

**PSYCHOSOCIAL OBSTETRICS AND GYNAECOLOGY:
CURRENT CONTROVERSIES**

5 and 6 August 2005

Hilton on the Park, Melbourne

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Welcome

The Australian Society of Psychosocial Obstetrics and Gynaecology is the third oldest Australian medical society relating to women's obstetrics and gynaecological health. The Society is multidisciplinary and involves obstetricians and gynaecologists, psychiatrists, general practitioners, paediatricians, psychologists, health researchers and administrators. The Society runs an annual meeting that is devoted to discussing the best way to manage the psychological and social aspects of pregnancy and gynaecological care of women, their infants and immediate families. This year we have an outstanding group of international and Australian keynote speakers discussing current controversies in care. We also offer a new investigator prize and the opportunity for free communications.

We hope that you will find the conference to be both stimulating and rewarding.

Professor Julie Quinlivan
ASPOG President on behalf of the Conference Committee:

Drs Amanda McBride and Heather Rowe

ASPOG

The Australian Society for Psychosocial Obstetrics and Gynaecology is a multi-disciplinary association devoted to furthering understanding of the psychosocial aspects of health, particularly in the field of obstetrics, gynaecology and reproductive medicine.

The strength of the Society is its multi-disciplinary membership and its informal, supportive meetings that foster interest in communication, counselling and psychosocial aspects of health. The Society welcomes health workers from all disciplines, e.g. medicine, midwifery, nursing, psychology, social work, social sciences, etc.

The Society holds a national congress that moves yearly between states and sometimes offshore. The topics debated reflect the Society's breadth of interests, including psychosocial aspects of puberty, fertility and infertility, contraception, pregnancy, menopause and men's reproductive health.

The broad **aims** of the Society are to:

- Foster and promote **increased awareness** of psychological, socio-cultural and ethical issues relevant to obstetrics, gynaecology and reproductive medicine.
- Promote and facilitate sharing of **scientific research** into psychosocial aspects of obstetrics, gynaecology and reproductive medicine.
- Increase sharing of clinical and practical knowledge relevant to **improving the psychological health** and well-being of women and their families, especially in obstetric and gynaecological settings.
- Provide a forum for cross-fertilisation of ideas from practitioners and researchers from the broadest possible spectrum of relevant areas.

PROGRAM CHANGES

There have been a number of program changes since the Registration Brochure was printed so please check the program in this book carefully.

SESSIONS

Unfortunately, it is not possible to guarantee delegates a place at their preferred session; if you find that a particular session is full, please choose the alternative session.

PRESENTERS

Presenters using data projectors are asked to load their presentations onto the computer in the room where they will be presenting in a break prior to the presentation. If you need help with this, please ask at the Registration Desk.

Presenters are asked to convene at the front of the appropriate room with the Chair of their session a few minutes before the start of their session.

SOCIAL PROGRAM

On Friday evening, delegates will have the option of continuing their discussions over dinner and drinks in the **Cliveden Room** at the Hilton. With original stained glass facades and marble fireplace from the 1887 Cliveden Mansion, this room has a wonderfully warm and opulent atmosphere. The 2005 Derek Llewellyn Jones Oration will be presented at the dinner by Professor Roger Short. If you wish to attend the dinner and have not purchased a ticket, please check at the Registration Desk to see whether additional bookings can be taken.

Farewell drinks will be served at the end of the conference on Saturday.

NAME BADGES/TICKETS

Admission to all sessions and social functions is by the official conference name badge – please wear it at all times when at the conference. Tickets are necessary for the conference dinner.

CERTIFICATES OF ATTENDANCE

If you require a certificate of attendance, please ask for this at the Registration Desk.

DELEGATES WITH ACCOMMODATION

Deposits paid when delegates registered for the conference should be credited to your hotel account....please check that this has been done when you check out. It is recommended that you make arrangements for your luggage to be held at the hotel, rather than bringing it to the conference venue, where storage space is very limited and security cannot be provided.

DISCLAIMER

At the time of printing, all information contained in this booklet is correct; however, the organising committee, its sponsors and its agents cannot be held responsible for any changes to the final structure or content of the programme, or any other general or specific information published here.



The
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8.00 *Registration and arrival coffee*

9.00-9.15 **President's Opening**
Julie Quinlivan

9.15-10.15 **Plenary Session: International Keynote Address**
Chair: Julie Quinlivan
Guidelines for Treating Postnatal Depression – an Edinburgh Perspective
Beth Alder

10.15 *Morning tea*

10.45-12.15 **Plenary Session: Psychosocial Assessments**
Chair: Julie Quinlivan

10.45 Antenatal Screening and Postnatal Depression
Judith Lumley

11.30 Postnatal Psychosocial Screening – Introduction of a Statewide Service
Victor Nossar

12.15 *Lunch*

1.15-2.45 **Plenary Session: Dilemmas in Parenting**
Chair: Amanda McBride

1.15 The First Time Fathers Study: Predictors of Father-to-infant Attachment Over the First Postnatal Year
John Condon, Phil Boyce and Carolyn Corkindale

1.45 When Parenting Goes Wrong
Jane Fisher

2:15 The Mental Health of Women Giving Birth in Australia 2002-4:
The beyondblue National Postnatal Depression Program
Anne Buist, Bryanne Barnett, John Condon, Jeannette Milgrom, Barbara Hayes, Janette Brooks, Marie Paule Austin, Nick Kowalenko, Rebecca Reahy

2.45 *Afternoon tea*

3.15-5.15 Parallel Sessions A and B**Paper Session A: Gynaecology Delacombe Room****Chair: Rodney Petersen**

- 3:15 When It's Not Normal: Women's Understandings of Pain in Seeking Treatment for Gynaecological Symptoms
Narelle Warren and Lenore Manderson
- 3:35 A Quality of Life Study on the Impact of Pelvic Floor Dysfunction
Jennifer Cook, Fariba Willison, Elvis Seman, Robert O'Shea
- 3:55 Women's Thoughts on Menopause and the Implications for Community Education
P.M. Schulz, G.Pretty
- 4:15 A Randomised Controlled Trial of a Psychological Program for Women with Gynaecological Cancer
Renee Gedge and David Clarke
- 4:35 Friends, Family and Fears: An Exploration of the Authoritative Knowledge Carried by Family and Friends and Their Impact on the Experiences of Women Contemplating Nuchal Translucency (NT) Screening in Brisbane, Australia
Fiona Hawthorne
- 4:55 'Pretty Woman' and the 'Other Self'
Romance, Reality and Substance Abuse
A Case of Severe Borderline Personality Disorder
Brian Hunt

Paper Session B: Childbirth Huntingfield/Stradbroke Rooms**Chair: Heather Rowe**

- 3:15 The Experience of Childbirth after Assisted Conception
Karin Hammarberg, Jane Fisher, Heather Rowe
- 3:35 Early Infant Contact after Caesarean Section – What Are Women's Experiences?
Michelle Kealy, Rhonda Small, Jeanne Daly, Judith Lumley, Stephanie Brown, Fiona Bruinsma
- 3:55 The Therapeutic Effects of Music and Dance on the Health of New Mothers
Beth Rankin
- 4:15 Lost Opportunity or Lifeline? Women with Substance Use Issues and Their Perceptions of the Barriers to Pregnancy Care
Mary Tobin
- 4:35 A Comparison of Midwives' Knowledge of and Attitudes to Hypnosis in Hospitals With and Without a Hypnotherapy Service
Allan M Cyna and Yen Huey Eng
- 4:55 The Social and Cultural Construction of Pre- and Post-Natal Care Amongst Migrant Ethnic Indian Women in Melbourne
Natasha Maharaj

7.00 for 7.30 Drinks, Dinner & the 2005 Derek Llewellyn Jones Oration**The Cliveden Room, Hilton Hotel****Chair: Julie Quinlivan**

A New Vision for Contraception ~ Roger Short

8.30 *Arrival coffee*

9.00-10.30 Plenary Session: Update on Infertility
Chair: John Condon

9.00 The Ageing Egg: The Biology
Alan Trounson

9.30 Male Infertility: The Biology
Gordon Baker

10.00 Counselling Infertile Men
Roger Cook

10.30 *Morning tea*

11.00-12.30 Parallel Sessions C and D

Paper Session C: Young Women **Huntingfield/Stradbroke Rooms**
Chair: Heather Rowe

11:00 A Qualitative Study of Teenagers and Teachers Views of Sexual Education in Victorian Schools
Kim Xia, Roger Short, Julie Quinlivan

11:20 Psychosocial Needs of Pregnant Teenagers in the Context of Antenatal Education
Ruth Martis

11:40 Can Teenage Mothers Make an Informed Decision Regarding Down Syndrome Screening?
Mardiana Lam, Julie Quinlivan, Heather Rowe

12:00 Postnatal Experiences of Breastfeeding among Child Sexual Abuse Survivors
Jan Coles

12.20 Discussion

Paper Session D: Pregnancy Care **Delacombe Room**
Chair: Jane Fisher

11:00 The Need for a Multidisciplinary Approach
Susan Krzanich

11:20 Evaluation of the Social Identification Tool
Ilana Jaffe and Christina Pitter

11:40 Supporting Pregnant Women and Recent Mothers with Learning Difficulties and Intellectual Disability
Brenda Burgen

12:00 Violence Against Women – Is Routine Screening Good Practice?
Marg D'Arcy and Keran Howe

12.20 Discussion

12.30 Lunch and AGM

1.30-3.00 Plenary Session: Counselling in Difficult Situations**Chair: Fran Orr**

- 1.30 When Mum has Cancer
Rodney Petersen
- 2.00 When There is an Unexpected Fetal Anomaly
Louise Kornman

Papers

- 2:30 "If I Were Ben..." What Have We Learned From the Study Using this Multi-Media Research Instrument?
Carolyn Corkindale, John T Condon, Alan Russell and Julie Quinlivan
- 2:50 Postnatal Debriefing Did Not Improve Health Outcomes after Operative Birth: An Investigation of Possible Explanatory Factors
Lisa Donohue, Jane Fisher and Heather Rowe
- 3:10 How Are Women's Psychosocial Needs Assessed and Managed in the Early Postnatal Period?
Yelland J, Forster DA, McLachlan HL, Rayner J, Lumley J.
- 3.30 *Afternoon tea*

4.00-5.00 Parallel Sessions E and F**Workshop Session E****Chair: Julie Quinlivan**

Working with Teenagers
John Moran

Delacombe Room**Workshop Session F****Chair: Jackie Stacey**

'I Like To Be Respected and Have My Body Respected': Elements of a Gynaecological Practice Sensitive to the Needs of Victim/Survivors of Sexual Assault
Marg D'Arcy, Maria Vucko and Jacqui White

Huntingfield/Stradbroke Rooms**5.00-5.30 Farewell Drinks**

Guidelines for Treating Postnatal Depression - An Edinburgh Perspective**Beth Alder**

Napier University, Edinburgh

Depression following childbirth is a significant factor in maternal mortality and affects between 10% and 15% of women. Postnatal depression occurs at a critical time and impacts on the partner, relationships, and the development of the infant. However, if recognized, it is eminently treatable and current guidance is to treat as for other depressive illnesses, but in the context of caring for a young infant. Over the last few years the importance of postnatal depression has become increasingly recognised by policy makers within the UK, and the Edinburgh Postnatal Depression Scale (EPDS) has become widely used.

