrust of any screening or measuring tool developed from a 'western' paradigm. It was suggested (personal correspondence, Professor Cunningham, Massey University) that Maori need to develop their own screening tools.

Further research is also required to evaluate the construct validity of PND in terms of the relationship between anxiety and depressive disorders, to evaluate the content validity of postnatal depression measures in this context, and to assess what constitutes normal postnatal mood adjustment.

In conclusion the short version of the PDSS may be a useful tool for community health professionals such as midwives, general practitioners and nurses while the long version adds greater discriminatory dimensions for follow up by clinical psychologists and psychiatrists and can be very useful in planning appropriate treatment and in research. The PDSS has also highlighted the lack of information about normal postnatal adjustment and the significance of anxiety. Its disadvantage is its cost. The EPDS however has good reliability and validity when used as a screening tool in the community and is freely available. Thus midwives can feel confident in their continued use of the EPDS as a screening tool in clinical practice at least among women of European origin although need to be watchful with women who are highly anxious.

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Sterile water injections for back pain in labour

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Abstract

Sterile water injections to reduce low back pain during labour have been used for the last 25 years in Scandinavia and since 1990 in the United States of America (USA) and Canada. The technique is not featured in current midwifery textbooks except for two USA publications. This paper reviews the use of sterile water injections in six studies published between 1990 and 2008, the various techniques used by the researchers and their results. The paper concludes with a discussion around some considerations for practice that emerged from these studies, including the different techniques and the number and type of injections to use. The evidence from the studies suggests that sterile water injections are an effective method to relieve low back pain in labour. They are simple to undertake and may provide women with an alternative option to narcotics and epidurals. The transitory pain experienced by the women immediately after the injection appears to be the only side effect.

Introduction:

Severe low back pain during labour is often associated with the fetus lying in a posterior position. It is estimated that posterior positions occur between 5.5% (Ponkey, Cohen, Heffner, & Lieberman, 2003) and 8% (Cheng, Shaffer, & Caughey, 2006) and can cause long and painful labours (Coates, 2003). One method that may assist in reducing persistent back pain associated with the posterior position is sterile water injections into the maternal lumbosacral region. The technique, known also as sterile water blocks (Trolle, Moller, Kronborg, & Thomsen, 1991) or papules (Ader, Hansson, & Wallin, 1990), to reduce pain during labour have been used by midwives for the past 25 years in Scandinavian countries (Peart, James, & Deocampo, 2006) and in the USA and Canada since the 1990s (Varney, Kriebs, & Gegor, 2004). A brief search of midwifery textbooks published during the last 10 years found only two that mention the use of sterile water injections (Lowdermilk & Perry, 2004; Varney et al., 2004). It has been included in the Canadian National Guidelines for Family-Centred Maternity and Newborn Care (Health Canada, 2000) and it is mentioned by Enkin, Keirse, Neilson, et al. (2000) as a method for reducing labour pain.

This paper examines the research surrounding use of sterile water injections to reduce maternal low back pain during labour. It describes the various techniques used by the researchers, assesses the results and considers issues for practice.

Literature Review

Early studies describe how lumbosacral subcutaneous injections of local anaesthetic were first used around 1929 to relieve labour back pain but these were not effective (Ader et al., 1990). In 1975 Odent (1991) used injections of distilled water into an area just below the ribs of labouring women before he accidentally found that sterile water (used for washing hands in the operating theatres) was more effective. According to Trolle, Moller, Kronborg et al. (1991) sterile water injections have been used effectively for relieving renal colic pain during the early 1980s. In 1986 the principle was successfully applied to women with low back pain in labour. However, none of the studies contained a control group (Ader et al., 1990). This led Ader and her colleagues to investigate the effects of sterile water injections compared to a placebo (normal saline) in a randomised controlled trial. Their study consisted of 45 women who required pain relief for low back pain during labour. One group (treatment group) received four intracutaneous injections. Intracutaneous injections are those that are given within the layers of the skin. It is a term derived from Latin with 'curtis' meaning skin and 'intra' meaning within. It is interchangeable with the term intradermal which derived from 'derma' meaning skin in Greek (Harris, Nagy, & Vardaxis, 2006). Each injection

