

**Narrative Accounts of Women who use Complementary
and Alternative Medicine in Pregnancy:
*'Forewarned, Forearmed and Relaxed'***

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The Significance of Narrative

“When you are in the middle of a story, it isn’t a story at all, but only a confusion: a dark roaring, a blindness, a wreckage of shattered glass and splintered wood; like a house in a whirlwind, or else a boat crushed by the icebergs or swept over the rapids and all aboard are powerless to stop it. It’s only afterwards that it becomes anything like a story at all, when you are telling it to yourself or someone else”
(Atwood 1999:298).

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Abstract

Pregnancy and childbirth are events of major significance in women's lives. In western countries women are increasingly using complementary and alternative medicine (CAM) (see glossary of terms) during this time. However, there is little research exploring and minimal empirical evidence to judge the significance and impact of CAM on pregnancy and childbirth. This thesis explores the experiences of women who use CAM during pregnancy and childbirth in an attempt to understand the meaning they ascribe to CAM use.

A narrative approach was chosen to explore women's experiences of CAM as it emphasises the meaning that individuals ascribe to life events (Czarniawska 2004, Elliott 2005). Additionally, through narratives it is possible to learn about the world of individuals, about their lives and their experienced reality (Engel et al. 2008).

A purposive sample of 14 women who had used a variety of complementary therapies during pregnancy and childbirth participated in the study. Women's narratives were obtained through open ended interviews on two or three occasions. The narratives were analysed using a 5 stage process. The words of one participant eloquently portrayed the significance and meaning of CAM use as one of being '*Forewarned, Forearmed and Relaxed*'. These words then became a framework to re-present participants' narratives.

Beck's (1992a) and Giddens' (1990) concept of risk and reflexivity provides a theoretical framework to aid interpretation of the data. The study findings offer insights into how CAM meets women's physical, emotional and spiritual needs during pregnancy and childbirth. CAM use signifies women's desire to achieve a normal birth without medical intervention, a need to make choices and be in control of their healthcare practices and a desire to enjoy their pregnancy and birth without fear.

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Chapter 1. Introduction

1.1. Introduction and rationale for the study

Pregnancy and birth are pivotal experiences in women's lives and hold powerful personal and social significance. In resource rich nations, childbirth has never been safer and women's expectations for a successful outcome are high. Yet some argue, with the ever increasing medicalization of maternity care, childbirth is in crisis (Wagner 1994, Walsh 2006). The medical approach views pregnancy and childbirth as inherently risky, and therefore in need of technological interventions. This is at odds with a philosophy of midwifery which views birth as a physiological event; interventions are viewed as the main source of risk and therefore should only be used if and when a need arises. Social, emotional and spiritual health are seen as essential to achieving a good outcome for the mother and baby (Heaman et al. 2004). For the majority of women, pregnancy and birth are normal life events, but frequently their own interpretation of risk is contrary to that of professionals (Smith 2006).

Thus women are confronted with a set of cultural and discursive practices that can impact significantly on their lived experience of pregnancy and childbirth (Rudolfsdottir 2000). For example, women's desire to have a normal birth (one without medical intervention) has been confirmed by numerous studies (Gamble and Creedy 2001, Graham et al. 1999, Hildingsson et al. 2002, Raynes-Greenow et al. 2004). However, in the UK less than two thirds of women achieve this with rates of medical intervention and operative birth rates at an all-time high (MCWP 2007, McAra-Couper et al. 2010). Downe et al. (2001) found only 17% of women having their first baby did so without interventions such as epidurals, intravenous infusions and caesarean section. Edwards (2009) argues that women are socialised to expect little from maternity services and to be grateful for what they get, they give up their ideals and submit to the oppressive and controlling power of the institution. Midwives too are constrained by the system (Brown 2003) and some argue midwives have lost the skills of supporting women through physiological birth (Edwards and Murphy-Lawless 2006). As Davis-Floyd (2004) suggests the

medical model shapes our expectations, beliefs and practices and makes it difficult to think about pregnancy and birth in any other way.

The medical approach to birth dominated my own education and practice as a midwife in the UK. I never *really* learned the wisdom and ways of being with women during normal birth until I practised in the Middle East, a culture where western medicine had not taken such a firm hold. There I learned what it is to be a midwife. I was humbled as I watched women labour and birth supported only by a close network of other women, without my assistance or any other medical input. Initially I felt hopelessly inadequate without resort to the range of technologies I had come to rely on. Gradually I learned to watch and support women through the physiological, psychological and social processes of giving birth. My skills too were honed in calling for medical attention if and when the need arose and in dealing with emergencies. I learned so much from the women I cared for and more from the woman who cared for them. My interest in complementary and alternative medicine (CAM) began at this point too. I learned how to use aromatic oils, massage aching legs and backs, how to stimulate contractions without recourse to drugs, and a whole range of customs and rituals women from different cultural groups use as supportive measures in labour.

In the UK and developed countries there has been an increasing interest in CAM amongst the general population (Harris and Rees 2000, Kessler et al. 2001, Hunt et al. 2010, Sibbritt et al. 2011). There is also some evidence that pregnancy prompts an increase in women's use of CAM (Allaire et al. 2000, Hope-Allen et al. 2004, Mitchell and Williams 2007). Many midwives have also embraced CAM with its emphasis on the link between mind, body and spirit and the significance of the therapeutic relationship (Mitchell et al. 2006, Hastings-Tolsma and Terada 2009). Both midwives and complementary therapists write in abundance of the supposed benefits of CAM in pregnancy including the belief that CAM empowers women, gives them confidence in their ability to birth and reduces the likelihood of medical intervention (Williams and Mitchell 2007, MacKenzie and Oliphant 2007). Midwives also claim CAM

supports the provision of a woman-centred, holistic and social model of care (Williams and Mitchell 2007, Adams 2006, Lane 2008).

However, these views are not universal. Some midwives suggest that use of CAM may prevent women from utilising and developing their inner resources and coping strategies (Leap 2000, Robertson 2002). Donna (2010) argues a desire to use CAM during birth suggests a lack of faith in normality and should be avoided as physiological processes may be disturbed. Many also caution against the use of CAM with concerns about safety (Johnson 2008, Tiran 2006, 2007, 2009, 2010, Wiebelitz et al. 2009). Policy guidance also discourages midwives and women from using CAM as there is limited evidence of efficacy and effectiveness (NICE 2006, 2008a). It is hardly surprising, therefore that women do not disclose use of CAM to health professionals citing negative attitudes and fear of ridicule (MacLennan et al. 2002, Holst et al. 2008). Women experience conflicting advice and express a desire for health professionals to be better informed and to be open minded about CAM (Holst et al. 2009). There has been little attempt to explore the experiences of women who use CAM, or to discover how CAM contributes to the overall experience of pregnancy and childbirth. Yet this information is vital if midwives wish to provide services that meet women's needs and that are congruent with the rhetoric of women-centred care, as espoused clearly in the political agenda for maternity services provision (DOH 2004). Thus, there is a clear identifiable gap in the literature which could explore the experience and meaning of CAM use in pregnancy and childbirth from a woman's perspective and a call for research in this area (Adams et al. 2010, Hall et al. 2010a).

1.2 Research aim:

To explore women's use of CAM during pregnancy and childbirth and to understand the meaning they ascribe to its use.

In Chapter 2, I explore the subjective experiences of pregnancy, birth and early motherhood and I investigate the literature to identify the complex and interrelated factors that draw people to CAM. In Chapter 3, I explore the theoretical framework of risk which later contributes to my interpretation of

participants' narratives. Chapter 4 outlines and justifies the methodology of narrative research and its contribution to achieving the aim of the study. In Chapter 5, I re-present participants' narratives and discuss these in relation to theories of risk to provide insights into women's use of CAM during pregnancy and childbirth. In Chapter 6, I provide a conclusion to this thesis and reflect on my learning and the contribution this research has made to new knowledge.