The Scottish Intercollegiate Guidelines Network (SIGN) carries out comprehensive literature searches on pre-determined questions, followed by expert independent reviews of evidence. These lead to the development of evidence-based recommendations graded according to strength of evidence. The SIGN 60 Guideline, Detection and Management of Postnatal Depression, was published in June 2002.

Guidelines can be produced by experts, but there is little point if they are not reflected in policy and practice. Previous studies have found that guidelines are often not followed in practice, and a number of reasons for this lack of compliance has been suggested. In 2003, the year following the publication of the guidelines, a scoping exercise was carried in Scotland to obtain a national picture of care of patients with postnatal depression in relation to the SIGN 60 guidelines and NHS policies. All fifteen NHS Boards in Scotland were asked for information on policy and all responded. Representative practices in Scotland (n=199) were asked in more detail about their services for postnatal depression, for information about routine practice, the administration of policy documents and the incorporation of Integrated Care Pathways into practice.

Half the NHS Boards had developed Integrated Care Pathways, and all NHS Boards followed the SIGN Guidance and recommended that the EPDS be used as part of a screening programme for postnatal depression. More than 95% of practices followed the recommendation on the use of EPDS into their practice, although there were variations. Not all practices had the resources to allow patients to select their preferred psychosocial treatment, even when this recommendation was included in NHS Board policy. Further recommendations were made by NHS Boards and followed by practices that were not supported by an evidence base. The paper will describe the result of the survey and implications for guidelines.

Male Infertility: The Biology**HWG Baker**

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Despite the genetics revolution of the last century, male infertility remains largely of unknown cause. Severe primary seminiferous tubule failure may result from chromosomal disorders particularly XXY, testicular inflammation, irradiation or cytotoxic drug exposure but known genetic causes such as microdeletions in the long arm of the Y chromosome or myotonic dystrophy are rare. Most cases are idiopathic. Cystic fibrosis gene mutations causing bilateral congenital absence of the vasa is probably the most common clearly genetic form of male infertility.

A few men have conditions can be treated medically or surgically to increase natural fertility such as ejaculatory duct, vasal or epididymal obstructions, gonadotrophin deficiency or suppression and coital disorders. Reversible impairments of sperm output from heat or drug exposure are very infrequent. Many patients are seen with defects of sperm number, motility or morphology which reduce fertility in proportion to their severity but do not cause absolute sterility. Some couples with no obvious abnormalities on testing of the female and with normal standard semen analyses have defects of sperm function which reduce the ability of sperm to bind to zona pellucida (ZP) of the oocyte, undergo the acrosome reaction and penetrate the ZP. Subfertile men may have associated conditions such as previous undescended testes, varicoceles, prostatitis, obesity or other health problems and their sperm may have increased reactive oxygen species generation and chromatin damage assessable by various methods but how these contribute to the infertility is unclear and treating them has not been proved to increase fertility.

The management of male infertility has changed since the introduction of intracytoplasmic sperm injection (ICSI) in the early 1990's. Some treatable conditions such as genital tract obstruction and sperm autoimmunity may be better managed by ICSI. Other previously untreatable conditions such as oligospermia from primary seminiferous tubule disorders are now effectively dealt with by ICSI. It has also been discovered that many severe spermatogenic defects such as Sertoli cell only syndrome are incomplete in some patients and that elongated spermatids (testicular sperm) can be obtained for ICSI by multi-site or microsurgical open testicular biopsies. These advances have reduced the use of donor sperm in infertile couples.

The increased use of assisted reproductive technology, particularly ICSI, has raised concerns about adverse effects in the mothers and risks for the offspring. However comparisons of the pregnancy outcomes from standard IVF and ICSI do not suggest there is greater pregnancy loss, maternal complications of pregnancy, low birth weight or major fetal malformations with ICSI.

The Mental Health of Women Giving Birth in Australia 2002-4: The beyondblue National Postnatal Depression Program

Anne Buist*, Bryanne Barnett, John Condon, Jeannette Milgrom, Barbara Hayes, Janette Brooks, Marie Paule Austin, Nick Kowalenko, Rebecca Reahy

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Aims: The project involving all states and territories except NT, aimed to capture data on the mental health of women during this stressful time, as well as evaluate the feasibility and impact of screening, training and educational material on attitudes, help seeking behaviour and knowledge.

Method: Thirty four maternity hospitals across Australia participated in a screening program for antenatal and postnatal women between 2002-2004, involving over 30,000 women. Data was collected antenatally, with postnatal depression scores. In a subgroup of women, and health professionals, detailed feedback on the program, supports and attitudes was obtained.

Results: This presentation will provide an overview of demographics and psychosocial variables in women giving birth across Australia, with reference to key risk factors. On preliminary analysis, 20% of women had high EPDS scores antenatally and 16% postnatally, appearing lowest in WA. Screening was generally seen as positive and acceptable (81% of women were comfortable, only 26% midwives requested more support), with positive feedback on training as well as improved knowledge scores. Depression continued to have a low rate of recognition in women, with 23% ignoring suggestions for further help.

Conclusions: Perinatal depression and distress is common in the Australian population. Screening is feasible and acceptable if implemented with training and support, but further measures are required to improve acceptability of services and their access.

Supporting Pregnant Women and Recent Mothers with Learning Difficulties and Intellectual Disability

Brenda Burgen

WIN Clinic, Women's Social Support Services, Royal Women's Hospital, Melbourne

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The Royal Women's Hospital in Melbourne has developed the Women's Individual Needs (WIN) antenatal clinic to best respond to the needs of women with learning difficulties, intellectual disability, physical disability and sensory impairments. The WIN clinic has a dedicated midwife and social worker providing a more intensive and tailored service to women throughout their pregnancy and after the birth of their baby.

The presentation will give an overview of the WIN clinic and its development. The discussion will focus on women with learning difficulties and intellectual disability and the psychosocial issues and service responses affecting the quality of their pregnancy and early parenting experiences.

Postnatal Experiences of Breastfeeding among Child Sexual Abuse Survivors**Jan Coles**

Monash University Department of General Practice

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This project is a qualitative study examining the breastfeeding experience of women who were sexually abused as a child (CSA) by a family member. The presentation examines postnatal experiences of community health professional contact with doctors and Maternal and Child health nurses amongst these women

Objectives:

- to explore and understand the experience of breastfeeding in mothers with a past history of CSA by a family member.
- To improve postnatal care given by health professionals to women who are survivors of CSA.

Method: 13 community volunteers recruited through general practices, maternal and child health centres, private obstetrician's rooms and via community newspapers participated in the study. All participants had successfully breastfed for at least 3 months. In depth semi-structured interviews were used, digitally recorded, transcribed and themes analysed. All interviews were conducted by the author.

Results: Significant themes that emerged were detachment, flashbacks, fear, exposure, lack of enjoyment in their breastfeeding experiences and the strong sense of maternal duty with breastfeeding as a necessary "task". Breast and nipple pain did not emerge as significant issues.

Health professional contact in the postnatal period raised a number of issues for the CSA survivors who participated; significant issues were observation, breastfeeding in a public space without privacy or choice, body privacy for both the mother and her baby, and gaining consent before 'professional' touch. Women felt disempowered by these experiences and for a number it recreated the trauma of their original abuse.

Conclusions: The data raises significant areas where health care contact could be improved simply by health professionals paying attention to patient privacy in public settings such as wards and clinics and by asking for consent to touch not only the mother but her baby.

The First Time Fathers Study: Predictors of Father-to-infant Attachment Over the First Postnatal Year**John Condon*, Phil Boyce** and Carolyn Corkindale***

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** University of Sydney

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The Australian First-time Fathers Study was a longitudinal investigation of the psychosocial impact of the transition to fatherhood. Approximately 250 men were followed from pregnancy to the end of the first postnatal year. Assessments were performed at 26 weeks gestation and at three, six and 12 months postnatally. This paper begins with a brief overview of the methodological issues of assessing parent-to-infant attachment using self-report questionnaires. The psychometric properties of the Father-to-Infant Attachment Questionnaire are summarised. The paper then presents a path analysis of the interrelationship between five variables, viz: depression, quality of the relationship with partner (sexual and nonsexual), infant temperament and father-to-infant attachment. The findings highlight the high degree of continuity over the four assessment points for depression, quality of partner relationship and father-to-foetal / infant attachment. A discriminate function analysis was utilised to identify which variables, assessed during pregnancy, best distinguished the upper quartile of highly attached men from the lower quartile at 6 and 12 months postnatally. The accuracy of the prediction was unexpectedly high. At 6 months postnatally, 85% of men could be correctly classified in terms of attachment score using only two pregnancy variables, viz antenatal attachment and quality of partner relationship. At 12 months, 78% of men could be correctly classified using these two pregnancy variables. Thus, pregnancy would appear to be a window of opportunity to identify men likely to have subsequent attachment problems. Interventions which foster men's antenatal attachment and facilitate involvement in their partners' pregnancy may have significant future benefits.

A Quality of Life Study on the Impact of Pelvic Floor Dysfunction**Jennifer Cook, Fariba Willison, Elvis Seman, Robert O'Shea**

Flinders Medical Centre, Flinders Endogynaecology, Flinders University

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Pelvic floor dysfunction (PFD) is a general term that describes conditions which adversely affect the female urinary and faecal continence mechanisms, together with genital prolapse. It is not uncommon for several pelvic floor disorders to coexist in the same woman or to develop sequentially over time. Disorders of the pelvic floor rarely result in severe morbidity or mortality. Rather, they affect the quality of a woman's life and it has long been assumed that sexual function and satisfaction are compromised by these disorders. Over a 12 month period, 61 women underwent laparoscopic Pelvic Floor Repair (PFR). Four questionnaires were administered pre-operatively. These were the Pelvic Floor Distress Inventory (PFDI), Pelvic Floor Impact Questionnaire (PFIQ), Pelvic Organ Prolapse-Urinary Incontinence Sexual Function Questionnaire (PISQ) and the WHOQOL-BREF, which is a general health related quality-of-life instrument. Follow-up questionnaires were administered six and 12 months following surgical intervention. Results showed that quality of life, urinary symptoms, and bowel symptoms were significantly improved following surgery to equal levels of the non-clinical comparison group (N = 50). Surprisingly, however, sexual satisfaction remained unchanged from pre-operative levels and did not differ from the comparison group. It may be concluded that neither the condition of PFD nor the intervention of Laparoscopic PFR impact on sexual function and satisfaction, despite the otherwise debilitating aspects of the condition and benefits of the operation.