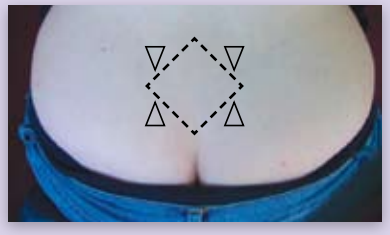

Figure 1. The location of injection sites in relation to the Michaelis' rhomboid.
(Photographer: M. Duff).

contained sterile water 0.1ml injected into the area marked by the sacral dimples (Michaelis' rhomboid) during a contraction. The area known as the Michaelis' rhomboid is shown in Figure 1 as a broken line, while the area where the injections can be inserted is indicated by the four small diamonds.

The other group (placebo group) received 0.1 ml of normal saline subcutaneously into the same region. All injections were given by a midwife, not involved with the woman's care. The researchers found that, while the subcutaneous injections were almost painless, the intracutaneous injections of sterile water caused a sharp 20 second long pain. Injections were therefore given during a contraction to 'mask' this experience. Women were asked to rate their pain using a visual analogue scale (VAS) on four occasions: before they had the injection; 10 minutes, 45 minutes and 90 minutes after the injection. The VAS was graded from 0 to 10 with "0" (no pain) to "10" (pain as bad as it gets). Results indicated that women in both groups identified that they had less pain after the injections compared to before the injection. However VAS scores for the treatment (sterile water) group were significantly less for each time period after the injection compared to the control (normal saline) group. That is, this study showed that both the treatment and the placebo reduced the level of back pain during labour, although more women in the sterile water group achieved an analgesic effect than in the normal saline group. ($p=<0.001$ at 10 minutes, $p=<0.02$ at 45 minutes and $p=<0.05$ at 90 minutes). The researchers noted that there were no long lasting side effects, that the injections could be easily administered by midwives; however the women did complain that the injection caused a burning pain which lasted a few seconds. Unfortunately, this study used two different injection routes for the treatment and control groups which may have influenced the results. This was rectified in the following study.

Trolle et al. (1991) in a double blind randomised control trial assessed the degree of pain relief achieved in 272 women with low back pain in labour using the same injection route for all participants. The researchers used the same technique as Ader et al's (1990) study (0.1 mls of fluid into four points of the Michaelis' rhomboid) of sterile water or normal saline. Both injection mediums were provided in identical ampoules and randomly mixed and numbered so that the midwives were not aware of the fluid being used. All participants received intradermal injections into the lumbar-sacral area. Women were asked to rate their pain using VAS on three occasions: before they had the injection, one hour and two hours after the injection. The VAS was similar in design to the one described by Ader et al. Results from both groups indicated that women had less pain after the injections compared to before the injections. The researchers found a significant difference between the two groups post injection results. They found that 89% of women in the sterile water group experienced an analgesic effect compared with 45% of women in the normal saline group ($p=<0.005$) with the effect lasting one to two hours. The authors noted that intradermal injections using normal saline were painful but those using sterile water were more painful. Yet significantly more women from the sterile water group would request the same pain relief again than from the normal saline group ($p=<0.005$).

The findings from these two studies indicated that intradermal injections of sterile water provided effective analgesia but were initially very painful. This led Mårtensson & Wallin (1999) to examine the differences in analgesia achieved between intracutaneous and subcutaneous injections using a randomised controlled trail of 99 women in labour. Two groups were given sterile water injections: one group received 0.1 ml intracutaneously while the other group received 0.5ml subcutaneously. A placebo group were given a subcutaneous injection of 0.1 ml normal saline. Each woman received four injections, during a contraction, into the same area described previously except this time the researchers asked the women to breathe on a combination of oxygen and nitrous oxide to reduce the pain sensation created by the injections. Women were asked to complete a VAS (similar to that described previously) before the injections, then at 10, 45 and 90 minutes after the injection. Women were also asked if they would request the injections during a future labour. Results indicated that there was no significant difference in the VAS scores between the groups using intracutaneous or subcutaneous sterile water. There was however, a significant difference in the VAS scores between the two sterile water groups and the placebo (normal saline) group indicating that sterile water had a greater analgesic effect than normal saline for more than 45 minutes after the injections. Women in the two treatment groups experienced more pain during the injection than the women in the placebo group yet significantly more women in the experimental groups would use the method again compared to the placebo group. A limitation of the study was that the researchers were unable to determine which injection route was more painful.