Chapter 2. Background to the Study: stories in context.

2.1. The experience of pregnancy, birth and early motherhood.

Motherhood is valued by most women (Oakley 1981, Woollett 1991) and for many constitutes part of a female choice biography, a life project that is anticipated and planned, often well in advance (Carolan 2007, Hadfield and Thomson 2009). Pregnancy is a time when women undergo immense physical and emotional changes. Understanding how this life event impacts on women's subjective experiences may provide insights into why many seek CAM during this time.

Women describe pregnancy as an emotional rollercoaster with simultaneous feelings of happiness, excitement, anxiousness and vulnerability (DOH 2011). Some women thoroughly enjoy being pregnant, experiencing it as a time of personal growth and fulfilment. Women describe becoming more aware of their femininity, a sense of wellbeing and of feeling proud of their bodies (Warren and Brewis 2004). Body awareness is increased to such an extent it is argued that pregnancy represents an 'epiphany' in a woman's life intensifying a sense of embodiment (Warren and Brewis 2004). However, for some women pregnancy is a challenge and a time of physical discomfort which impacts on perceptions of wellbeing (Raphael-Leff 1995). The majority of pregnant women experience minor health problems such as nausea, indigestion, and backache and many describe the social pressure to continue their daily lives despite facing these distressing side effects (Redshaw et al. 2007). Women's feelings about the way in which pregnancy changes the body are diverse but a core narrative is that pregnancy is characterised by physical transformations over which the woman has no control (Ayrlie et al. 2005). This experience of loss of control is at odds with the contemporary western perspective of the body as one which can be controlled and manipulated at will (Featherstone et al. 1991, O' Connor 2003, Schilling 2005).

Pregnancy is also often experienced as an opportunity and motivational force for women to improve their health and wellbeing in preparation for birth and to maximise the potential for a healthy baby (Ayrlie et al. 2005). Decisions that

women make in pregnancy can impact significantly on their health and that of their baby. Many women find these decisions challenging and thus it is recognised that pregnancy is a time when education and support are required (O’Cathain et al. 2002). Antenatal education is provided by the maternity services and a number of organisations such as, the National Childbirth Trust, Active Birth groups, and Homebirth groups, who advise and support parents during pregnancy and in preparation for birth and parenthood. However, those who attend such preparation tend to be white, middle class and well educated (Nolan 1995, Likis 2009, Cliff and Deery 1997, England and Horowitz 1998). Later in the literature review I will discuss it is this group too who are more likely to use CAM, perhaps signalling a desire, to be fully informed about the decisions they make and to prepare themselves for labour and birth.

Women’s experiences of birth vary enormously and are influenced by many factors including fears, beliefs and expectations (Gaskin 2002, Nolan et al. 2009, Hall 2001). A pervasive sense of uncertainty is felt by most women as they anticipate how they will respond to the process and pain of labour and birth (Goodman et al. 2004, Larkin et al. 2009). Despite the intensity of labour pain many women report fulfilling birth experiences. Positive experiences of birth are associated with being involved in decision making, being supported and feeling in control (Waldenstrom 1999, Green and Baston 2003, McCrea 1999, Gibbons and Thompson 2001). For some women childbirth may be experienced as healing and life changing, particularly when the care they receive is empowering, reassuring and emotionally supportive.

Conversely, fear of childbirth is common and seems to be on the increase (Melender 2002, Hofberg and Ward 2003, Maier 2010). Women may find this fear difficult to articulate but it includes, fear of pain, fear of surgical intervention and fear of being out of control (Lundgren 2004, Morris 2005). Fenwick et al. (2010) suggest women have lost confidence in their ability to birth without medical intervention. Women also report feeling shocked and unprepared for the events of labour (Cronin 2003, McKellar 2010). Birth then may also be perceived as traumatic and lead to such emotional distress as to contribute to postnatal mental health disorders (Soderquist et al. 2004, Baker

et al. 2005), and possibly to long term effects on the baby (Austin et al. 2005, Mohler et al. 2006). How women experience pregnancy and childbirth therefore is critical and can impact on transition to motherhood, on physical and mental health, on the wellbeing of the child and on the family as a whole (Beech and Phipps 2004).

The postnatal period and early parenthood can also be a physically and emotionally challenging time for women and their partners. The love, protectiveness and responsibility a mother feels for her newborn is primordial, intense and awe inspiring (Odent 1999). However, many women report feeling unprepared for the reality and responsibility of parenting (Cronin 2003, McKellar et al. 2010). Women worry constantly about whether they are doing right for their baby and experience a huge range of conflicting emotions including feelings of guilt and failure when unable to meet their expectations of motherhood (Hunter 2004, Ward and Mitchell 2004). Women also perceive a lack of value placed on motherhood in society and often experience a sense of social isolation. Thus, a complex and contradictory ideology of motherhood is revealed. Motherhood is romanticised and idealised as the ultimate fulfilment and achievement in a woman's life but when women become mothers they find the reality of everyday tasks challenging and socially devalued (Phoenix and Woollett 1991, Miller 2011).

Contemporary social changes also impact on women's experiences. Most women in the UK have limited experience of pregnancy and childbirth before they embark on it and support from family is not guaranteed (Kitzinger 1987, The Prime Ministers Commission 2010). The ability to control fertility means women are having fewer children and have them later in life (RCM 2011). Opportunities for education, employment, extended legal rights such as maternity pay, and the rise of consumerism have all raised expectations and contributed to the 'have it all culture' (Becker 2010). Many sociologists refer to the fast pace of contemporary life, a world of constant change in which our hopes, expectations and conditions around us are forever in a state of flux (Giddens and Hutton 2001, Bauman 2010). It is also argued that it is women who have faced the most dramatic changes to their role. Indeed Becker (2010)

argues that stress is a defining characteristic in the lives of modern women as they seek to juggle their commitments in private and public domains. Maybe it is not surprising that it is women who are more likely to turn to CAM for support with health and wellbeing and during times of illness. In the following section I explore what attracts individuals to CAM to provide insights into the contemporary phenomenon of rapidly increasing use of CAM in western societies.

2.2 Complementary and alternative medicine

A considerable increase in CAM use has been reported in most developed countries over the last few decades (Ernst and White 2000). Cant and Sharma (1999:6) prefer the term 're-emergence', since throughout history various forms of healing have always been practised. Goldstein (1993) also argues the belief in the interconnectedness of the mind, body and spirit is not new but a traditional one which has found renewed vitality. Nevertheless, over the last century western medicine has achieved such social, political and cultural hegemony as to marginalise CAM from mainstream healthcare (Saks 2003). The literature review explores why CAM approaches to health and wellbeing are assuming such popularity and where relevant research is available these notions will be applied to pregnancy and childbirth. Firstly it is important to define CAM and outline the philosophical differences between CAM and western medicine.

2.2.1. Defining complementary and alternative medicine

There is no agreed definition of CAM which illustrates its convoluted domain and suggests an evolving social trend (Kelner et al. 2003). For the purpose of this thesis, CAM is defined as "a broad domain of healing practices, other than those intrinsic to the politically dominant health system of a particular society" (Cochrane Library 1998). However, neither the term 'complementary' (use alongside western medicine) nor 'alternative' (use instead of western medicine) illustrates fully the range of approaches individuals use in relation to their healthcare choices (Spencer and Jacobs 1999). Despite a critique of nomenclature it is likely that, during pregnancy and birth, women use a range of therapies alongside medical and midwifery

care but also in some instances as alternative to it. Thus, I will use the term CAM as an illustrative and pragmatic choice. There are hundreds of individual CAM modalities with differing traditions, beliefs and therapeutic interventions. Some argue therefore that it is inappropriate to view CAM as a unified concept (Robinson et al. 2009). Nevertheless, they are generally underpinned by similar concepts of holism, vitalism, and the body as self-healing, (Furnham et al. 1995, Hirschhorn and Bourgeault 2006, Lee-Treweek 2005a). This justifies exploring issues around CAM as a whole and not just from the perspective of different modalities. Since most CAM is accessed outside of mainstream healthcare provision, a further commonality is the role of consumer choice. To gain an understanding of the appeal of CAM it is important to appreciate how CAM philosophy differs from that of western medicine.