Counselling Infertile Men**Roger Cook**

Psychology Centre, Swinburne University, Melbourne

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It has taken considerable efforts by the relevant professions for infertility in men to be acknowledged as a major factor in couples' inability to conceive children. It is gradually being more widely recognised and consequently treated. An important part of that treatment is the management of the emotional responses of men patients and the provision of their psychological and emotional counselling has achieved considerable significance. This counselling of men needs to take account of the different ways in which men respond to their diagnoses and also to the impact that it has on men's families. Men's infertility is typically seen by men to be a personal threat and one to which they feel vulnerable. It creates stress and a sense that it must be quickly solved. The different considerations and strategies that can be useful in counselling infertile men will be discussed including evaluating threat and stress levels, provision of information, appraising the availability of support and utilising personal strengths.

"If I Were Ben..." What Have We Learned From the Study Using this Multi-Media Research Instrument?**Carolyn Corkindale*, John T Condon[†], Alan Russell* & Julie Quinlivan****

* Flinders University

** University of Melbourne

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The study aimed to investigate adolescent males' responses to the pregnancy of a partner. Of particular interest was whether the boy decided to stay with the girl and whether he wished her to continue the pregnancy or have a termination. We were also interested in the role of masculine ideology and idealization in these decisions, and whether we could identify the key elements in the decision-making process.

The instrument used in the investigation was a multi-media computer role-play 'game' in which was embedded a questionnaire. Participants were 386 secondary school students of mean age 15.4 years. Additional questionnaires assessed masculine ideology, idealization and self-esteem.

Preliminary results of this study were presented at ASPOG in 2003. Additional analyses have now been performed and the presentation will focus on the factor structure of the questionnaire embedded in the game, the predictors of the decisions made, and a discussion of how these young men may be struggling to find a basis on which to make crucial personal and moral decisions.

A Comparison of Midwives' Knowledge of and Attitudes to Hypnosis in Hospitals With and Without a Hypnotherapy Service**Allan M Cyna* and Yen Huey Eng****

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The use of hypnosis in obstetrics has been practiced for more than a century(1) and has been shown to be a real phenomenon especially in controlling pain.(2) Hypnosis appears to be a conscious state of intense focused attention and is characterised by an increased receptivity to verbal and non-verbal communications, commonly referred to as suggestions. Suggestions generate subconscious responses that result in changes in patient perception, mood or behaviour. Many women request strategies for minimising their need for medical intervention during childbirth and although regional analgesia is a popular choice for labour analgesia, it is not without side effects. Systematic review evidence of the effects of hypnosis in childbirth suggests an association with a reduced need for labour analgesia, a lower incidence in the use of oxytocics for labour augmentation and an increased incidence of spontaneous vaginal birth.(3) There is anecdotal evidence of hypnosis reducing the incidence of post-partum depression and anxiety and it may increase maternal satisfaction with the childbirth experience.(1) Newbold endorsed the teaching and use of hypnosis by midwives over 50 years ago.(4) We performed a cross-sectional survey, of midwives knowledge of and attitudes to hypnosis, in hospitals with (CH) and without (NCH) a clinical hypnotherapy service in June 2004. A 28-item questionnaire was distributed to a random sample of midwives at the two hospitals. The overall response rate was 118 of 130 midwives (91%). Compared with NCH, CH midwives were more likely to support; the use of clinical hypnosis ($p < 0.001$), hypnosis as being helpful during childbirth ($p < 0.001$), and recommend hypnosis as an analgesic adjunct during childbirth ($p < 0.001$). CH midwives were also more likely to express an interest in hypnotic techniques being taught during midwifery training. The vast majority of respondents (83%) agreed that positive suggestion techniques should be taught during midwifery training.

References

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2. Nash M. The truth and the hype of hypnosis. *Scientific American* 2001:47-53.
3. Cyna AM, McAuliffe GL, Andrew MI. Hypnosis for pain relief in labour and childbirth: a systematic review. *Br. J. Anaesth*; 2004;93:505-11
4. Newbold G. The importance of hypnotism in midwifery. *Br J Med Hypn* 1950;2:2-6

Violence Against Women – Is Routine Screening Good Practice?**Marg D’Arcy and Keran Howe**

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This paper will use the experience of the development of clinical practice guidelines on effective practice for women who have been subjected to violence to suggest that the focus on routine screening with the goal of the patient disclosing domestic violence may not meet the goal of increasing women’s safety and enhancing their experience of health practitioners. We will suggest that women’s health is effected by a wide range of violence, including domestic or intimate partner violence, sexual assault as an adult, sexual assault as a child, trafficking, workplace violence and female genital mutilation. By focusing narrowly on domestic violence and on asking questions, receiving a disclosure and referring, the issue of good practice which recognises the health impacts of all forms of violence and the issues for victim/survivors of violence in accessing health services is in danger of being overlooked. Given that up to 1 in 3 Australian women experience some form of violence over their lifetime, the paper will explore the possibility of developing health practices which are sensitive to the needs of women who have experienced violence which may or may not involve them having to identify that they have been victim/survivors. It will draw on consultations undertaken with victim/survivors of violence and Keran Howe’s study tour of hospitals in Canada and United States to identify what women identify as important to them and what are the supports that staff have identified they require to be able to implement good practice.

‘I Like To Be Respected and Have My Body Respected’: Elements of a Gynecological Practice Sensitive to the Needs of Victim/Survivors of Sexual Assault (Workshop)**Marg D’Arcy, Maria Vucko and Jacqui White**

Royal Women’s Hospital, Melbourne

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This workshop will present what has been learnt from the CASA House research, Barriers to Cervical Screening Experienced by Victim/survivors of Sexual Assault, and the consultations with women about the development of practice guidelines on violence against women for the Royal Women’s Hospital. The paper will discuss the prevalence of sexual assault and argue that all practitioners should be aware that many women they provide a service to will have experienced some form of sexual violence during their lifetime. It will acknowledge that often women will be reluctant to disclose their experience of violence, particularly to a health practitioner with whom they have little or no ongoing professional relationship. It will discuss what women have said they want from practitioners that would assist in reducing the potential for trauma and identify the elements of good practice for working with women who have experienced sexual assault.

Postnatal Debriefing Did Not Improve Health Outcomes after Operative Birth: An Investigation of Possible Explanatory Factors.**Lisa Donohue, Jane Fisher and Heather Rowe**

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Background and aims: A randomised controlled trial found that a midwife-led, in-hospital, debriefing session for women following an operative birth did not reduce subsequent maternal depression, improve overall health status, or increase satisfaction with postpartum care (Small et al 2000). The aim of this study was to investigate possible explanations for these findings.

Methods: Two sources of data that had not previously been analysed in the randomised trial were used. First, data collected during the single debriefing session with each woman undertaken in the hospital in the first few days after the birth and second, data provided via a postal questionnaire sent to all participants' six months later. The EPDS and SF-36 health scores collected at six months postpartum were used in both studies. Data were analysed by mode of delivery, parity and health insurance status.

Results: Women's accounts of their birth in the first few days postpartum were consistent with their recollections six months later. Mode of delivery, parity and health insurance status all influence women's operative birth experience and the type of physical and psychological problems reported immediately, and in the six months after the birth. Women who had a caesarean section were more likely than women who had an instrumental vaginal delivery to be separated from their infant at the time of birth. Women who experienced a caesarean section, especially an elective procedure, anticipated less postnatal support after hospital discharge. The presence of physical health problems and low family income contributed to poorer health status in the first postnatal year. These factors were more prevalent amongst first time mothers.

Conclusions: A listening intervention provided by the single midwife-led debriefing session was not able to ameliorate chronic physical health problems or low family income which were associated with poorer mental health six months after birth. Health professionals who provide care to women in the postpartum period should not routinely use postnatal debriefing.

When parenting goes wrong**Jane Fisher**

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The work of sustaining life in, and caring for an infant cannot be learnt through simulation or theory and in reality is more difficult than anticipated for all parents. Caretaking capacity is multifactorially governed by individual factors and social circumstances. Most of the current educational material for parents of newborns encourages them to trust intuition, but many parents feel acutely uncertain about what constitutes optimal and sustainable caretaking. There is increasing evidence that both reproductive events and infant behaviour influence maternal caretaking capacity, perhaps through their impact on the development of maternal efficacy and a confident maternal identity. These are not usually addressed in current standard primary health care for mothers and newborns. Caretaking skills and maternal confidence can be improved through psycho-educational approaches that use supported practise and learning by doing rather than by listening or reading.

A Randomised Controlled Trial of a Psychological Program for Women with Gynaecological Cancer

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Following a diagnosis of gynaecological cancer, many women experience clinically significant mood disorders and impaired quality of life. Multiple factors may contribute to the anxiety and depression experienced by this group of patients. In common with all cancer patients, they face the possibility of protracted illness and/or early death, particularly with ovarian cancer, where prognosis is often poor. Multiple physical problems may follow treatment, including toxicity induced by radiotherapy or chemotherapy, reduced fertility, abrupt menopause, and sexual problems. Unique psychological issues may arise because of the involvement of sexual and reproductive organs. Although for many women psychological symptoms decrease over the six to twelve months following treatment, levels of distress may be very high during this period, and for a significant number of women, symptoms may persist much longer. Relatively few psychosocial interventions specific to gynaecological cancer have been reported. This paper reports some early results of an intervention designed to address the unique sources of anxiety and depression in this group. The program, which consists of six weekly two-hour modules, is being conducted as a randomized trial, using a wait list control group. The program includes components of psycho-education, mindfulness training and expressive writing. Participants complete several measures of well being, including the Hospital Anxiety and Depression Scale, and The Functional Assessment of Cancer Therapy, with an additional Spiritual well-being Scale. Measures of social support, & coping style are also completed. This paper reports quantitative and qualitative data, from both a pilot study, and initial implementation of the program at the Moorabbin campus of Monash Medical Centre. Early data suggests the program is effective in improving quality of life, and reducing anxiety and depression.

The Experience of Childbirth after Assisted Conception

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Background and Aim: There is emerging evidence that women who conceive with assisted reproductive technology (ART) are at increased risk of early parenting difficulties, but the determinants are as yet unknown. There is no existing evidence about the psychological aspects of childbirth following assisted conception. A prospective, longitudinal study of a consecutive cohort of women who conceived with ART between July and December 2001 has been conducted and one of its aims was to investigate the childbirth experiences of women conceiving with ART.

Method and study population: Participants completed self-report questionnaires in early and late pregnancy and 3, 8 and 18 months after the birth. At three months postpartum questions were asked about the experience of the birth and postnatal care.