To assess which injection route caused more pain for the women Mårtensson, Nyberg and Wallin, (2000) investigated, in a double blind study, two injection routes: intracutaneous or subcutaneous. The study involved 100 non pregnant women between the ages of 18-45, randomised into two groups. Both groups received the same treatment: two injections 10 minutes apart. One group were given 0.1 ml of sterile water intracutaneously into the left sacrum followed 10 minutes later by 0.5 ml sterile water subcutaneously into the right sacrum. The same method was used with the second group except they were given the subcutaneous injection first and the intracutaneous injection 10 minutes later. Women were asked to rate the pain they experienced 90 seconds after each injection on a VAS, similar to those described previously. A second trial was undertaken a week later with both groups receiving the same injections but in reverse order. The researchers found that women experienced significantly more pain with the intracutaneous injections than with the subcutaneous injections. These women however, were not pregnant and not in labour.

In an Australian study, Peart et al. (2006) evaluated the effect that sterile water intradermal injections had on low back pain of 60 women during labour from two different hospitals. Women were required to request this type of pain relief prior to labour to be eligible for the study. The researchers used a similar VAS to those studies described previously and injected the sterile water into the Michaelis' rhomboid region using four injections. To reduce the pain of the injections each pair of injections were given simultaneously by two staff. The injections were not given until women indicated a VAS pain score of seven or more. This was because the researchers had undertaken a preliminary evaluation which indicated that the pain of the injections was unacceptable to the women unless their VAS pain score was seven or more. VAS sores were collected prior to the injection, five minutes after the injection and then every 30 minutes for two hours. Results showed a significant difference in responses between the pre and post injection VAS scores indicating 90% of women were experiencing less pain after than before the injection. There was also a significant reduction in the VAS scores for a period of 90 minutes following the injection indicating the period of analgesic effect. Women were very satisfied with the technique and would use it again although 96% indicated that it was very painful. Unfortunately, the authors stated they administered between 0.1 and 0.5 mls of sterile water but no mention was made why there was a difference in the volumes injected or if this effected the period of analgesia.

In another randomised control trial (Bahasadri, Ahmadi-Abhari, Dehghani-Nik, & Habibi, 2006) explored the effect of the subcutaneous route and one injection site rather that the four injections used by Ader et al.(1990); Trolle et al (1991); Mårtensson & Wallin (1999) and Peart et al. (2006). Bahasadri et al. investigated the effect of using subcutaneous injections of sterile water (treatment group) and normal saline (placebo group) on 100 women during labour. Both groups received one 0.5 ml of fluid injected into subcutaneous tissue in one area only. This area was the one women considered most painful in the sacral-lumbar region. Pain scores were calculated using a faces rating scale (FRS) prior to the injection and again 10 and 45 minutes after the injection. The FRS used was the Wong-Baker Faces Pain Rating Scale which has six faces with varying expressions from smiling (scored as "0" and labelled No hurt) to crying (scored as "5" and labelled Hurts worst) (Belville & Seupaul, 2005). Although the FRS was developed for paediatric use (Crisp & Taylor, 2005) it has been used across cultures and has been translated into a number of languages (McCaffery, 2002). It has also been validated reliably in adults against the visual analogue scale (Freeman, Smyth, Dallam, & Jackson, 2001; Ware, Epps, Herr, & Packard, 2006). Results indicated that there was a reduction in the FRS pain scores in both groups after the injections compared to before the injections. However, there was a significant difference ($p < 0.01$) between the two groups at 10 and 45 minutes after the injections; indicating that sterile water had a greater analgesic effect compared to normal saline. The researchers found that women complained that the injection was painful and the pain lasted approximately two minutes.