2.2.2. Differentiating complementary and alternative medicine from western medicine.

Comparisons are frequently made between CAM and biomedicine, a term most commonly used in CAM literature to refer to the tradition of western medicine (Quah 2003). Biomedicine is placed as the dominant medical care in western societies (Shoval and Mizrahi 2004). In this paradigm the body is viewed in a mechanistic way, mind and body as separate entities; an outlook which supports the maintenance of health and treatment of disease by physical intervention, pharmaceuticals or surgical procedures (Greaves 2004, Diamond 2001). Biomedical underpinnings lie in positivist philosophy: the belief in an objective reality (Crossman 2003) and acceptance that knowledge can be gained only by the criteria of science, namely reliability, objectivity, precision and coherence of theory (Polifroni and Welch 1999, Seale and Pattison 1994). There is no doubt that biomedicine and scientific methods have led to worthwhile and substantive benefits for the management of health and illness (Oakley 1990, Gortner 1999). Nevertheless, these biomedical and positivist philosophies hold such social, cultural and political hegemony in most western countries that other ways of knowledge generation, particularly in the human sciences, have been marginalised (Carper 1999, Heller et al. 2005).

The philosophies and principles of CAM differ considerably in their focus on the interconnectedness of mind, body and spirit, the individual within their cultural context, and the recognition of the power of the body to self-heal (Furnham et al. 1995, Kelner et al. 2003, Feinstein and Eden 2008). The comparisons made between the two paradigms are principally in relation to these philosophical underpinnings, but these are essentially contestable concepts. Some CAM concepts may be similar to those of biomedicine but are presumed to be distinctive of CAM and are often discussed as dichotomous variables, for example, CAM is holistic and natural and biomedicine is not. This false polarity is a distinguishing myth in much CAM literature. Tomes (2007) believes that there is a convergence of some discourses between the two paradigms, for example, the notion of patient participation, but practices within biomedicine are constrained by financial resources and attitudes of some practitioners.

I agree, however, with Coulter's (2004) assertion that much of CAM philosophy is distinctive and often in opposition to biomedicine in its ontological and epistemological assumptions. Spencer and Jacobs (1999) believe the most continuing dichotomy between the two paradigms lies in the technology and pharmaceutical focused regimes of biomedicine compared to a more person centred, culture bound approach of CAM in which personal beliefs, subjective judgments and the meaning that individuals attach to their health are emphasised. I would argue the most distinctive feature between the two paradigms relates to CAM theories which explain the nature of health and illness. Such concepts as qi, and meridians in Traditional Chinese Medicine (Maciocia and Kaptchuck 2007), the universal healing energy of Reiki (Gerber 2000:402) or the vital force of Chiropractic (Coulter 1993) are not recognised in biomedicine as identifiable anatomical or biochemical constructs (Hughes 2007). Other theories such as the Homeopathic Law of Similars and the Law of Potencies (Gold et al. 2008) are in direct opposition to biomedical and scientific theories (Quah 2003), (see glossary of terms). It is these notions that receive the most criticism as any claim of effect is viewed as

implausible. Some understanding of the differences between the two approaches may be gained through the lens of the consumer and an analysis of their behaviour in relation to the use of CAM.

2.2.3. Prevalence of complementary and alternative medicine use

Surveys in the UK and other developed countries cite an increased consumption of CAM, but a wide variation of between 20-71% of the adult population reporting use (Harris and Rees 2000, Kaptchuk et al. 2001, Featherstone et al. 2003). Cant and Sharma (1999) refer to the CAM modalities most frequently used as the Big Five: acupuncture, homeopathy, herbalism, osteopathy and chiropractic. Aromatherapy, massage and reflexology are also frequently used modalities (Ernst and White 2000). Over the counter use of CAM is also common with individuals self-prescribing herbs, food supplements and vitamins (Cramer et al. 2009).

The typical consumer of CAM is white, middle class, and well educated (Eisenberg et al. 2001, Sirois and Purc-Stephenson 2008). Differences in use exist across cultural groups and women in particular play an increasing role as consumers, practitioners, and advocates for CAM within families (Beal 1998, Adams et al. 2003, Chao et al. 2006, Flesch 2007a, 2007b, Robertson and Johansson 2010, Nichol et al. 2011). A number of studies have found increased use of CAM during pregnancy with reported rates between 7.1% and 87% (Pettigrew et al. 2004, Baxter and Perrin 2006, Hemminki et al. 1991, Gibson et al. 2001, Pinn and Pallet 2002, Hollyer et al. 2002, Westfall 2003, Upchurch and Chyu 2005, Wang et al. 2005). Variations in rates between studies result from the inclusion of differing CAM modalities and how these were defined. For example, Gaffney and Smith (2004a) report 87% of pregnant women used CAM during pregnancy but this included folic acid which is recommended for all women, thus inflating the figures. More to the point, these prevalence surveys do little to deepen our knowledge and understanding of women's motivations in seeking CAM.

Increased consumption of CAM reveals not only behavioural change but also mirrors shifting needs, beliefs and values in contemporary society (Lee-Treweek 2005b). Coward (1989:28) claims that the increased prevalence of CAM parallels the growing 'ecological consciousness' of contemporary western society. Many technological interventions and human interference such as mass processing and genetically modified foods are believed to be against the forces of nature and rejected as harmful while nature is seen as beneficial and healing (Shaw 2002). CAM with its alliance to natural products fulfils people's aspirations for a more natural way of living. Indeed both midwives and women are drawn to CAM because they are perceived as natural and by implication safer than technological or pharmaceutical interventions (Campbell 1998, Adams 2006, Chitty 2009). A philosophy which embraces the normality and naturalness of pregnancy, labour and birth is therefore at one with the fundamental principles of CAM.

A key tension in the literature is whether people use CAM because it is congruent with their values and beliefs or whether they are disillusioned by science and biomedicine (Vincent and Furnham 2003). Some studies have found CAM users have a world view more orientated to holistic health, spirituality and personal growth, compared to non-users (Testerman et al. 2004, Hildred and Elman 2007, Robinson et al. 2009). Yet Furnham et al. (1995) could find no difference in values and beliefs between those accessing biomedicine and those choosing homeopathy. It is suggested that in pregnancy congruence between CAM and an individual's personal philosophy is important in choice of therapy but there is little evidence to support this claim (Anderson and Johnson 2005, Warriner 2007, Low Dong 2009).

In contrast, many studies suggest people turn to CAM because they reject and are dissatisfied with biomedicine (Jonas 2003, Sharma 2003, Sirois 2008). Raynor and Easthope (2001) believe the contemporary ethos of scepticism in science permeates cultural beliefs surrounding health and medicine and that this is influential in CAM use. Individuals who reject biomedicine are often criticised as 'desperate', driven to try anything, with

unrealistic expectations and a concern that they place themselves at risk due to lack of medical attention (Sirois 2008, Goldacre 2007). Similarly, women may also choose CAM to avoid technological and pharmaceutical interventions in pregnancy or where biomedicine has not had the therapeutic outcomes anticipated (Ingram et al. 2005, Smith and Crowther 2008). Analysis of research findings reveals a number of paradoxes. For CAM consumers' scientific evidence is not considered a priority, individuals resort to other sources of evidence such as instinct and intuition particularly when choosing CAM modalities (MacKensie and Oliphant 2007, O' Keefe and Coat 2010). The expertise of CAM practitioners is judged through a pragmatic and contextual approach using 'common sense' judgements, the practical skills of the therapists and the derivative benefits experienced (Hughes 2007, Pederson 2010). However, some studies suggest CAM users do not reject biomedicine outright, but refuse specific interventions and medications in certain circumstances (Connor 2004, Conby 2007). Additionally it has been found that only a very small minority of individuals have unrealistic expectations of CAM (Ritvo et al. 1999, Lewith et al. 2002). It seems that individuals recognise the value of both and perceive the combination to be superior to either alone. Thus for the majority, CAM is used to complement biomedicine rather than replace it (Thomas et al. 2001). Perhaps indicating as Sharma (1992:47) believes the emergence of a 'new medical pluralism', demonstrating a growing consumerist attitude to healthcare.