Results: The response rate was 96% with 166 returned questionnaires. Compared with all Victorian women who gave birth in 2002, study participants were older (34.5 versus 30.0 years, $p<0.0001$), more likely to be primiparous (70% versus 42%, $p<0.0001$), have twins (19% versus 1.6%, <0.0001) and caesarean section birth (51% versus 25%, $p<0.0001$). Compared with participants in the Victorian Survey of Recent Mothers women in this study were less likely to report having a sense of autonomy and inclusion in the management of the birth (47% versus 58%, $p=0.01$) and to feel confident about baby care when leaving the hospital (48% versus 72%, $p<0.001$). Among study participants those who had a caesarean section were less likely than those who had a vaginal birth to see their baby straight away (66% versus 87%, $p=0.002$), hold their baby within a few minutes (73% versus 96%, $p<0.001$), and to feel included in the management of the birth (66% versus 95%, $p<0.0001$). Furthermore, they were more likely to experience considerable postnatal pain (71% versus 56%, $p=0.04$), to want a lot of advice about infant feeding (79% versus 55%, $p=0.001$) and to feel disappointed with the birth (45% versus 17%, $p<0.0001$).

Conclusion: Caesarean section is known to be associated with some adverse psychological consequences in the early postpartum. In addition to the intervention of ART over half the participants had a caesarean section. The combined effects of assisted conception and caesarean section may increase risk of early parenting difficulties after ART.

Friends, Family and Fears: An Exploration of the Authoritative Knowledge Carried by Family and Friends and Their Impact on the Experiences of Women Contemplating Nuchal Translucency (NT) Screening in Brisbane, Australia

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This paper will present preliminary findings and discussion from an exploratory study being conducted in Brisbane Australia regarding the thoughts, feelings and decisions of a diverse range of pregnant women about nuchal translucency ultrasound screening. Twenty one pregnant women aged between 23 and 40+ and with a range of characteristics, were interviewed for the study. The paper will discuss the role played by family and friends in shaping how women think about NT screening. It will examine the value placed by these women on what their family and friends feel about the scan and abnormality and how the opinions of their care providers fit into this view. It will discuss the Social Authoritative Knowledge Model that has been derived from this data.

**'Pretty Woman' and the 'Other Self'
Romance, Reality and Substance Abuse
A Case of Severe Borderline Personality Disorder**

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The film 'Pretty Woman' has two principle female characters, the two prostitutes who share an apartment. One is an unglamorous drug using caricature and the other a glamorous romanticised almost heroic figure- the 'Pretty Woman'. The story is about how the 'Pretty Woman' is rescued by a rich and powerful prince charming and the unfolding of the story implies a happy ending.

The story I wish to tell in this paper does not have a happy ending. It is about a woman who closely identified with the 'Pretty Woman. She was a 'working girl'. This title and the title of the film are both embodiments of a myth that has allowed our society to construct a romantic fantasy. This fantasy denies the necessity to care for and contain many individuals who are in great need.

A single case history will be presented illuminated by a theoretical model of developmental process. This model should provide a treatment structure that gives opportunity for maturation and integration. However the failure in this case will be described in relation to the following factors.

- The presence of substance abuse as a major symptomatic manifestation of the disorder.
- The greater risk of decompensation when pregnancy occurs.
- The need for protection and containment when chaotic and destructive family dynamics as well as terrifying intra-psychic processes are evident.
- The presence of a resonance between individual fantasy and mythic social structures and ideas such as the notion of the 'Pretty Woman' or the 'Happy Hooker'.

It is hoped that the details of the life described in this paper will be seen to refer to an increasing number of tragedies that result from both our lack of capacity to care and a misunderstanding of the real nature of the problem of substance abuse.

Evaluation of the Social Identification Tool

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Health care professionals can play a vital role in identifying women who are experiencing emotional and social concerns and can offer them appropriate care or referrals to programs of which they may either be unaware or may not otherwise access. The Royal Women's Hospital (RWH) has developed an increasing recognition of the importance of identifying and addressing

not only the clinical, but also the social needs of women during their ante and post-natal care. In this light, the RWH conducts a routine social needs identification tool to all new pregnant service users to complement the clinical care that women receive. This allows health care providers to gain a broader awareness of issues that may require referral to more specialised and appropriate service systems

The aim of this evaluation was to gain an understanding of women's thoughts/feelings and comfort levels with the social identification tool during their first antenatal appointment at the RWH. Furthermore, the current rate of completion and documentation of the social needs identification tool was audited.

The paper will seek to report on the methods, issues, findings and recommendations that were brought to light by this evaluation.

Early Infant Contact after Caesarean Section – What Are Women's Experiences?

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The Victorian population based Survey of Recent Mothers 2000 found that 33% of women who had an elective caesarean section and 38% who had an emergency caesarean section reported not being able to hold their baby as soon as they would have liked after the birth (compared with 10% of women who had spontaneous vaginal births). Women who were not able to hold their baby as soon as they wanted were more likely to score as depressed on the Edinburgh Postnatal Depression Scale (EPDS) at five months post partum (OR=1.64, 95% CI: 1.14-2.35).¹

As caesarean section rates continue to rise in Australia and abroad, are hospitals able to deliver on their individual policies to enhance early infant contact after operative birth?

What do women say of their experience from the operating room to the ward? Are women supported to see, touch or hold their baby in the operating room as much as they would like? Is there opportunity to facilitate bonding in recovery and on the ward?

This paper will present findings from face to face in-depth interviews with women who experienced caesarean section. The interviews were conducted as part of the Health And Recovery after operative birth Project (HARP), and explored in part women's experiences of contact with their babies post-operatively. The implications for women of delayed contact with their baby will be discussed.

¹ Brown S, Lumley J. Physical health problems after childbirth and maternal depression at six to seven months postpartum. British Journal of Obstetrics and Gynaecology 2000;107:1194-1201.

Counselling in Difficult Situations – When There is an Unexpected Fetal Anomaly**Louise Kornman**

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Ultrasound of the fetus has become an almost routine investigation in pregnancy. In Australia it is estimated that >90% of women have at least one scan in their pregnancy.

There are various medical reasons for performing an ultrasound: to determine the gestational age of the pregnancy, ensure the fetus is alive, check the number of fetuses, determine the position of the placenta and exclude fetal abnormality. For many prospective parents, their reason for having a scan is for reassurance, to “see” their developing baby for the first time, and often to determine the fetal sex. It is often described as making the baby seem real. It is frequently perceived as a social event.

Many couples have not considered the possibility that there may be an abnormality with their baby.

It is this incongruence between the expectations of the patient and the practitioner that heighten the difficulty in counselling if an abnormality is detected unexpectedly.

Around 97% of ultrasounds will be reported as normal. However, approximately three in a hundred women will be confronted with the possibility of an abnormal baby after their 18-20 week (mid-trimester) ultrasound. An abnormal finding is usually made in a consultation for which 15 minutes has been allowed, in a darkened room, often with several onlookers (friends and relatives of the couple). The nature of the procedure has meant that there has been no time for rapport to build up with the couple, there has been eye-contact only at the initial greeting, and any communication has been with the ultrasonographer looking at one monitor, the patient at another. There is often background chatter, and an air of excitement in the room. This scenario is not an ideal setting in which to break bad news.

Factors that influence delivering news about a fetal anomaly include:

- That many women/couples have different expectations and limited knowledge about the intention of the ultrasound (ie detecting fetal anomalies). Distress is often greater in those women who did not realise that there was a chance they would be confronted with a fetal anomaly.
- the initial state of shock and disbelief that the bad news engenders. This results in impairment of cognition so that the majority of information given after the initial diagnosis cannot be recalled.
- the uncertainty of the diagnosis can also be a problem. This uncertainty can occur with any structural malformation, as its implications for function are not always clear. It is also an issue when the abnormality is only a “soft marker” for Down Syndrome. In this situation, couples need to be aware that they are being told their *risk* of an abnormality, not 100% certainty.
- The authority that the person performing the ultrasound has to divulge the abnormality to the parents. In many cases, sonographers are only allowed to tell the parents there may be a problem, and then refer them to another clinician. Radiologists who interpret the ultrasounds will usually leave the discussion of the findings to the referring physician, which necessitates delay in the giving of the information.
- the behaviour and manner of the clinician giving the bad news

- dichotomy between the personal wish not to find abnormalities and the professional satisfaction when they do (Simpson and Bor ¹)
- The difficulty in scheduling time to deal appropriately with unexpected abnormalities. The demand for ultrasound (many women, particularly in capital cities have at least 2 scans per pregnancy) means that most centres are working to capacity just providing the ultrasound examination.

There is not a large body of literature on this subject. Garcia and others ² conducted a systematic review on women's views of pregnancy ultrasound. They found only 5 studies that addressed women's experiences after the detection of a fetal malformation
A more recent paper by Alkazaleh *et al* ³ investigated by means of a questionnaire, what things women value when receiving news of an abnormality.

These issues, the literature available about them, and suggestions for practice and further study will be the focus of the talk.

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- 3 . Alkazalah F, Thomas M Grebenyuk L. 2004. What women want: women's preferences of caregiver behavior when prenatal sonography findings are abnormal, *Ultrasound Obstet Gynecol* **23**: 56-62.

The Need for a Multidisciplinary Approach

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Historically, practices in obstetrics and gynaecology have focused wholly on medical health care during pregnancy and childbirth and overlooked critically important psychosocial issues in a woman's life that will influence her physical and psychological well being. As with any disadvantaged group, drug and alcohol using women have suffered disproportionately from the lack of understanding that is a consequence of such disinterest.

There has been an epidemic rise in substance use amongst women of child bearing age and heightened awareness of community drug problems.

The Women's Alcohol & Drug Service at the Royal Women's Hospital in Melbourne is a unique maternity health service that provides specialized pregnancy care for women with complex substance use issues and state wide professional support on pregnancy related drug and alcohol issues.

Pregnant women who attend the service have a high risk pregnancy complicated by complex psychosocial issues.

The impact of psychosocial issues can be modified by case management, counselling, support, improved problem solving and coping skills, education, information and linkages to appropriate services.

The focus of the presentation will explore the model of care provided by the Women's Alcohol and Drug Service and discuss the importance of a multidisciplinary team approach in addressing pregnancy care and complex substance use issues.

Can Teenage Mothers Make an Informed Decision Regarding Down Syndrome Screening?

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Background: Screening for Down Syndrome (DS) has become routine in obstetric practices. The psychological implications and ethical dilemmas associated with screening have been well-documented. Enabling women to make an informed decision about screening has been recommended as one strategy to reduce the psychological costs. A few studies have explored the importance of informed decision-making in pregnant women. However, no studies have explored informed decision-making in pregnant teenagers.

Teenage pregnancies are associated with high levels of psychosocial stress. Several studies have documented higher baseline levels of anxiety in teenage mothers. However, the psychological impacts of undertaking DS screening on teenage populations have never been explored. It is possible that undergoing DS screening may exacerbate anxiety. Alternatively, teenagers may regard their personal risks of carrying a baby with DS as so low that undergoing screening has no impact on their anxiety levels.

Objectives: The aim of the study is to assess knowledge and informed decision-making in respect to DS screening in pregnant teenagers. The secondary aim is to establish whether teenagers with good knowledge and/or made informed decisions experienced less psychological symptomatology compared to those with poor knowledge and/or did not make informed decisions.