A recent RCT (Mårtensson, Stener-Victorin, & Wallin, 2008) evaluated pain relief and relaxation achieved during labour in 128 women using 0.05ml of sterile water injections compared with acupuncture. Both interventions were administered by 40 midwives trained in the procedures and the interventions were repeated when required. In the sterile water group four to eight injections were administered subcutaneously during a contraction in the area indicated by the woman as being the most painful. The area was not restricted to the lower lumbar sacral region. The pain relief achieved was assessed by VAS prior to the intervention then at half hourly intervals after the intervention for three hours by the women and also assessed by another midwife. Results from women indicated those in the sterile water group reported significantly less pain ($p<0.001$) than the acupuncture group and had a higher degree of relaxation ($p<0.001$). The sterile water group continued to have significantly less pain ($p =< 0.04$) for 180 minutes after the interventions except for at the 150 minute point, which produced a non significant result. Midwives also assessed women in the sterile water group as having less pain ($p<0.001$) and greater relaxation ($p<0.002$) than those in the acupuncture group. There were no significant differences in birth outcomes however there was only a 7% caesarean section rate of the study. Interestingly, this study did not exclude women from the study if the location of their pain was other than low back pain. Earlier studies only included women with severe low back pain. Unfortunately, the authors did not report the most common areas where this pain occurred but is an interesting issue since the results support sterile water injections as an effective pain relief measure. Pain relief has been reported using this method in other anatomical areas (Trolle et al., 1991).

The evidence from these studies suggests that sterile water injections are an effective method to relieve low back pain in labour although the placebo (normal saline) also produced, to some degree, an analgesic effect. Table 1 provides a summary of the studies reviewed. Interestingly, when reported none of the studies identified any statistical differences between birth outcomes of the experimental or control groups except Trolle et al (1991) and Mårtensson et al.(2008). The former study was the largest and they found a significant difference in the caesarean section rates between the groups ($p=<0.05$) which

Table 1: A Summary of the Studies Reviewed.

Note: VAS – Visual analogue scale; FRS – Faces rating scale. Note- For ease of comparison the term intradermal has been used throughout this summary in place of intracutaneous used by some authors.

Authors (Year)	Participants	Intervention	Control	Outcomes measured	Main results
Ader et al (1990)	45 women with low back pain in labour >37 wks	4 intraderrmal sterile water injections	4 subcutaneous isotonic saline injections	VAS scores before treatment and at 10, 45 and 90 minutes after treatment.	Mean VAS scores reduced in the intervention group • 10 minutes p=<0.001 • 45 minutes p=<0.02 • 90 minutes p=<0.05
Trolle et al. (1991)	272 women with severe low back pain in labour > 39 wks	4 intradermal sterile water injections into lower lumbar sacral area	4 intradermal saline injections into lower lumbar sacral area	VAS scores before treatment and at 60 and 120 minutes after treatment	More women (89%) in the intervention group reported an analgesic effect (p=<0.0005). Less C/S in intervention group (p = <0.05).
Mårtensson & Wallin (1999)	99 women with severe low back pain in labour. Term pregnancies	**Group 1** 4 intradermal sterile water injections into lower lumbar sacral area **Group 2** 4 subcutaneous sterile water injections into lower lumbar sacral area	**Group 3** 4 subcutaneous isotonic saline injections into lower lumbar sacral area	VAS scores prior to treatment and at 10, 45 and 90 minutes after treatment	No difference in the VAS scores between the two sterile water groups. Less pain in sterile water groups and the isotonic saline group at 10 minutes (p=<0.002) and 45 minutes (p=<0.006). <0.001)
Mårtensson et al (2000)	100 non pregnant women between 18 and 45 years	**Group 1** Intradermal sterile water into left sacrum followed 10 minutes later by subcutaneously sterile water into right sacrum. **Group 2** Subcutaneous sterile water into right sacrum followed 10 minutes later by intradermaly sterile water into left sacrum.	One week later the two groups received the intervention again but in reverse order	Pain intensity of the injections measured by VAS scores 90 seconds after injections	Intradermal injections were significantly more painful than subcutaneous injections (p=<0.001)
Pert et al. (2006)	Women in early labour with VAS> 7	4 intradermal sterile water injections into lower lumbar sacral area given simultaneously by two staff		VAS scores prior to treatment and at 5, 30, 60, 90, 150 and 180 minutes after treatment. Satisfaction survey	VAS scores decreased significantly from pre treatment to 90 minutes post treatment (p<0.000) • 90% satisfied with the pain relief • 96% stated the worst aspect was the pain of the injection
Bahasadri et al. (2006)	100 women in labour with low back pain.	1 subcutaneous sterile water injection into the lower lumbar area	1 subcutaneous normal saline injection into the lower lumbar area	FRS score prior to treatment and at 10 and 45 minutes after treatment.	Sterile water group had a significantly lower pain score at 10 and 45 minutes compared with the normal saline group (p=<0.01).
Mårtensson et al. (2008)	128 women in spontaneous labour at term	All women treated by acupuncture at GV20, L14, and SP6 and at another 4-7 acupuncture sites selected from BL23-24; BL54; EX19; GB25-29. Needles inserted, and stimulated every 10 mins for 40 mins.	Four to eight subcutaneous injections sterile water in the area indicated by the woman as being the most painful.	VAS scores prior to treatment and after the last treatment at 30, 60, 90, 120, 150 and 180 minutes by the woman and another midwife.	Women in the sterile water group reported significantly less pain than the acupuncture group (p= <0.001) and greater relaxation (p= <0.001). Women were significantly older in the acupuncture group compared to the sterile water group (p=<0.018). More women (71%) in the sterile water group would use the treatment again compared to 59% in the acupuncture group (non significant)