Theoretical analysis of CAM use, however, does little to reveal the meaning individuals ascribe to their choices and experience. In the subsequent section I explore the subjective experiences of those that have used CAM both as a result of ill health and from a desire to support health and wellbeing. This is of fundamental importance in comprehending its pervasive appeal.

2.2.4. The contribution of CAM to health and wellbeing

There is an emerging body of qualitative research which has explored CAM users' perspectives, particularly in those with health problems (Adler 1998,

Scott et al. 2005, Little 2009). Individuals seek CAM as a way of coping with their symptoms, and continued use is determined by effectiveness (Luff and Thomas 2000). In pregnancy, the limited research evidence suggests that women find relief with a range of CAM modalities from specific pregnancy induced symptoms such as nausea, vomiting and back pain (Jewell and Young 2003, Elden et al. 2005). Within a biomedical paradigm these are frequently inappropriately labelled and dismissed as the 'minor disorders of pregnancy' (Ranzini et al. 2001). Women also report high levels of satisfaction with a number of therapies, such as yoga, meditation, aromatherapy, chiropractic, massage and herbal treatments (Gaffney and Smith 2004b, Lobo 2007, Hope-Allen et al. 2004). As Kelner et al. (2003) suggest individuals are rejecting biomedicine's lack of attention to their subjective experiences in seeking CAM, reflecting the more knowledge seeking and agentic individual who desires to be involved in their own health care.

The effectiveness of CAM is often dismissed by biomedicine as improved outcomes are judged to arise only as a result of the placebo effect. However, emerging theories of neuroscience support the ontological view of health and illness as holistic: the body, mind and spiritual domains as inseparable (Graham 1999, Cohen 2006). Certainly, individuals choose CAM for its perceived holistic approach (Richardson 2004, Thompson et al. 2007, Little 2009). The benefit of this holistic approach is evident, for example, deLacey et al. (2009) and Rayner et al. (2009) explored women's use of acupuncture for infertility. Women felt acupuncture facilitated the development of coping strategies, building resilience and helped them deal with the emotional aspects of fertility treatment. It seems CAM consumers assess their health not just in relation to physiological parameters but also to feelings of wellbeing, satisfaction and of being at peace. For some individuals the experience of CAM has been transformative, facilitating changed perspectives, personal growth and fulfilment (Willison 2007, Malpas et al. 2011). Consumption of CAM may be a symbolic search for a more holistic focus on health, one in which meaning, purpose and individual identity are acknowledged. Certainly, pregnancy and birth are viewed by

many as a spiritual event but this is often under acknowledged within maternity services (Hall 2001). CAM use may then signify a woman's desire for the spiritual aspects of pregnancy and birth to be acknowledged.

CAM users desire more from their health practitioners in terms of a therapeutic relationship, people who have time and are more sensitive to the emotional impact of illness (Caspi et al. 2004). Indeed, women frequently complain of the temporal intensity of their encounters with midwives, time restrictions ensure their concerns are rarely fully heard (DOH 2011). CAM users may also be discontented with their perceived role within biomedicine. CAM philosophy also recognises that causes of illness are rarely just biological, that the body has the power to self-heal, and that individuals should take responsibility for their own health (Lupton 2003). CAM use then appeals to an individual's desire for autonomy (Astin 2003, Sointu 2006a). The decision to utilise CAM implies personal choice and agency, leading to feelings of empowerment and personal control (Steen and Calvert 2007, Mitchell and Allen 2008). It is these factors that contribute to psychological wellbeing.

The contribution that CAM makes to an increased sense of wellbeing may also play a role in its appeal as an overall health maintenance strategy (Sointu 2005, Gaffney and Smith 2004). The expansion of the health and fitness domain is testimony to the emerging concept of "wellbeing" sought after by increasing numbers and consumption of CAM may be a reflection of this wider trend in society. Coward (2005) argues that the affluent West is preoccupied with attaining positive health by reducing stress, and achieving harmony in mind, body and emotions. Health and wellbeing are seen as something to be actively pursued, requiring commitment and dedication and the responsibility for this lies firmly with the individual (Smith and Goldblatt 2004). Thus CAM philosophy has a clear correlation with public health messages and the notion of preventative medicine. Engagement with CAM provides a way in which consumers take responsibility for their own health and wellbeing (Goldstein 2003). Consumers report enhanced body awareness from CAM use, and that this contributes to their ability to self-

manage health and wellbeing (Busby 1996, Hughes 2004, Thorne et al. 2002). The role of CAM in this respect may be even more important for pregnant women, since pregnancy fundamentally changes a woman's perceptions and relationship with her body (Warren and Brewis 2004). CAM approaches may help women to follow professional advice on monitoring their own and their baby's wellbeing by noting the progressive changes of form, function and structure that take place throughout pregnancy. Lupton (1999a) also discusses the body as a focus for consumerism in contemporary western society. The body has become something to be managed, kept under control and in need of regular maintenance and care to ensure health and wellbeing (Featherstone et al. 1991). It could be argued that herein lies a paradox: while CAM users strive to demedicalize their lives by avoiding or limiting biomedical approaches, CAM discourse which stresses the importance of lifestyle, emotions and spirituality to the attainment of health creates just the same authoritarian stance (Cant and Sharma 1996). Indeed women feel tremendous pressure to stay healthy during pregnancy since the weight of responsibility for the wellbeing of their baby lies firmly on their shoulders (Besset 2010). Although there is little evidence that women seek CAM to ameliorate perceived risks or to cope with the stress of modern living, it seems a reasonable assumption to suggest this. Baxter and Perrin (2006) report antenatal classes focussing on stress reduction and relaxation are well attended and highly valued by women. Sointu (2006a) argues that the subjective sense of wellbeing achieved through CAM enables individuals to cope with life's difficulties and transitions. Pregnancy and childbirth require enormous physical, emotional and social adjustments for women (Dahlan et al. 2010). The use of CAM may help women to cope during this time.

Women may also access CAM to prepare physically and emotionally for birth. It could be argued this preparation also develops women's confidence and provides a way of asserting their right to choose how they wish to bring their baby into the world. A number of studies have found CAM improves labour and birth experience for women (Field et al. 1997, Burns et al. 1999, Simpkin and O'Hara 2002, Cyna and McAuliffe 2004, Huntley et al. 2004,

Smith et al. 2006, McNabb et al. 2006). However, these studies have focused on measuring effectiveness and evaluating safety. The approaches used; survey, quasi experiments and randomised controlled trials lie firmly in the positivist paradigm where the emphasis is on quantitative measuring of phenomena and identifying generalizable rules on human behaviour. Randomised controlled trials are criticised for their artificiality and inability to study complex human phenomena (Jaded 1998), while survey research has limitations in its ability to explore depth of information (Luff and Thomas 2000). Such approaches do not lend themselves to exploring issues in such a way as to untangle complex and interrelated aspects of CAM use. My own reflection of how I became a CAM user also provides me with some insights and understanding of why people turn to CAM.

2.2.5. My Journey: from sceptic to converted to questioner

Following the birth of my second son some 15 years ago I enrolled in a night class to study aromatherapy: nice smelling oils and massage but more importantly the opportunity to escape, for one night a week, the routine of putting the children to bed. I found the oils very effective for a range of minor health problems. They became my first course of action when the children were ill, I rarely visited the doctor. Aromatherapy is a science, the oils have a chemical structure and their effects can be explained in biological and physiological terms, so it did not particularly challenge my beliefs.