Methods: A prospective longitudinal cohort study was conducted with teenagers being assessed at three time-points, 14 weeks, 20 weeks and 30 weeks respectively. Data collected included demographic variables, education background, knowledge and attitude towards DS screening and anxiety and depression levels using validated questionnaires.

Results: Eighty-six teenagers were recruited in the study. 37% had good knowledge regarding DS screening and 29% made informed decisions in respect to undergoing screening. Teenagers with good knowledge were significantly older (p -value=0.001) and tended to present earlier for their first antenatal appointments (p -value=0.020) compared to teenagers with poor knowledge. Partners of teenagers with good knowledge were also significantly older than partners of teenagers with poor knowledge (p -value=0.031). However, differences in knowledge were not associated with differences in psychological symptomatology. Teenagers who made informed decisions were likely to be older (p -value=0.001) and had longer relationships with partners (p -value =0.001 and 0.039 respectively). They were also significantly less anxious at 20 weeks (after undergoing DS screening) compared to those who made uninformed decisions.

Conclusion: The level of knowledge of pregnant teenagers regarding DS screening were relatively poor, however attitudes towards screening were relatively positive. Only a small proportion of teenagers (29%) made informed decisions in respect to undergoing DS screening. Age may be a good predictor of knowledge level and informed decision-making. Pregnant teenagers who made an informed decision in undergoing DS screening experienced significantly less anxiety in the mid-trimester, suggesting that informed decision-making reduced anxiety associated with undergoing DS screening.

Antenatal Screening and Postnatal Depression

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Maternal depression after birth is now widely accepted to be a major health problem with the potential of adverse flow-on effects for the mother, child(ren) and family. One approach to reducing the impact of depression after birth has been early identification, followed by an intervention. The organisation of antenatal care and the high uptake of antenatal care in Australia and New Zealand have made it possible to contemplate and carry out programs of universal antenatal screening, including 'routine' universal screening for current depression, or for risk of developing postnatal depression. This paper will summarise the evidence from systematic reviews on the extent to which screening for depression in antenatal care meets the well-defined criteria for *a screening program*. The second half of the paper will focus on two areas in which antenatal screening might contribute to effective *treatment* (women currently depressed) or to effective *prevention* (women identified as being at increased risk of depression). The available evidence, from an updated systematic review, does not suggest that either of these strategies is effective.

The Social and Cultural Construction of Pre- and Post-Natal Care Amongst Migrant Ethnic Indian Women in Melbourne

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In the last few decades, there has been a significant increase in the number of ethnic Indians migrating to Australia, who bring to an existing cultural environment their own traditions and customs. This 'difference' underpins a general assumption that, to be a migrant woman is to be marginalised and disadvantaged. This paper draws from a study that explores, in the Australian context, the cultural and societal contexts of motherhood, and the extent to which these are influential amongst migrant ethnic Indian women from India, Fiji, South Africa and Britain. Women in this study belong to strong, female, familial networks that provide special care and support during early motherhood. I challenge assumptions of disadvantage, and instead, present narratives of motherhood that are positive and embedded in cultural expectation.

Psychosocial Needs of Pregnant Teenagers in the Context of Antenatal Education**Ruth Martis**

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Teenage pregnancies have become an issue of increasing concern in New Zealand with the second highest teenage pregnancy rate in the world. Pregnant teenagers do not seek early antenatal care for a variety of reasons and are very unlikely to participate in antenatal education. Limited evidence in the literature shows teenage antenatal education can prevent problems developing not only for the teenage mother and her baby's health but also reduce the risks associated with social and maternal behaviours including substance abuse and other addictive behaviours.

This qualitative study aimed to explore needs and issues that might surround and affect teenage antenatal education. The results provide maternity service providers with a clearer understanding of teenage antenatal education needs and issues as a basis for providing effective antenatal education and maternity care. 30 participants, distributed over four focus groups, each comprising of 8 - 10 pregnant teenagers or recent teenage mothers, were interviewed in the Palmerston North region, New Zealand. All participants were expecting their first baby or had recently given birth to their first baby and had all attended at least one antenatal education session.

Overall it showed clearly that a developmental based programme with a participatory development format is the most effective way of providing antenatal education for pregnant teenagers. This needs to take the form of a teenage support group lasting the whole pregnancy rather than the traditional approach of a set course for a limited time towards the end of the pregnancy.

The presentation today will only focus on the findings of the psychosocial needs as identified by the participating pregnant teenagers of the study and in the context of antenatal education. Eric Erikson (1968) termed the teenage years as the developmental stage of identity versus role confusion. If a teenage girl becomes pregnant a crisis that could contribute to role confusion may arise. It is therefore important that the emotional and social needs of young pregnant women are understood. The focus groups participants of this study identified the need for safety, self-esteem/self-worth building exercises, body image issues and overall emotional support within a teenage antenatal education programme.

Working with Teenagers**John Moran and Warrick Brewer**

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ORYGEN is the only specialist youth mental health service of its type in Australia. ORYGEN's core competency is the development, implementation and dissemination of best practice in youth mental health.

ORYGEN provides mental health services to young people in the North West area of Melbourne through its clinical program funded by Victorian State Government. The catchment area for ORYGEN's clinical service (operated through Melbourne Health) has a total population of about 900,000, with approximately 130,000 young people in its target age group of 15-25. ORYGEN provides services to up to 800 young people with severe mental disorders each year.

ORYGEN conducts an extensive program of research through the ORYGEN Research Centre, a private, not-for-profit company, which has the University of Melbourne, Melbourne Health and the Colonial Foundation as its member organisations. ORYGEN manages a number of federally funded projects including multi-million dollar grants from the National Health and Medical Research Council and the Alcohol Education and Rehabilitation Foundation.

Young people need youth appropriate services. Youth is not only the peak period for the onset of psychiatric illness; it is also a complex and often precarious phase in the life cycle for psychosocial development. Evidence [1, 2, 3] demonstrates significant benefits from a separate system of youth psychiatry, a guiding principle by which ORYGEN operates [2].

Mental health issues are responsible for 55% of the overall burden of disease for young people between 15-24 [4]. One in four young people in this age group will experience a mental disorder in any 12 month period [5]. Landmark surveys have revealed that the onset of major mental disorders, such as schizophrenia, bipolar disorder, depression and anxiety, substance use disorders, eating disorders and personality disorders, is most common in adolescence or young adult life, between the ages of 12 and 26 [6]. Recent Australian surveys confirmed this, finding that the peak period for mental disorder is the young adult period of 18 – 24 years [5]. Treatments have never been better - if treated appropriately and early, a young person has excellent prospect for a happy and healthy life. Early case identification and intensive treatment of the emerging disorder has been shown to reduce the need for inpatient treatment and is associated with better outcomes and subsequent cost reductions for the health care system [6,7].

Mental disorders are often complicated by co-occurring substance abuse. Treatment of both the mental illness and the substance use disorder by the same treating team at the same time is more effective than non-integrated treatments for people with both mental health and drug and alcohol problems [8,9,10,11]. The lack of integration between drug and alcohol and mental health services in Australia has significantly contributed to the poor detection and treatment of mental illness amongst young people with substance abuse. This results in waste of resources and long-term psychiatric and substance use problems for individuals who could otherwise be helped.

Mental health issues can also complicate treatment and health care approaches to a range of general life and health issues that young people might face including reproductive health.

The workshop presenters will provide an overview of youth mental health issues from a broad and clinical perspective in the workshop including an opportunity for questions and discussion.

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Postnatal Psychosocial Screening – Introduction of a Statewide Service

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Early years of children's lives play critical roles in their future health and development. While several interventions have demonstrated the capacity to improve life outcomes of vulnerable children, they have been shown to have less benefit for children in families with greater resources, and, importantly, little or no benefit for children in some particularly "at risk" families.

Since July 2004 the postnatal psychosocial screen, *Pathways to Parenting*, has been used for nearly all of the 17,500 children born in South Australia. Its primary role has been the identification of "populations of need", most likely to benefit from the sustained nurse home visiting program that is being rolled out in South Australia. The information gathered is also used to assist all families access assistance most appropriate to their needs.

In September 2004, *Pathways to Parenting* was evaluated utilising staff focus groups, a client survey, consultations with other service providers and through analysis of the data gathered. While concerns about the acceptability of the assessment instrument were expressed by service

providers, a large proportion of client families indicated strongly positive acceptance of the *Pathways to Parenting* assessment.

To address the particular requirements of families with Aboriginal infants a specific accompanying booklet *Pathways to Parenting – The Indigenous Way* was developed. This has proved highly successful.

Results of these evaluations have informed the current format of the *Pathways to Parenting* assessment instrument and it is being incorporated into the eCHIMS electronic child health record, which is currently being rolled out in South Australia.

Family Home Visiting, which is the sustained nurse home visiting service in South Australia, continues to expand with more than 685 families enrolled in the first twelve months, over 21% of enrolled families having Aboriginal infants, and maintaining high retention rates.

Counselling in Difficult Situations: When Mum has Cancer

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There are large quantities of data available on both the psychosocial effects of cancer and on the benefits of interventions designed to reduce these adverse effects. However, virtually all of the trials are in non-gynaecological cancers therefore presenting some issues of specificity or relevance of the interventions. How do we sort out which interventions are applicable to gynaecological cancers? Is there a need to continue to document the adverse effect of specific cancers? Do we need to run more expensive clinical trials of interventions designed just for gynaecological cancers or can we use the available evidence to implement change? The sparse data on interventions trialled in gynaecological cancers will be discussed and perhaps ideas of where efforts need to be concentrated will be generated.

The Therapeutic Effects of Music and Dance on the Health of New Mothers

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A randomised controlled trial, pilot study was conducted to test the hypothesis that active participation in music and dance classes would make a difference to the health and well-being of new mothers. A total of 84 new mothers were recruited from Maternal and Child Health Centres in the inner north eastern suburbs of Melbourne. The women were randomised into groups with other new mothers and offered twenty weeks of active music and dance classes with their babies present. The women were randomised into 'early' groups and 'late' groups. The 'early' group started the classes immediately while the 'late' groups waited four to six months before starting the intervention classes. Participation was noticeably different between the 'early' and the 'late' groups, with a significant drop out rate from those who were asked to wait. Health outcomes measured included the SF-36, Health and well-being questionnaire, the Edinburgh Postnatal Depression Scale, (EPDS) and the Sarason Social Support Questionnaire, (SSQ).

Participants answered self administered questionnaires before and after participating in an interactive music program. The results are presented as descriptive analysis.