the authors were unable to explain. Fewer women from the sterile water group (4.2%) required surgery compared with 11.4% from the normal saline group and both groups had similar rates of instrumental deliveries. It is possible that reduction in the back pain allowed women to relax sufficiently to permit contractions to rotate a malposition. In the later study (Mårtensson, Stener-Victorin et al., 2008) reported no differences in the birth outcomes between the two groups but their caesarean section rate for the study was very low (7%). It would have been of value to know the caesarean section rate for the population from which this study was drawn.

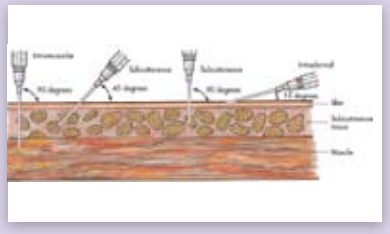

Figure 2. Comparisons of angles of insertions for injections (Figure 35.23 reproduced with permission from Potter & Perry (2009, p.751)).

Figure 3. A bleb or papule is formed as the fluid is injected into the skin layers (Photo Step 22C(4) reproduced with permission from Potter & Perry (2009. p.748)).

There have been three systematic reviews of RCT's covering complementary and alternative medicine (CAM) in obstetrics which have included the technique of sterile water injections for the relief of pain in labour. Simpkin & O'Hara (2002) evaluated five non pharmacological methods including continuous labour support; touch and massage; baths; movement and positioning; and sterile water injections. They found that although all methods reduced labour pain temporarily, sterile water injections had the most consistent results. Huntley, Thompson Coon & Ernst (2004) found 12 RCTs which included acupuncture, hypnosis, massage, biofeedback, respiratory autogenic training and sterile water injections in their systematic review of CAM used to treat labour pain. They concluded that only those trials using sterile water injections provided significant evidence of effectiveness. A later review by Anderson and Johnson (2005) examined CAM used in health promotion and for obstetric treatments during the prenatal, intrapartum and postpartum periods. In the intrapartum period they identified four interventions used to treat the pain of labour: acupuncture; massage; acupressure and sterile water injections. These authors also found that the only intervention that was effective was sterile water injections.

Considerations for Practice

The literature raises some interesting issues that require consideration. The following section discusses these in relationship to midwifery practice within the context of New Zealand and includes points related to performing the techniques; guidance and informed consent.

a) Techniques

Firstly, the technique for inserting subcutaneous injections is easier than intradermal (intracutaneous) injections and has fewer problems. Figure 2 provides a diagram of the layers of the skin and the angles used of each type of injection.