However, some two years later after the birth of my third son, I enrolled in a reflexology night class. I was introduced to the concepts of vitalism: the body as an energetic being, the interconnectedness of mind, body and spirit, the body as self-healing and the power of the therapeutic relationship. Some of these concepts challenged me deeply on a personal and professional level. I questioned and challenged the teachers. Mostly my questions were not answered to a level I was satisfied with. I read extensively and practised reflexology at every opportunity. The 'proof of the pudding' worked for me as I began to see the benefits for those I worked with. I became a user at

this time too, a friend and I providing treatments for each other, gradually branching out to include other practices such as visualization and therapeutic touch. I use the word converted at the outset to illustrate an awakening in my consciousness of myself as a spiritual being, of being convinced of the interconnectedness of body and mind, the recognition of the holistic and spiritual nature of pregnancy and childbirth and my beliefs about the contribution that CAM makes to health and wellbeing. However, I retain a healthy scepticism; I have a foot very firmly in the biomedical paradigm. Yet I am not convinced that scientific ways of knowing can reveal all I want to know. At the same time, I cannot accept all that is claimed for CAM. So I have become a questioner, I adopt a challenging, questioning approach, one that constantly wants to know and learn more.

I am acutely aware of the various attitudes of my professional colleagues, from outright scepticism and dismissal to uncritical acceptance and use (Tiran 2004, Sewith et al. 2008, Hall et al. 2010b). The dominant discourse within the scientific community continues to disparage CAM for lacking an evidence base and as having no foundation within conventional scientific thinking (Beyerstein 2005, Polich et al. 2010, House of Commons 2010). There is a belief that the public need protection from potentially unsafe or unjustifiable practices (Jonas 2003, Manheimer and Berman 2003). Tallis (2004) argues that CAM has become just another health product and modern consumers have the time and money to spend on what he considers nonsensical and quirky therapies. Those that use CAM are seen as gullible consumers with little understanding of science (Mitchell and Allen 2008). I question my own use of CAM and wonder at times whether these criticisms apply to me. I experienced 3 healthy pregnancies and birthed 2 of my children at home. Interestingly, my use of CAM during these times was minimal, only resorting to self-administered homeopathic remedies for post birth aches and discomforts. Perhaps I was lucky and did not experience any debilitating 'minor disorders' of pregnancy, I did not struggle with the emotional adjustment to

motherhood, nor did I feel the need to seek additional means of support. As a midwife I had the support of my midwifery colleagues and an inherent belief and trust that my body would be capable of childbirth without the need for unnecessary medical intervention. Thus I am intrigued about the reported increase in CAM use during pregnancy and childbirth.

In qualitative and social research the researcher is not neutral, distant or emotionally uninvolved (Alvesson and Skoldberg 2000). Therefore, I offer these insights into my own experiences and beliefs so the reader can judge for themselves whether I have achieved what Rubin and Rubin (1995:12) refer to as 'balance' rather than 'neutrality'. My scientific background as a nurse and midwife, my work in different cultures, my CAM practice and my own experiences of pregnancy and motherhood provide me with particular insights for conducting this study. My personal use of CAM mirrors that described by many in the literature as one which complements biomedicine rather than replaces it, offers effective treatment for many minor ailments without the risks associated with biomedicine, enables choice and a way of being in control (Connor 2004, Sointu 2006a).

Through my own reflections and from listening to stories of pregnancy, birth and CAM use, I came to a realisation that participant practices in relation to CAM had a resonance with concepts of risk, in particular a need to contain and reduce risk. I made the decision to choose risk as a theoretical framework with the belief that this provided the potential for a fruitful interpretation and a way of making sense of women's use of CAM in pregnancy. Additionally, I identified a gap in the literature as I could not find any published work which had explored CAM use in pregnancy through a lens of risk. In the next chapter I aim to orientate the reader to my interpretations of the theoretical field on risk. My own position on risk will be revealed as I explore the impact of risk on the National Health Service (NHS) maternity services provision and on women's experience of pregnancy and childbirth.

Chapter 3. Theoretical Framework: Concepts of Risk

Sociologists such as Giddens (1990), Beck (1992) and others (Watson and Moran 2005, Douglas 1992, Lash et al. 1996) have highlighted the complexities of contemporary western societies in relation to risk. Beck's seminal 'Risk Society' (1992a) is widely acclaimed as the most influential writing in this field. Mythen (2004) suggests that Beck's work has accelerated social and political debates and stimulated extensive academic research and scholarship on risk. Beck's and Giddens' theories are closely aligned thus I have chosen both as central to my exploration of women's use of CAM during pregnancy.

The principal argument in Beck's (1992a) and Giddens' (1990) thesis is that risk has become an increasingly important and pervasive concept of contemporary society. The 'risk society' is one in which the advantages of scientific and technological developments are overshadowed with risks and dangers, leading to a world dominated by anxiety and uncertainty (Beck 1992a, Giddens 1990). Although a complex set of interrelated phenomena it is argued the risk society has come about because of three major sociological changes which can be summarised as follows. Firstly, society is dominated by pervasive and omnipresent risks of a globalised nature. Secondly, their theory of reflexivity originates from the increasing recognition by the public of the fallibility of science and distrust of expert knowledge (Thompson 2005). Thirdly, the individualisation thesis proposes that traditional institutions no longer have a stronghold over individual lives; therefore it is up to the individual to shape their own biographies with autonomy and choice assuming priority (Beck 1994:13).

With such wide sweeping claims it would be possible to find explanations for most aspects of human behaviour within this theoretical framework. Indeed, a consistent and important critique is that Beck's and Giddens' theories are overstated and lack an empirical basis (Lupton 1999a, Mythen 2004). However, a central theme in the conceptual analysis of risk is the everyday experience of living with risk and this has not yet been explored in relation to

pregnancy, childbirth and the concomitant use of CAM. Thus my overarching question is whether women's use of CAM in pregnancy can be explained by or is a response to Beck's and Giddens' concept of the risk society. Of particular interpretative relevance is their thesis of reflexivity and my analysis will centre on whether this concept can illuminate women's decision making in choosing CAM during pregnancy and childbirth. First, I outline Beck's and Giddens' central thesis of risk before moving on to explore reflexivity and its implications for understanding the dynamics between structure and agency in decision making.

3.1. The evolution of risk

Both Giddens (1990) and Beck (1992b) claim the risks individuals faced in pre-modern times were as a result of natural events such as fire, storms and plagues. Their occurrence was explained by nature, acts of God or fate. Individuals were not responsible for these dangers nor could they have control over these events. Lupton (1999a) suggests in these times religious beliefs, magic, superstitions and rituals provided a way for people to deal with feelings of risk and danger and gave them a sense of being in control of their lives. Belief in the strength of science and its potential in dealing with both human and natural risks grew during the Enlightenment Project of the 17th century. During the 18th and 19th century, Lupton (1999a) argues the growth of positivist philosophy with its values on objective knowledge and a reliance on probability statistics led to a conviction of the calculability of risks i.e. risks could be anticipated, prevented and controlled. Beck (1999) agrees that in early modernity the risks of industrialisation could be predicted and thus individuals could choose to avoid or ameliorate them with some certainty.

Conversely, the risks posed to contemporary individuals arise as a result of human action, in particular, continued industrialisation and scientific progress. Risks such as pollution, global warming and food production are globalised and therefore have the ability to impact on everyone (Adam et al. 2000). These risks are referred to by Beck (1999:6) as '*manufactured*' risks or uncertainties. Additionally, many risks operate at an invisible level, e.g. radiation, pollution, and additives in food production. As a result their effects

are realised long after exposure and often only through expert analysis. The continued progression of science and technologies offer new opportunities and ways of dealing with risks but the possibility of even greater risk is always present. As Giddens and Hutton (2001:213) point out the contemporary world is both a “glorious and frightening time”. Scientific advancements replace knowledge so rapidly that the concept of uncertainty and ‘unknowability’ about potential risks of new technologies takes centre stage (Beck 1999). In his later work Beck (1999, 2009) continues his pessimistic portrayal of these risks, as catastrophic, unprecedented, impossible to calculate, prevent or avoid and as such constitute a major threat to human life and wellbeing. Consequently, individuals in the risk society experience a constant feeling of uncertainty and danger, with risk avoidance strategies guiding every action.