The purpose of the pilot study was to test the methods and to make recommendations for a larger trial. The study concluded that a large trial was warranted with some minor changes recommended in the definitive study design

Women's Thoughts on Menopause and the Implications for Community Education

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The purpose of the study was to identify how women view menopause so that health promotion professionals have a better understanding of women's health education needs as they approach and traverse menopause. Survey data and interview information regarding women's thoughts about menopause was collected from women in three stages, premenopause, perimenopause and postmenopause. Data about the various discourses that influence these thoughts was also collected. Analysis of the questionnaire survey indicated that postmenopausal women endorsed the positive aspects of menopause to a greater degree than women in the perimenopausal or premenopausal groups. Positive beliefs about menopause were also associated with both income and education. The results of the survey also showed that women accessed four primary discourses on menopause (popular culture, professional, peers and research) and the information sources accessed differed at the three menopausal stages. Analysis of individual interviews with a sample of participants highlighted differences in the meaning of menopause for women in each stage and that women more actively anticipate the onset of menopause as they move toward their forties. This anticipation process increases their awareness of the available menopause information sources encountered in the course of their daily life. The results of this study identify the differences in attitude and awareness of women in different stages of menopause that health education programs must address.

A New Vision for Contraception

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Contraception has become yesterday's news. We have lost interest in it both internationally and nationally. But the continuing growth of the world's population, especially in developing countries, continues to pose the greatest single threat to the natural environment and to global peace and prosperity. Remember those old slogans about "Many children make you poor"? There was not a whisper about improving contraceptive services in the G8 Summit. Who will provide the contraceptives that the developing world so desperately needs? It will never be the Western world's Big Pharma, that is solely driven by the profit motive. We need to give every support to the developing State-run pharmaceutical companies in China, India, and Thailand,

and let's ensure that they are not shackled by the patent protection laws of the developed world.

Moving closer to home, Derek Llewellyn Jones would be horrified to learn that Australia is an international disgrace, with the second-highest teenage abortion rate in the developed world. Surely everybody would agree that improved contraceptive information, education and services for teenagers is a far preferable alternative, but the topic is still so mired in misplaced religious dogma that no Australian Government, Federal or State, seems to have the courage to address the issue.

There can be no argument on health safety grounds for keeping the oral contraceptive pill on prescription; this practice significantly impedes teenagers from having access to it. So it was with some incredulity that I learned from a senior colleague in the pharmaceutical industry, who must remain anonymous, that the industry would be totally opposed to having the pill available over-the-counter. They would lose money on the deal, as it would break the cosy collaboration they have with the Medical profession, who are their marketers. If the pill was available from pharmacies, costs would come tumbling down, and those who need it most would not be denied access. Derek, if you were with us, I am sure you would do something about it.

The field of contraception has stagnated because there have been no new ideas around. So here is one that could transform attitudes to oral contraception throughout the developing and developed world. Instead of taking the pill orally, take it vaginally. Studies have demonstrated that if anything, this increases contraceptive efficacy, and the oestrogen content of the pill significantly thickens and keratinizes the vaginal epithelium. Monkey studies have shown that this in turn provides almost complete protection against vaginal simian immunodeficiency virus infection. Clinical trials are urgently needed to see if women taking the pill intra-vaginally would be protected from HIV infection. If this were true, the end of the HIV pandemic would be in sight. Derek, we need you back from Heaven immediately to start the clinical trials.

Lost Opportunity or Lifeline? Women with Substance Use Issues and Their Perceptions of the Barriers to Pregnancy Care

Mary Catherine Tobin

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The issue of pregnancy care attendance for women with substance use issues at the Royal Women's Hospital (RWH) was explored in this research project which occurred in 2004. Twenty – three women with substance use issues and a history of poor attendance were interviewed during the post natal period to identify possible factors that impacted on their ability to attend pregnancy care. Possible motivating factors were also identified.

In addition, quantitative methods were adopted to provide a context to the qualitative data. This involved the collection of 1250 Royal Women's Hospital pregnancy and attendance records over a period of six months. Records of women with substance use issues were compared with records of women without substance use issues to identify differences in patterns of attendance. Outcomes of this data revealed that early attendance will greatly increase the likelihood of ongoing retention in the service. Surprisingly the data also revealed that overall attendance rates for women with substance use issues at the RWH do not differ greatly from those without substance use issues, though their attendance rates generally fall short of what is expected of them.

Results from this study have confirmed previously held beliefs about women with substance use issues and their lack of access to pregnancy care. Key themes emerging from the study included women's fear of child protection and fear of judgmental attitudes as the main barriers preventing them from seeking pregnancy care. Additionally, factors that motivated women to attend pregnancy care included a desire to have a healthy baby and the opportunity to make changes to their substance using lifestyle.

Outcomes from this project have identified the need for comprehensive multidisciplinary services and improved strategies to increase access for pregnant women with substance use issues. Additionally it is recommended that pregnancy care agencies continue to promote and provide access to ongoing training for health professionals working in this complex area of health care.

The Ageing Egg: The Biology

Alan Trounson

Monash Immunology and Stem Cell Laboratories, Monash University

The oocytes (eggs) in the female are all established in prenatal life and the population of around 1 million declines after birth as a result of continual recruitment to growth and atresia throughout life until menopause. Little is known about the molecular mechanisms that are responsible for the recruitment and loss due to atresia. More is known about the very small number of oocytes that eventually grow to be ovulated (usually only oocyte each menstrual cycle). Superovulation due to fertility drugs has little or no effect on the primordial oocyte population because the very early follicle that contains the primitive oocyte is not responsive to gonadotrophins. As the woman ages, there is a progressive increase in chromosomal errors in oocytes that are ovulated. This reduces the viability of oocytes. Other molecular characteristics of oocytes are also affected by increasing age. New strategies may evolve for the widening of the reproductive window for women but little is known about the consequences of oocyte normality as yet.

When It's Not Normal: Women's Understandings of Pain in Seeking Treatment for Gynaecological Symptoms

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Australian women experiencing high levels of pain and discomfort associated with menstruation will live with their symptoms for extended periods of time before seeking medical advice. On average, the delay between symptom onset and attending a health professional is 3.6 years (Cox et al. 2003). These women will typically experience a further delay of approximately 3.5 years before obtaining a diagnosis (Cox et al. 2003); these pathways to diagnosis have been reasonably well articulated in social science literature and have highlighted the doctor-patient relationship. In contrast, this paper explores women's experiences prior to presenting to a medical practitioner. To understand how women make sense of disruptive gynaecological health concerns, qualitative research was conducted across urban and regional Victoria between 2003 and 2005. We were particularly interested in understanding the lived experience of women's symptoms, and how these impacted upon (and were influenced by) formal and informal social

supports. Through in-depth interviews with 90 women, several themes were identified: 1) the construction of period pain as 'normal' has problematic consequences for some women; 2) evaluating when pain is not normal is a time-consuming process and requires experience; 3) women measure their experiences of pain against social and personal 'benchmarks' – thus interpersonal interactions are fundamental to the experience of gynaecological pain; and 5) social supports are fundamental to women's experience of pain itself and associated health-seeking. During this paper, we will discuss the implications of these themes on women's encounters with health professionals, particularly when they are faced with delays in diagnosis.

A Qualitative Study of Teenagers and Teachers Views of Sexual Education in Victorian Schools

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This qualitative study aims to explore adolescents' views on their experience of the Victorian sexual education system. In particular, the views of adolescent girls who were actually pregnant or were at greater risk of unplanned pregnancy (due to their disadvantaged socio-economic background), were sought from the Womens' Choices, "Young Mums" and Adolescent Gynaecology Clinics of the Royals Womens' and Sunshine Hospitals. These views were compared with those of teachers of sexual education to examine the degree of concordance between them.

The data were gathered by carrying out semi-structured, in-depth interviews with 20 adolescent girls and 15 teachers. Adolescents were aged 16 to 19. Ten of the adolescents were pregnant and intending to deliver, 4 were pregnant and seeking an abortion, and the remainder were not pregnant but came from disadvantaged backgrounds and were seeking other health advice from the hospital. All teachers had experience teaching sexual education and were from a random selection of state schools in Metropolitan Victoria.

The results of the study show that the Victorian sexual education system is very disjointed. Great variation was reported with regard to what was taught and how it was taught. A majority of adolescents reported that they believed sexual education was important, however they were dissatisfied with their experience of it. The main criticism was that there was insufficient time dedicated a topic which was not a curriculum priority. Sexual education is currently taught under a variety of subject headings including Science, Physical Education and Health or without a discrete topic allocation at all, such as one-off workshops. Generally it was agreed that the discussion of sensitive and controversial issues were best delivered in the Health context, where students were more comfortable exploring such issues.

The lack of a definitive sexual education curriculum has resulted in some adolescents having discussed the subject in great detail, while others have been exposed to little or nothing at all. In addition to the need for information on safe sex practices and contraception, adolescents also wanted more emphasis on emotions and values. They did not however, want values imposed upon them, such as through the promotion of 'abstinence.'

Teachers were inclined to believe their classes were well received, whereas adolescents described their experience of sexual education as a joke. Many were unimpressed with the delivery of the subject, sensing that their teachers were uncomfortable or unsuited to teach the

subject. This is due in part to the lack of teacher training in sexual education and also to the personality of the teacher. Adolescents reported getting the most out of classes when delivered by a young female teacher who was comfortable, open, non-judgemental and who made the classes relaxed and fun. Additionally, adolescents suggested that the most effective method of engaging them was to have a young mother describe her experiences and mistakes; above all else, adolescents wanted to hear from someone who had experience.

Overall, these results suggest that there is a lack of priority given to sexual education within the Victorian education system, and it is essential that students themselves, particularly the girls, should be involved in the design of the curriculum.

How Are Women's Psychosocial Needs Assessed and Managed in the Early Postnatal Period?

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Aims: The PinC (Postnatal in-hospital Care) study aimed to explore the structure and organisation of early postnatal care in Victorian public hospitals. One of the objectives of PinC was to explore the role postpartum caregivers play in the promotion of maternal and infant health.

Methods: Stage one: a structured questionnaire was sent to all public maternity hospitals in Victoria that provided postnatal care (n=71), exploring the structure and organisation of care (eg staffing, routine observations and maternal health assessment, discharge planning). Stage two: managers, midwives and medical practitioners from 14 maternity units were invited to participate in individual interviews, to explore the provision of hospital postnatal care in more detail.

Results: Sixty-six of the eligible hospitals (66/69, 96%) responded to the postal survey and 38 interviews were conducted with key informants from 14 hospitals across Victoria.

Close to half of the survey respondents (30/66, 46%) indicated that their hospital used a psychosocial risk assessment tool in the days following birth. Analysis of these 'tools' reveals that most are clinical care pathways which include a small number of questions about depression. Responses to the question regarding assessment of women's emotional well-being suggests that in the majority of cases mood is assessed by observation and by talking with women (36/59, 59%).

The key informants reported that assessment of women's psychosocial needs is undertaken primarily antenatally (28/38, 74%) and that social worker referral in pregnancy (22/38, 58%) was the most common management strategy.

Other findings from PinC indicate diversity in care including the undertaking of some routine practices for which little or no evidence exists.

Conclusion: The dearth of evidence to guide many postnatal practices, staffing constraints and lack of flexibility in tailoring care to each individual, are barriers to meeting women's psychosocial needs in the early days following birth.