Subcutaneous injections are inserted into the connective tissue under the dermal layer of the skin however the depth of subcutaneous tissue is determined by body weight. Both the needle angle and needle length are determined by the woman's body weight. For example, the angle is determined by the amount of tissue that can be grasped or pinched. If you can grasp about 2.5 cms of skin, the needle is inserted at a 45 degree angle (Figure 2) using a 17 mm 25G needle. You can then continue to pinch the skin fold as you insert the needle quickly or you can stretch the skin and then insert the needle. It is easier to penetrate and it is less painful when the skin is pulled tightly. In both situations release the skin before injecting the sterile water slowly. It may however, be difficult to give a subcutaneous injection to very thin women who have little connective tissue. If 5cms of skin is grasped however, then the needle is injected at a 90 degree angle using a 25G needle with a length that is approximately half the length of the skin fold. Inject the sterile water slowly while you continue to maintain a grasp of the skin fold as obese women have a layer of fat above the subcutaneous layer. (Crisp & Taylor, 2005). An intradermal injection is typically used for vaccine or serum screening (ibid) or to apply a local anaesthetic (Johnson & Taylor, 2006). Fluid is injected under the dermis at a 5 - 15 degree angle (as shown in Figure 2) so that a blister, papule or bleb is formed (Figure 3). During the procedure the skin should be stretched and a 25 G needle inserted into the skin until resistance is felt. The needle is then advanced for about 3mm so the bevel of the needle is still visible under the skin. Further resistance should be felt as the sterile water is injected slowly. A blister should be visible however if it does not form, it means the injection has been placed lower into the subcutaneous tissue. Also, if no resistance is felt the fluid is probably being injected into the lower subcutaneous level (Crisp & Taylor, 2005). As pain relief is achieved by both routes this is probably not so important for midwifery. This is supported by Mårtensson & Wallin (1999) who found that 89% of women having had intracutaneous injections in their study would be willing to use the technique again compared to 81% in the subcutaneous group.

The second consideration around the technique is the number of injections and the anatomical location. All the studies on labouring women used four injections except Bahasadri et al. (2006) who used one and Mårtensson et al.(2008) who used up to eight. Again all except for Mårtensson et al.(2008) used the lumbosacral region. Therefore, the number of injections used and the anatomical location may depend on the situation: where the woman feels the pain; where the woman is labouring; the number of health professionals available; and the midwives' skills. If the woman is experiencing generalised pain over the lower sacral area then the four injection technique may be the method of choice however if the woman can localise her pain to one particular spot then one injection may be appropriate.

Varney et al. (2004) stated that the injections are more effective if women identify their own points of pain. This is supported by Mårtensson et al. (2008) and Bahasadri et al. (2006) studies. However, if the location is in the lower back, Varney et al. (2004) suggest that the woman leans forward while standing, kneeling or sitting during the procedure. This permits the sacral dimples to be observed more easily if the four injections technique is to be used. Peart et al. (2006) noted that having an assistant to help administer the injections simultaneously decreased the pain sensation experienced by the women. Women are also more willing to have the procedure repeated in another labour if simultaneous injections are given (Mårtensson & Wallin, 1999).

Varney et al also suggest (using the one subcutaneous injection technique) that once the woman has identified the area that is painful with her finger, that it is marked by the midwife or an assistant (Figure 4). Marking a circle around the woman's finger allows the injection to be placed correctly. It also permits the midwife to monitor the position for further injections if pain returns although one author noted that it is not necessary to be exact in the placement of the injection site (Reynolds, 1998). The subcutaneous injection can then be inserted (Figure 5).

With the exception of Peart et al. (2006), all researchers used 0.1 ml of sterile water when the route was

Figure 4. Marking an outline of the area the woman indicates as the most painful. (Photographer: M. Duff).