3.2. Theoretical perspectives

A number of different paradigms from realist to social constructionist perspectives inform the discourses of risk in social and scientific literature. Beck and Giddens adopt a realist perspective as risks are viewed as objective facts with the potential for real danger. A realist perspective is also seen in scientific traditions most notably that of statistics, psychology and medicine, where risk is viewed as that which can be assessed, measured and controlled. Beck uses the term ‘natural-scientific objectivism’ to express his realist views and argues that this approach is useful because risks need to be calculable before they can be perceived (1995:162). However, Mythen (2004:8) accuses Beck of ‘wilfully’ changing his mind as his position alters over time. For example Beck (1999) acknowledges that there is a difference between real risk and how people perceive risk, demonstrating a more social constructionist viewpoint. This view becomes more prominent as in later work Beck (2009:11) recognises the ‘*blurring of the boundaries*’ in the distinction between real risk and the cultural perception of risk. Indeed, Beck does not see the relevance of such a distinction arguing it is a ‘*matter of degree not principle*’. (Beck 2000:211). Giddens (1990, 1991, 1994) has also written prolifically on the risks and uncertainties that people face in every day. He agrees with Beck on many issues and refers to the “double edged’ phenomena of the contemporary world, as a time of opportunity but also a ‘dark side’ of technology with its

accompanied risks (Giddens 1990:7). Giddens prefers the term 'risk culture' as he argues the global nature of risk has the potential to affect the lives of every nation. However, Beck's and Giddens' work is criticised on a number of fronts, most notably for its ethnocentric focus on affluent western societies (Mythen 2004, Lupton 1999a). Furthermore, Slovic (2010) suggests the impact of risk on everyday life is under acknowledged by Beck and Giddens. To begin an exploration of individual response to risk I turn to the concept of reflexivity described by both Giddens (1990) and Beck (1992a).

3.3. Reflexivity

In the context of risk, reflexivity or reflexive modernisation refers to individual and institutional decision making in the face of uncertainty (Beck 1994). Uncertainty arises because contemporary risks are invisible and thus must be revealed and interpreted by experts. In this interpretation the impact of risks can be downplayed, overemphasised or manipulated (Lupton 1999:59). Controversies and disagreements among experts are publicly debated, challenged by political or interest groups and played out by the media, leading to public loss of trust in scientific knowledge and authority. Thus there is both a simultaneous reliance and rejection of the authority of scientific knowledge in solving problems. The continued progression of scientific knowledge adds to feelings of uncertainty since everyday decisions and practices have to be constantly revised in the face of new knowledge. Furthermore, it is impossible to know whether decisions are the most appropriate since there is always the potential for new unknown risks to be uncovered. Beck (1999:123) places more emphasis on the significance of 'non knowing' and its impact on uncertainty, fear and anxiety than Giddens. As a way of explanation, he refers to the impossibility of knowing that Chlorofluorocarbons would contribute to global warming. Reflexivity takes place at both individual and institutional level and is the response to these uncertainties. Beck (1996) argues that individual reflexivity includes critical reflection, self-confrontation and self-transformation as the anxieties and uncertainties about risk leads to a questioning of modern day practices. It refers to the self-authorisation of individuals, as they learn to

negotiate contradictory discourses of science and expertise and exercise their autonomy in dealing with the problems and risks they face in everyday life.

Beck and Giddens also differ in their view of the relationship between risk and reflexivity. Beck's concept of reflexivity incorporates a critique of expert systems based on distrust. He believes when individuals cannot trust the experts or institutions which govern daily practices they are '*thrown back upon themselves*' and are compelled to seek their own solutions for the problems they face (Beck 2009:55). Within Beck's perspective the individual is viewed as making rational conscious decisions, weighing up the pros and cons of different expert views, and often developing their own areas of expertise. This process is made easy by other contemporary changes such as ease of access to information and the increasing desire of individuals for autonomy in decision making.

Giddens (1990:35) also believes that risk is consciously calculated, individuals make cognitive decisions but, in contrast, these are taken with a basic trust in institutions and experts. Giddens (1994:89) highlights that all actions of daily living require acceptance of advice from 'absent others' i.e. unknown people or familiar institutions such as medicine and the law. Trust arises as a result of childhood experiences resulting in feelings of confidence or 'ontological security' in the reliability of people and social institutions. Giddens (1990:78) believes that without this basic trust an individual could not take the 'leap of faith' involved in taking actions or advice based on expert knowledge which they may have little understanding of. Ontological security provides an 'emotional inoculation' or 'protective cocoon' which leads to an attitude of hope and protects individuals against constant anxiety (Giddens 1991:39,40). A number of empirical studies since the publication of Beck's and Giddens' work confirm that trust is central to risk perception and individual decision making strategies (Watson and Moran 2005, Green et al. 2003). Later in this thesis I will argue that notions of trust are an important factor in participants' decisions to use CAM in pregnancy.

Concepts of risk are also central to debates about individual agency and how it operates within structural forces (Walklate and Mythen 2010). In Beck's and Giddens' realist position risks are inescapable and thus individuals are compelled to confront, to avoid, or minimise risks. Although Beck (1999) is overly pessimistic about the risks of our contemporary world, he is optimistic about the power of social actors and agency in seeking creative solutions for themselves and in transforming social structures. The cornerstone of Giddens' (1994) thesis also lies in his belief in the power of the agentic individual. He argues that individuals actively create the social world around them rather than being determined by it (Tucker 1998). Thus for both Giddens and Beck, the reflexive individual is viewed as an active agent motivated by risk into making informed decisions, seeking autonomy and progressive social action. Although Beck (2009:116) acknowledges that uncertainty and 'non knowing' could lead to inaction, 'crippling fear and hysteria'. Mythen (2004) argues that Beck underestimates the coercive power of institutions and the state.

My own position on risk differs in a number of respects to that of Beck and Giddens. I favour an approach to risk that places the emphasis on socio-cultural dynamics in risk perception as more important than whether a risk is real or not. How individuals make sense of risk and how they experience risk is influenced by their socio-cultural context. Additionally, past experience can significantly impact on an individual's perception of risk, either ameliorating or increasing perceptions of risk and danger. My views have evolved over considerable time and experience of working as a midwife within the institution of the NHS, from caring for childbearing women and as a result of a synthesis of the theoretical field on risk. I turn now to the obstetric and institutional view of risk and how it impacts on women's experiences and perception of risk to demonstrate the utility and limits of Beck's and Giddens' realist perspective. I will argue there is always the potential for risk and danger to the health of the mother and baby during pregnancy and childbirth. Nevertheless, women's perceptions and reactions to this risk vary considerably and are often at odds with professional discourses. Through an analysis of these different perspectives I suggest an approach which emphasises the social construction of risk and cultural influences on reflexivity provides greater insights into

women's decision making in the face of risk and then later in the thesis how this impacts on their decisions to use CAM in pregnancy.

3.4. The impact of risk on maternity services

Formalised risk management systems were introduced into the NHS in the 1990s (National Health Services Management Executive 1996, Symon 2006, Lankshear et al. 2005). The assessment, management and prevention of risks is now the pivotal focus of the maternity services and as such is congruent with Beck's and Giddens' realist position. The laudable aim of risk management is to improve the quality of care and patient safety (Heyman et al. 2010). However, risk is viewed in diverse ways by different professional groups providing maternity care. This reflects the social and culturally bound nature of risk argued by other social theorists such as anthropologist, Douglas (1992) and sociologist, Lash (2000). Douglas and Lash are critical of Beck's and Giddens' scientific and individualised approaches to understanding risk arguing that the influences of culture and community play a more significant role in people's perception and response to risk. Both contend that risks have not increased in contemporary society but in the social construction of risk, expert and public perception of risks have intensified (Douglas 1992). The reason why some phenomena are identified as risks and others are not, is defined more by cultural group identity, differences in world views and philosophical orientations rather than individual perception (Lash 2000). The differences between a medical and a midwifery perspective on risk provide support for their views and for my philosophical position.