Professor Beth Alder

Professor Beth Alder graduated from Aberdeen University with a BSc Hons Psychology degree, followed by a PhD from Edinburgh University. She worked part time at the MRC Reproductive Biology Unit from 1975-1987 and then lectured full time, first at Queen Margaret University College, Edinburgh and then at Dundee University Medical School. In 2000 she was appointed Professor at Napier University in Edinburgh. She is a health psychologist with a special interest in reproductive psychology and has published over 30 academic papers, two books, sixteen chapters and numerous international conference papers and presentations. She was the founding Chair of the Society of Reproductive and Infant Psychology (SRIP) 1982-1986, Secretary of the Marcé Society (1988-1991), Secretary of the British Psychology Society Division of Health Psychology (1998-2000), and Chair of BSPOGA (2001-2003). She is Chair of the BPS Division of Health Psychology-Scotland and President of the International Society of Psychosomatic Obstetrics and Gynaecology 2004-2007. Her research includes sexuality and the puerperium, infant feeding and postnatal depression. She was a member of the SIGN 60 guideline group, and is Principal Investigator for the NAPD project looking at management and detection of postnatal depression. She is married and has three daughters, born 1974, 1977 and 1979.

Professor Gordon Baker

Gordon specialises in clinical research on male infertility and has supervised the research of numerous higher degree students. He has published widely on causes and management of male infertility, human spermocyte interaction, semen testing and analysis of fertility and in vitro fertilisation data. Professor Baker lectures on infertility from undergraduate to subspecialist levels. He is a frequently international speaker, and is particularly renowned for his team's discovery of the male infertility problem known as disordered zona pellucida induced acrosome reaction.

Associate Professor Anne Buist

MBBS, M.Med., M.D., FRANZCP

Anne Buist is a leading clinician and researcher in the area of postpartum psychiatric illnesses and women's mental health.

From 1993 to 1997 she was Director of Psychiatry at the Mercy Hospital and was appointed Associate Professor, University of Melbourne in 1997 when she moved to the Austin and Repatriation Medical Centre, where she is Deputy Director of Psychiatry. She was a member of the Ministerial Advisory Committee on Women's Health from 1996 to 1999, past Secretary of the Australian Society of Psychosomatic Obstetrics and Gynaecology and is currently President of the Australasian Marce Society, and a member of the WPA Section on Women's Health. She is currently the Chair of the Undergraduate Psychiatry and subspecialty health committee at the University of Melbourne and is responsible for developing the new psychiatry curriculum, and headed a review subcommittee into Child Deaths amongst Protective Service clients. A/Professor Buist was awarded the Annual Traveling Fellowship by ASPOG in 1999, and the AMA National Women's Health Award in the same year.

She completed the first follow up study of infants exposed to antidepressants in breastmilk and has an international reputation for her studies of antidepressants in breastfeeding women. Other research areas include the long term effects of childhood abuse and parenting, for which she received her MD at the University of Melbourne in 1999, antenatal prevention of postpartum depression and intervention studies in improving postnatal outcomes. She also evaluated telepsychiatry services in Victoria.

In 2001 she received a \$4 million dollar grant from beyondblue, for which she is the National Director, for an Australian wide study looking to increase awareness, decrease stigma and promote early detection and intervention in postnatal depression.

Ms Brenda Burgen

Brenda Burgen has worked across the disability sector as a social worker, educator and community development worker for fifteen years. Brenda is currently the social worker in the Women's Individual Need's Clinic, an innovative clinic designed to tailor maternity care to the needs of women with disabilities.

Brenda has also worked as university tutor and guest lecturer and is completing a doctoral study on young adults with intellectual disability and social and emotional development through the School of Social Work and Social Policy at La Trobe University.

Dr Jan Coles

I graduated from Monash University in 1979. Internship followed at Queen Victoria Medical Centre in 1980-1982 and subsequent JRMO and SRMO paediatric training. This was followed by a year of child psychiatry at the Royal Children's Hospital. In 1984 I commenced general practice at in Melbourne. In 1998 I became interested in doing practice based research but lacked the necessary skills returned to University, completing a masters degree in December 2000. The research presented in the abstract is part of my Phd study on the impact of child sexual abuse on early mothering. I am a senior lecturer at Monash University Department of General Practice teaching clinical skills.

Professor John Condon

John's current leadership roles include Director of Psychiatry: Repatriation General Hospital (Daw Park SA); Professor of Psychiatry: Flinders University of South Australia; and Fellowships Board of Royal ANZ College of Psychiatrists (Chair-elect). He is Deputy Editor of Archives of Women's Mental Health. For over 20 years he has been conducting research into psychosocial aspects of pregnancy and parenthood. John will be presenting data from his longitudinal Australian study of fatherhood, the largest study to be published in this area to date.

Dr Roger Cook

Roger has extensive experience in counselling with infertile people and his research interests lie in the impact of infertility on men. He is currently engaged in the study of people who are involved in surrogacy treatments. He has other interests in the study of 'in-law' relationships and of the knowledge that parents and children have of each other. Other projects concern men's friendships, impact of divorce, and acceptability of assisted reproductive technologies. Roger established and is the current Director of the Psychology Centre at Swinburne University, which provides training facilities and opportunities for Masters and Doctoral students of professional psychology and has a reputation for best practice delivery of counselling, assessment, training and consultancy.

Dr Jennifer Cook

Dr Jenny Cook completed a 2 year Fellowship in Minimally Invasive Surgery with Flinders Endogynaecology in Adelaide. She has published in the areas of Laparoscopic Hysterectomy and Laparoscopic Pelvic Floor Reconstruction. She VMS appointments at The Queen Elizabeth Hospital and Flinders Medical Centre in Adelaide. She is also has Clinical Lecturer appointments with the University of Adelaide and Flinders University. Recently she has been elected onto the Board of Directors of the Australian Gynaecological Endoscopy Society.

Ms Carolyn Corkindale

I have been working as a researcher with Professor John Condon at Flinders University for 14 years, on psychosocial obstetric and gynaecological studies. These have ranged from longitudinal projects with both men and women over the perinatal period to studies relating to teenage pregnancy and its idealisation. We are currently working on a pilot project concerning the transition to grandparenthood. I also work as a departmental researcher for Sociology at Flinders, and as a post graduate student in the field of Event Management!

Dr Allan Cyna

Dr Allan Cyna is a senior consultant anaesthetist at the Women's and Children's Hospital, Senior Clinical Lecturer at the Department of Anaesthesia and Intensive care University of Adelaide and part-time PhD student (2nd year) at the Dept of Obstetrics and Gynaecology, University of Adelaide. The title of his ongoing PhD is "The use of hypnosis in pregnancy and childbirth". He obtained the Diploma in Clinical Hypnotherapy in 2003 and has full membership of the Australian Society of Hypnosis. He is currently practicing hypnotherapy as an adjunct to his anaesthetic clinical practice.

Ms Marg D'Arcy

Senior Program Manager, CASA, Cancer Advocacy, Diversity and Social Support
BA, Masters Policy and Law LaTrobe University 1996

I have worked in Victoria on the issue of women and violence over the last 20 years from a variety of perspectives. This has included working with women's refugees, police and women in prisons.

I am currently the Program Manager of CASA, Cancer and Advocacy, Diversity and Social Support, Royal Women's Hospital. This means I am responsible for CASA House and the Sexual Assault Crisis Line and a number of areas that provide social, cultural and linguistic support and advocacy for women who access the hospital as well as the Oncology ward, Dysplasia clinic and breast services. The Royal Women's Hospital has a commitment to working within a social model of health and to respecting the rights and integrity of women who access the hospital.

I am also a member of the editorial committee of Women Against Violence, An Australian Feminist Journal.

I have a strong commitment to developing and maintaining mechanisms which allow a diversity of women's voices to play a strong role in the development of health services policy and practice and in reflecting women's experiences in the public agenda.

Dr Lisa Donohue

Lisa Donohue is a midwife with a background in women's health, community nursing and maternal and child health. She was the National Co-ordinator for the UNICEF Australia, Baby Friendly Hospital Initiative from 1992 until 1995. Lisa was a lecturer in midwifery and women's health at La Trobe University from 1995 until 2002. From 1996 to 1999 she worked in collaboration with research staff at La Trobe University, Mother and Child Health Research on a randomised trial of debriefing after operative birth. Lisa completed her doctoral studies with the assistance of an APA scholarship at the Key Centre for Women's Health in Society, University of Melbourne in 2004.

Dr Jane Fisher

Jane, a Clinical Psychologist, is currently Senior Lecturer at the Key Centre for Women's Health. She has supervised more than 20 postgraduate student research projects, which currently include: postpartum mental health after assisted conception; voluntary childlessness among Australian women; childhood sexual abuse and pregnancy mental health; debriefing after traumatic childbirth; traditional beliefs about sexuality and pregnancy mental health in Vietnam; determinants of the decision to resume employment after childbirth and the effects of smoking traditional cigarettes on pregnancy health and infant birth weight in rural India.

Ms Renee Gedge

I am a third year doctoral student in clinical psychology at Monash University. I have an interest in the efficacy of mindfulness training for anxiety and depression, including its use in people with chronic illness. I am also interested in the role of meaning and spirituality in coping with illness. I have been a student of classical yoga for over 20 years, and drew on these principles in developing the psychological intervention for women with gynaecological cancer. My doctoral supervisor Associate Professor David Clarke of Department of Psychological Medicine is a psychiatrist with a special interest in the medically ill.

Ms Karin Hammarberg

Karin Hammarberg was born in Sweden where she trained to become a registered nurse and midwife. Between 1984 and 2000 she worked as clinical co-ordinator of IVF programs in Sweden and Australia. In 1999 she completed a major thesis about women's experience of IVF treatment and was awarded a Masters of Women's Health. She is now in the third year of her PhD candidature working on a longitudinal study about women's experience of childbearing after assisted conception.

Ms Fiona Hawthorne

Fiona Hawthorne is the principle antenatal counsellor for First Counsel in Brisbane. She is currently completing her PhD at the School of Social Work and Applied Human Sciences at the University of Queensland. The research, entitled 'Power, Pedagogy and Pregnancy', examines the experiences of women contemplating nuchal translucency screening. First Counsel assists women in the decision-making involved in pregnancy and early parenting.

Mr Brian Hunt

Brian hunt has been a practising psychoanalyst for more than 40 years. During the past 22 years he has worked extensively with post addictive, severely depressed and borderline patients and their children. Cases such as the one examined in this paper have led Brian to try to understand more fully the relationship between culture and pathology, an interest that has grown out of having had the opportunity to work in a wide variety of settings with varied populations. Brian has been in private practice for the past 16 years and is an active member of the Australian Association of Infant Mental Health and has recently been appointed as a director/trustee of a fund to establish a dual diagnosis clinic.