Photo 5. Using the marked area as a guide, pinch the skin and inject the fluid at a 45 degree angle. (Photographer: M. Duff).

intradermal and 0.5 ml of sterile water used when the route was subcutaneous. Therefore these volumes should guide practice. Sterile water injections are easy to administer and have no side effects except that the initial injection can cause pain described as a bee or wasp sting lasting 30 to 90 seconds (Varney et al., 2004). The relief of pain is fast (Mårtensson et al., 2000) lasts two to three hours, and the injections can be repeated although these should be limited to three as local irritation may occur (Varney et al., 2004).

b) Guidance

This is a technique that is not well known. For example, although it has been identified as being used since 1990 in the USA, a survey of 107 midwives knowledge and attitudes in that country (Mårtensson, McSwiggin, & Mercer, 2008) found that 32% of the midwives used the technique while 46% of midwives had no knowledge of it. From personal discussions with a number of midwives across the North Island not one identified that they had heard of the technique. Furthermore, a personal enquiry to four of the education institutions offering Bachelor of Midwifery programmes found that none included the technique as a midwifery skill and in addition did not include intradermal injections in their curriculum. Therefore, midwives from these programmes, as well as other midwives, may need additional education and theoretical practise in the technique in order to gain competence.

A number of authors have provided advice regarding undertaking the different techniques. For example, when withdrawing the needle after insertion of an intradermal injection do not massage the site with a swab as this may cause the fluid to escape (Crisp & Taylor, 2005). Likewise, don't recommence any therapeutic massage over the injection site as it may dislodge the fluid and shorten the effect (Reynolds, 1998). Larger blebs have been suggested as resulting in longer periods of effective relief (Mårtensson, McSwiggin et al., 2008) however this requires further research. Other issues would also need consideration. For example, observing the site for the injections and making sure they are free of skin infections or damage such as bruising. Likewise, in the hours and days after the injections the area should be observed for signs of infection.

Most of the studies recommended that the injections be given during a contraction to minimise discomfort. However, the midwives who used this technique in the USA could not agree that this was an appropriate recommendation although they gave no reasons (Mårtensson, McSwiggin et al., 2008). It could be argued that it would be easier to administer the injections between contractions when a woman might reduce her bodily movements. However, this is an area that has not been researched. Providing women with nitrous oxide and oxygen to breath during the administration may help to diminish the pain of the injection (Mårtensson & Wallin, 1999).

Sterile water injections provide midwives with another option to offer women as they work with the pain of labour. It has been reported that between 70%-90% of women experience pain relief for at least 60 minutes after the injection (Reynolds, 2000) although this relief can last up to two hours (Mårtensson, Stener-Victorin et al., 2008) and the injections can be repeated (Varney et al., 2004). It may be ideal for women who require pain relief prior to transfer from a rural area or for women waiting for an epidural. It may also be an option for women who do not want to use narcotics or to have an epidural.

c) Consent

Sterile water injections are another option for women to consider particular if they are keen to use only non pharmacological methods of working with pain. Women should be offered concise information about this technique during their pregnancy once midwives are competent to offer it. The information should include advantages and disadvantages of using the techniques; an explanation of the different techniques; when the method may be used; and a scientific explanation of how the technique works.

The advantages of this method of pain relief is that it is relatively quick to administer in any situation, is cheap and can be used in homebirths, birthing units or major hospitals. It may be used as a main pain relief measure or used as an interim measure if the woman is being transferred to secondary care for an epidural. Therefore it may be idea tool for midwives working in rural areas to include in their skill repertoire as studies suggest that 90% of women were satisfied with the degree of pain relief achieved (Peart et al., 2006).

The major disadvantage of the technique is the initial severe burning pain that can last up to 90 seconds and has been described as a bee or wasp sting although research indicates that the pain sensation can be reduced using the subcutaneous method (Mårtensson et al., 2000). This information needs to be carefully explained to the woman together with the fact that, like other pain relief measures, it may not be 100% effective or last for hours but it can be repeated.