The medical model of healthcare stems from a dualistic and technocratic world view that mechanises the body and relies on science, technology and expertise (Lane 1995, Mansfield 2008). The assumption is that science and technology are required to ensure safe outcomes for the mother and baby. The belief that expertise and the application of technologies are superior to nature, physiological processes and women's experiential and intuitive knowledge prevails. Risk is a central concept within this medical view and like Beck and Giddens the focus of concern is on physical threats to the health of the mother or baby (Agustsson 2006, Edwards 2008). In this paradigm,

pregnancy and birth are seen as potentially life threatening for the mother and baby. Thus surveillance and monitoring are required to identify any deviations that are judged to be abnormal. At first contact with maternity services, a woman's risk is assessed, epidemiological statistics are used to denote a high or low risk status and this determines the type of care received. Further screening and surveillance continue as pregnancy progresses and the status of low risk can change at any point. Lauritzen and Sachs (2001) refer to this as the problematisation of normal, everyone starts out as normal but screening may uncover previously unknown risks many of them of a theoretical nature. Indeed, Stahl and Hundley (2006) found that large numbers of women were labelled as 'high risk', many of these risks were arbitrary or founded on outdated knowledge. Hospital policies and guidance are developed for every conceivable risk scenario, and an ever increasing range of technologies have been developed to deal with problems identified or to avert risk (Mackensie and van Teijlingen 2010). These interventions introduced to reduce risk often pose additional risks for women or their babies. This phenomenon has been described by Inch (1989:244) as the 'cascade of intervention' i.e. one intervention in an otherwise normal birth leads to further interventions and eventually to a complicated birth and potentially a compromised baby: the very 'manufactured' risks described by Beck and Giddens. The concept of 'manufactured' risks is also well illustrated by the alarming rise in caesarean section (CS) rates as a result of increasing technological surveillance and medical approaches to labour management (Lankshear et al. 2005). There are known health risks associated with CS such as infection and thromboembolic disorders (RCOG 2001). Others have also pointed out the potential for unknown and unpredictable risks of medicalized birth (Odent 1999). Foureur (2008:79) dramatically suggests the 'future of humanity' is dependent on reclaiming normal birth. These would constitute the classic 'unknown unknowns', the risks that Beck (2009) refers to in his later work.

The effectiveness of risk assessment and the safety of many interventions have yet to be established, many have failed to live up to expectations in improving outcomes for the mother and baby (Enkin et al. 2000, Sinha and Donn 2008, Steer 2008). Thus Davis-Floyd and Sergeant (1997) argue that

much of birth technology serves only to maintain the authority of the medical model, thus revealing the social construction of risk. Beck (1995) would agree that the classification of risk is not always in the interests of the public but about claims of the legitimacy of particular forms of knowledge and expertise. This supports Beck's claim that risks are always created by the very organisations which are meant to be managing and controlling risks.

The cultural perspective of risk is evident in the contrasting approach of midwives to risk. The philosophy of midwifery is that childbirth is a normal life event and that physiological processes work better if undisturbed; risk is therefore reduced by avoiding unnecessary use of technology or medical intervention (Kirkham 1999, RCM 2000). A midwifery focus on health promotion supports risk reduction as one of essentially strengthening the woman to give birth to her baby rather than on surveillance and control (RCM 2003, Guiver 2004). Indeed there is much research evidence to suggest that this model of maternity care is associated with improved outcomes and leads to increased satisfaction with maternity services (Thompson 2000, Kirkham 2003). Nevertheless, midwives are also profoundly influenced by the biomedical paradigm and their practices often serve to maintain a medical and risk approach to maternity care (Pollard 2011). Risk definition is therefore political, what and who defines risk in pregnancy and childbirth is open to interpretation and is heavily influenced by the dominant paradigm, the culture and world views of different professions and by organisational structures (Tracey 2006, Bones 2005, Fahy 2008).

A reflexive critique of medical approaches to birth has been evident in the politics of childbirth since the 1970s (Oakley 1992a,b, Kitzinger 2005, Tew 1998, Campbell and MacFarlane 1994). Professional and lay organisations such as the Royal College of Midwives and the National Childbirth Trust lobby for a reduction in medical intervention and for a more social and holistic model of maternity care (Nolan 2007). It could be argued that organisations such as these who critically engage with and challenge institutional risk practices are the 'reflexive communities' described by Lash (2000:47). Indeed, Lash (2000) argues that Beck and Giddens neglect the shared symbolic and cultural

aspects of risk, seen in such communities. These 'reflexive communities' have been instrumental in influencing government policy. Since the early 1990s numerous government reports have advocated changes in the maternity services to reflect a social model of service provision with midwives as the lead carers (DOH 1993, 2004, 2007a,b, 2008, 2010). Nevertheless, the dominance of risk systems has ensured that this is not reality within current patterns of maternity care (Stapleton et al. 2002, RCM 2010, RCOG 2011). Beck (1992a) acknowledges the medical stronghold over all matters of health and illness. He cites medicine as an extreme case of sub-politics in that its professional status means its practices are aloof to political influence. Other factors, however, are at play which serve to maintain the status quo. The increasing birth rate, financial constraints, centralisation of services and falling numbers of midwives have exacerbated temporal pressures and the quality of care offered to women (RCOG 2011). The social and cultural values that underpin contemporary society such as convenience, choice and autonomy create an environment where intervention in childbirth is being normalised (McAra-Couper et al. 2010). Midwives experience conflict balancing the requirement for risk management with the needs and desires of individual women; they talk of being silenced by the system and unable to fulfil their role (Hunter and Deery 2005, Dykes 2009). Medical models of practice prevent midwives from developing skills and expertise to support women in normal birth (Edwards and Murphy-Lawless 2006). These discourses of risk have a significant impact on women's experiences of pregnancy and childbirth. In the next section I explore how these discourses impact on women and discuss both the strengths and limitations of Beck's and Giddens' work in providing insights into women's response to the risk practices of the maternity services.

3.5. The impact of risk on women's experiences of childbirth

Women are more likely than professionals to emphasise risk in relation to psycho-social parameters and the meaning of risk to their own individual circumstances (Lindgren et al. 2010). However, the dominance of the medical approach to risk impacts on women's feelings, choices and decision making (Berg 2010). Marken et al. (1999) attribute an increase in women's anxiety to the risk approach within maternity services, confirming Beck's and Giddens'

view of the fear generated by risk. The preoccupation with risk changes the way women think about themselves and maybe on an unconscious level undermines women's confidence in their ability to birth without medical intervention. Dahlan (2010a) believes the ever increasing use of technology and the resulting 'manufactured fear' are endangering normal birth. In contrast to Beck's (1992a:4) focus on physical risks, Furedi (2004) suggests risks and uncertainties are re-interpreted as risks to the emotional health of individuals, leading to feelings of vulnerability and powerlessness. Furedi's (2004) prediction that in this culture of risk, fear, anxiety and stress become the normal state of being is relevant to women's contemporary experience of pregnancy and birth.