Ms Michelle Kealy

Michelle Kealy is a final year doctoral candidate at Mother & Child Health Research, School of Public Health, La Trobe University, Melbourne. She is a Registered Nurse and Midwife with a Masters in Primary Health Care. Her thesis is a qualitative study utilising in-depth interviews with women who have experienced caesarean section. This study is an important contribution to the literature as little has been reported from women's perspective on maternal health and wellbeing after surgical childbirth.

This year Michelle is the sole recipient of an International Student Bursary awarded by the British Sociological Association (Medical Sociology Group). This will support her attendance in September at the 37th annual conference in England where she will present a paper on bodily changes after caesarean section.

Dr Louise Kornman

Louise commenced her Obstetrics and Gynaecology training in Sydney (Westmead Hospital), and spent her post-membership training in Bath (UK) and Groningen (The Netherlands). She undertook Doctoral research in Down Syndrome screening which culminated in a thesis "Optimising Down Syndrome Screening" at the Rijksuniversiteit Groningen. Currently she is head of one of the maternal-fetal medicine teams and deputy co-director of the ultrasound department at The Royal Women's Hospital. She is a member of the team that won the inaugural University of Melbourne Norman Curry Award for innovation and excellence in support of teaching and learning for 2004.

Ms Susan Krzanich

BSW. Cert Ed. Cert IV. Dip D&A

Drug and Alcohol Clinician Social Worker, Women's Alcohol and Drug Service, Royal Women's Hospital

Susan is a Drug and Alcohol Clinician, at the Women's Alcohol and Drug Service. The Women's Alcohol and Drug Service at the Royal Women's Hospital is a statewide drug and alcohol service providing pregnancy care and counselling for pregnant women with complex drug and/or alcohol issues. The service works within a multidisciplinary service model and comprises a team of drug and alcohol clinicians, midwives, obstetricians, a pediatrician, pharmacist and dietician. As well as clinical care for pregnant women and the newborn the multidisciplinary team provides statewide professional education, training and consultation and research. Prior to Susan's five years at the service Susan worked for many years as a manager in Community Mental Health in New Zealand.

Ms Mardiana Lam

My name is Mardiana Lam. I am doing fourth year medicine in the University of Melbourne. The project which I am going to present to you is done as part of my course requirement, called the Advanced Medical Science. I spent a year (2004-2005) in Young Mum's clinic of the Royal Women's Hospital recruiting young mothers for my study. I have great interest in obstetrics and gynaecology and hope to pursue a career in the area in the future.

Professor Judith Lumley

Judith is Director of the La Trobe University Centre for Mother and Child Health Research. She has an international reputation in research in maternal and infant health. She has completed an evidence-based review of antenatal screening tools for the management of postnatal depression. She has been awarded the Sidney Sax Public Health Medal by the Public Health Association of Australia, and was recently invited to join the International Advisory Board of The Lancet. She has been selected as one of the health and medicine finalists in The Bulletin's 'Smart 100'.

Ms Natasha Maharaj

Natasha Maharaj is currently a PhD student at the Key Centre for Women's Health in Society, School of Population Health, at The University of Melbourne. Her research explores the social and cultural context of early motherhood for migrant ethnic Indian women in Melbourne. Born in South Africa, she has also lived in New Zealand, and received her BSc and BA in 1996 and 1998, respectively, as well as her MA in Medical Anthropology in 2000, at the University of Auckland; thereafter migrating to Australia to pursue her doctorate in 2001. This year she has presented at the 5th National Women's Health Conference in Melbourne in April, and will also be presenting at the International Conference on Mothering at the University of Queensland in September. She also continues to be a casual research assistant on Prof. Lenore Manderson's Federation Fellowship projects.

Ms Ruth Martis

Ruth has practiced as a independent midwife for over 22 years in a variety of settings including home births and rural primary care facilities, mainly in New Zealand. Recently a move to Australia saw her terminate her positions as part time midwifery lecturer at Massey University, as the Central regional chairperson of the New Zealand College of Midwives, and as an Expert Midwife for the Health and Disability Commissioner. She set up and taught child birth education programmes for the Manawatu Home Birth Association, Feilding Maternity, a rural birthing unit and set up the first development and participatory based teenage antenatal education support group in Palmerston North, NZ, in 2001. She has a passion for pregnant teenagers. Her training and experience as a youth worker in Germany has assisted her in this work, as well as the provision of her midwifery service for many pregnant teenagers.

This year Ruth graduated with a Master of Arts (midwifery). Her research and thesis focused on the antenatal education needs of pregnant teenagers.

Currently she is also the bi-monthly author of 'teen talk' for the New Zealand magazine called 'Kiwi Parent'.

Ruth now works at the University of Adelaide as a part time clinical educator for a project called SEA-ORCHID. She is the mother of four wonderful children and two very special grandsons.

Mr John Moran

John is the Director, Research Program at the ORYGEN Youth Health Research Centre. He is involved in a range of NHMRC funded research projects aimed at contributing to the knowledge base of realistic prevention and early intervention strategies in youth mental health.

Associate Professor Victor Nossar

Victor is Associate Professor in the School of Medicine at Flinders University and Clinical Associate Professor in the Department of Paediatrics at the University of Adelaide. He is a specialist Community Paediatrician and is the Senior Paediatric consultant with Child and Youth Health in South Australia. He heads the "Every chance for Every Child" early childhood initiative in South Australia. Associate Professor Nossar has a long history of work in child health, community and rural, with Government and non profit organisations, in disability and early childhood areas. He has also undertaken consultancies on many international child health projects.

Dr Rodney Petersen

Rodney has research interests in the emotional and sexual concerns of women undergoing treatment and follow-up for a gynaecological cancer and preinvasive diseases of the genital tract. Dr Petersen graduated from the University of Queensland and undertook a Masters in Business Administration at Sydney University before completing his Fellowship from the RANZCOG. He then completed a further three years of subspecialty training in gynaecological oncology. He currently works as a Senior Lecturer in Obstetrics and Gynaecology at The University of Melbourne and is a Consultant in Gynaecology/Dysplasia at The Royal Women's Hospital and is Director of Dysplasia at Sunshine Hospital.

Professor Julie Quinlivan

Julie graduated from the University of Western Australia and completed her Fellowship from the RANZCOG. She has obtained a PhD for a thesis evaluating the effects of fetal cortisol exposure on brain development, winning several Australian and two international research awards. She has research interests in teenage pregnancy, domestic violence, adolescent medicine, and maternal-infant interaction. She is the Foundation Dean of Health and Head of the School of Medicine at the University of Notre Dame-Sydney, a Member of the Social Security Appeals Tribunal and a Government advisor on domestic violence and home visitation services for new mothers.

Ms Beth Rankin

Beth Rankin is a Performing Arts Lecture Lecturer at the University of Melbourne. She is currently studying for a doctoral thesis in "The role of music in Public Health". Beth is committed to music and Arts programs as a way of promoting community health and well-being.

Ms Paula Schulz

Paula Schulz is both a registered psychologist and registered nurse. She is currently writing up her doctorate in health psychology. She has 15 years experience as a lecturer in the School of Nursing, Australian Catholic University, Brisbane where she teaches in areas pertaining to the psychosocial aspects of health, illness and healthcare delivery. Her research area is in women's health.

Professor Roger Short

Roger has published more than 350 scientific papers in a variety of scientific journals. One of his main research interests has been the evolution of human reproduction. He has shed new light on the causes of the human population explosion and been actively involved in contraceptive research and development for two decades. He is currently involved in trialling lemon juice as a contraceptive and anti-HIV microbicide in women.

Ms Mary Catherine Tobin

Ms Mary Catherine Tobin (B.A. B.S.W. M.S.W.) conducted this research as part of an 18 month project for her Masters in Social Work Research at the University of Melbourne in Carlton. She has been working as a Drug and Alcohol Clinician and professional trainer with the Women's Alcohol and Drug Service at the Royal Women's Hospital for the past five years. Her previous work has been in the field of child protection and sexual assault. This has involved working with marginalised and disadvantaged groups in the community, including those with drug and alcohol issues, mental health issues and women and children.

Professor Alan Trounson

Alan is the Director of Monash Immunology and Stem Cell Laboratories. His research during the late 1970s established IVF as a practical and repeatable method for the treatment of human infertility that was adopted worldwide. He has received numerous medals and awards for his contributions to medical research, including in 2004, the Bertarelli Foundation Award in Reproductive Health for his outstanding contribution to the field of assisted reproductive technologies. His research includes fertilization and embryo culture, sperm microinjection, embryo biopsy, oocyte maturation, egg and embryo donation, embryo freezing (cryopreservation) and development of embryonic stem cells.

Ms Maria Vucko

Counsellor/Advocate, Centre Against Sexual Assault, CASA House
 Royal Women's Hospital, Carlton Victoria
 BA, BSW – La Trobe University
 Masters in Social Work – Sydney University (2000)

I have worked in the area of violence against women for the majority of my 14 year Social Work career, in both Melbourne and Sydney. This has included work within the legal system, in family support, and as a domestic violence worker, providing counselling, advocacy and running groups for women victim/survivors. In addition, I am also a sessional seminar leader in Social Work at La Trobe University.

I have been permanently employed at the Royal Women's Hospital as a Social Worker for over 4 and ½ years. In that time I have been involved in a number of hospital initiatives in the area, including the provision of training to medical staff. Most recently have been involved in the development of clinical practice guidelines for staff in terms of responding to any form of violence against women.

I am currently based at CASA House providing crisis care, counselling, advocacy and public advocacy/training, specifically on the issue of sexual violence/abuse perpetrated against women and men.

Ms Narelle Warren

Narelle Warren is a sociologist, and is currently a PhD candidate and research assistant at the Key Centre for Women's Health in Society. She received her BA(Hons)/BSc from the ANU and, since then, has worked on a range of research projects, including: a psycho-social follow-up of egg donors, family formation decision-making, and young women's physical activity and healthy eating behaviours. Her PhD research is a qualitative study of women's midlife experiences in an isolated Victorian community, with a particular focus on health-seeking and health-provision. Her most recent projects have explored women's experiences of gynaecological and reproductive health concerns, with a particular focus on rural women, and the social aspects of amputation in urban and rural Victoria.

Ms Jane Yelland

Jane worked on the Victorian Ministerial Review of Birthing Services in the late 1980s and has spent 14 years at Mother and Child Health Research. She was a chief investigator with: the Mothers in a New Country Study, which explored immigrant women's views and experiences maternity care; the EPOCS (Evaluating Practice and the Organisation of Care at Southern Health and Sandringham Hospital) study in which she co-ordinated a comprehensive evaluation of major change to maternity care across four hospitals; a state-wide review of hospital postnatal care conducted in 2004. Her doctoral research (passed February 2005) examined the use of evidence to inform mainstream approaches to enhancing maternity care and the impact these changes have on consumers of health care.

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Mrs Andrea Hayward	QLD Fertility Group, QUEENSLAND
Ms Christine Hill	VICTORIA
Ms Jenny Hillier	VICTORIA
Dr Noel Holmes	QUEENSLAND
Mrs Jill Humann	VICTORIA
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