Conclusion

The evidence from these studies suggests that sterile water injections are an effective method to relieve low back pain in labour. They are simple to undertake and may provide women with an alternative method to narcotics and epidurals. The severe transitory pain experienced by the women immediately after the injection appears to be the only side effect. The number of injections and the route to be used will depend on the woman, her place of labour, and the midwife's skills. However, a single subcutaneous injection, into the area identified by the woman as being the most painful, appears to be effective and cause the least pain. This would be an ideal topic to be included in the Technical Skills Workshops. An evaluation of the technique in a New Zealand based population is also required.

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BOOK REVIEW

Continuity of midwifery care - the practical guide

Authors:
Caroline Homer, Pat Brodie, and Nicky Leap (2008).

Churchill Livingstone Australia. 1st Edition. ISBN 9780729538442.

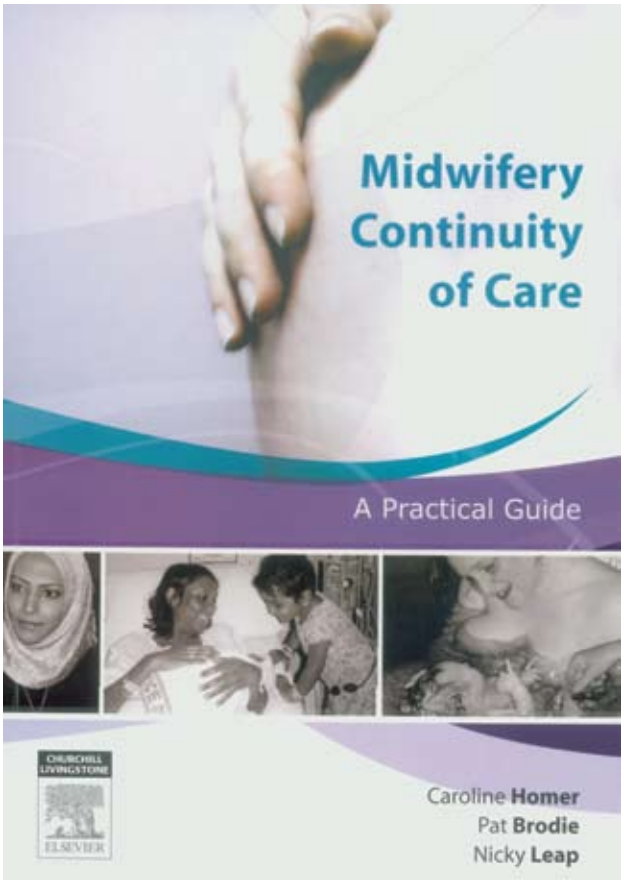
Reviewer:
Nimisha Waller, Senior Lecturer in Midwifery, AUT, Self employed midwife and Midwifery Co-ordinator NZCOM Auckland Midwifery Resource Centre.

Recently there has been much discussion about how we can continue to provide midwifery continuity of care while facing midwifery workforce issues, rising intervention rates and increased complexity in pregnant women. This book by renowned international contributors from Australia, New Zealand (Dr Chris Hendry, Associate Professor Liz Smythe and PhD Candidate and independent midwife Caroline Young), Canada, England and Scotland introduces midwifery models of care (including LMC care), care within different settings: i.e. city, rural and remote as well as different organisational and industrial challenges faced in provision of midwifery continuity of care.

The book as the title says is a guide on "how to' establish midwifery continuity of care. The inclusion of theory around the concepts related to midwifery continuity of care and the evidence provides robustness while the use of summaries and vignettes bring the practice of providing continuity of care to life. The issues of safety and quality (uppermost in all practitioners' minds), working collaboratively with other colleagues effectively (a good reminder that we do not work in isolation) and of achieving sustainable change as well as looking after yourself as a midwife are fully explored. The information in the appendices is useful for midwives as well as organisations providing continuity of care or thinking of doing so.

Midwives, midwifery managers, student midwives, educators, policy makers and health service executives will find this book invaluable. Women and women's groups that advocate for better maternity services for women may also find aspects of this book useful.

The book is dedicated to Tricia Anderson who inspired and encouraged many midwives to find ways of providing continuity of care and reflect on what "woman centred" care really means. This book is a fitting tribute to an inspiring midwife.



NEW ZEALAND COLLEGE OF MIDWIVES (INC) JOURNAL

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