However, perception of risk is not as uniform or universal as Beck and Giddens suggest. Research shows considerable variation in the factors that influence woman's perception of risk in pregnancy (Darra and Norris 2008). Psycho-metric studies have illustrated that risk perception is a highly complex activity dependent on a range of factors such as education, gender, and social circumstances (Slovic 2000). These studies too, however, neglect the importance of understanding the meaning that individuals apply to risk. During pregnancy and in other contexts personal experience is known to impact significantly on an individual's perception of vulnerability to risk (Fleming 2006, Shaw 2004). Drapkin-Lylery et al's (2007) study revealed that women who had experienced complications in pregnancy were much more likely to experience anxiety and accept medical decision making without question compared to women who experienced no complications. Generally, women perceive low risk in pregnancy, but they are aware of the uncertainty of pregnancy and birth and are grateful for medical expertise and technology if and when it is required (Enkin 1994). For many women the perception of birth technology is equated with progressive medicine. Women request the use of electronic fetal monitoring in labour and report that access to pain relief at all times is essential in a quality service (Rothman 1994, Green and Baston 2007). For some women, the risks of natural childbirth pose such fear they request elective CS believing it is a safer option for themselves and their baby (Fenwick et al. 2010). Furedi's (2002) view of the individual living in this

'culture of fear' is evident in these women's perspectives: as one who is so preoccupied with risk and negative aspects of the contemporary world they become fearful, inward looking and paralysed to action. Walklate and Mythen (2010) refer to the individual in Furedi's world as the 'neurotic citizen' and criticise his depressing and pessimistic view of human ability for agency. However, the power of individual agency too is evident, for example, some women seek to minimise the risks of medical intervention by declining specific screening tests or technological interventions, by having their baby at home or for a small minority, by rejecting medical advice completely to birth their babies without professional assistance in the growing phenomenon of freebirthing (Nolan 2008). Women's reactions to risk thus highlight how perceptions of risk are inextricably linked with personal understanding of what constitutes a danger or a threat.

My experience suggests that frequently women's responses to risk are not easily understood, that anxiety is a complex multidimensional concept and often decision making seems contradictory and inconsistent. Women's stated rationale behind choosing various options at times appear illogical, non-rational and based often on conflicting values. For example, in this thesis a number of participants chose to give birth in hospital because they felt experts were immediately available. Nevertheless, they articulated a lack of trust in the very same experts as they acknowledged their decisions are bound by institutional pressures and policies. Giddens (1991:7) accepts that individuals adopt a variety of strategies in dealing with risks and often display inconsistent attitudes of trust, acceptance, rejection and scepticism. Individuals respond to risk and uncertainty in complex ways thus how an individual makes personal sense of that risk is more relevant in understanding their reactions to risk (Adam et al. 2000). I accept that discourses of risk, impact on women's belief that pregnancy and birth is a dangerous time, instilling fear and creating greater dependence on healthcare professionals. Individual agency is impeded by the generation of universal truths that are internalised by individuals, for example; women choose to have their baby in hospital believing this is a safer option than home birth. In this way power relations are reproduced not by force but by discourses that promote self-regulation and

adherence to the status quo, human agency is thus undermined by the power of the institution, and structure dominates. I suggest like Bauman (2006) that individuals are induced to search for biographical solutions to systematic and institutional problems. Women's actions and behaviours including the use of CAM may be illustrative of this.

Beck's and Giddens' belief in the rational actor taking reflexive decisions to avoid or reduce risk implies conscious cognitive processes but this is not necessarily the case. Pregnancy is a time when women make important decisions that will impact on their health and that of their baby. Women seek out expert opinion, they read prolifically and also seek support from other women. However, their emotions, philosophical and moral views are more influential than logical and rational models of decision making. I have often witnessed the torturous decision making process as women and their partners grapple with conflicting emotions and deeply held values and beliefs in deciding what is best to do in difficult circumstances. Zinn (2008a) would agree there are a whole range of in-between strategies that people use in everyday life to make decisions in the face of uncertainty. Both rational e.g. knowledge seeking and weighing up the pro and cons are incorporated with non-rational means such as belief, hope and intuition.

Furthermore, the notion of reflexivity does not seem as important in the complexity of everyday life as Beck and Giddens suggest. Some women do not seem to make conscious decisions, accepting the decisions of experts (Bluff and Holloway 1994). Others follow the normative practices of their culture, family and peers (Edwards and Murphy-Lawless 2006). As Lash et al. (1996) suggest an individual does not consciously think about their actions all of the time, as their world view and habits that develop through upbringing and acculturation take priority. Beck's claim that individuals are overtly influenced by global risks is also challenged. People are aware of global risks but their responses are moderated by the practical constraints of everyday life, immediate local and personal experiences assume priority (Scott 2002, Hier 2003). Giddens (1991:131) agrees, he suggests risk perception and reflexivity come to the fore at 'fateful moments' which threaten ontological security, e.g.

illness or catastrophic events such as global terrorism or ecological disasters. It is possible that pregnancy is such a time when ontological security is breached and reflexivity comes to the fore as women make important decisions which have the potential to significantly impact on their future. Pregnancy may alter risk perception as women experience a heightened awareness of the world to which they will bring their newborn.

Lupton (1999b:59) describes the intense focus on the pregnant women in risk discourse as she alone is responsible for the wellbeing of herself and the baby. Women are subjected to constant and ever changing advice from experts about how to reduce risks: what to eat or not eat, what activities are beneficial or not, the amount of alcohol that is considered safe etc. (RCM 2003, Eriksson et al. 2007, Henley-Einion 2009). Wolf (2007) argues that public health campaigns are emotionally laden and exploit cultural assumptions that mothers are solely responsible for protecting their baby from harm. Consequently, many women perceive pregnancy to be inherently risky with the possibility of unforeseen events always present (Heaman et al. 2004, Dahlan 2011). In the realist paradigm being at risk is also increasingly seen as a personal responsibility and it is up to the individual to modify their behaviour and lifestyle to reduce these risks (Crafter 1997). Douglas (1992) argues that this approach intensifies people's fears and anxieties. Thus women's choices tend towards compliance if they are told or led to believe that they or their baby is at risk. Non-compliance is seen as irrational or risky behaviour, women are seen as bad mothers or as irresponsible and not acting in the best interests of the baby (Marken et al. 1999). The impact of these discourses has been explored in a number of studies. Health professionals have been noted to reprimand or judge women if they fail to follow expert advice. Women report feeling punished and stigmatised, they experience anxiety and fear about harming their baby and respond by non-disclosure of risky behaviour and avoidance of professional contact (McKinnon and McCoy 2006, Lee 2007, Nolan 2011). Some women's reflections on the risk approach to care during pregnancy and birth reveal a reflexive criticism towards medical authority (Lane 2008). However, Murphy-Lawless (1998) describes an 'immense wall of silence' from women themselves as medical view points and interventions

become the norm. It seems that women have lost confidence in their natural ability to birth as practices of risk predominate. However, counter discourses emerge as women attempt to regain control of their pregnancy and birth experiences. The rise in CAM use during pregnancy may be one strategy which women adopt in learning to trust their own body and have faith in their ability to birth. Women may be turning to CAM in an effort to avoid risk, enhance their health and wellbeing during pregnancy and in preparation for birth, to help them reduce risk and avoid the need for unnecessary medical intervention. These strategies reflect the symbolic nature of health care practices and the importance of meaning in decision making. However, Beck and Giddens have been accused of ignoring this aspect of reflexivity. Lash (2000) argues reflexivity should be understood as a process of hermeneutics, i.e. self-interpretation and decision making involving aesthetics such as cultural aspects of taste, style, and leisure activities. Viewed in this way reflexivity is a process of meaning making dependent on emotions, intuition and imagination involving cultural understanding of language, actions and institutions (Lash 1994). This perspective provides me with greater insight into women's decision making in pregnancy and their concomitant use of CAM.

My analysis and synthesis of the theoretical field of risk leads me to conclude that much of Beck and Giddens' writings on risk and reflexivity are evident in the studies of risk perception in pregnancy. It seems many women experience anxiety and feel emotionally vulnerable during pregnancy. Fear of childbirth is common and may be driven by the risk approach to maternity care. I have also found support in the literature for Beck and Giddens' thesis of reflexivity. The role of support and pressure groups in lobbying for change in the maternity services illustrates the questioning of modern day practices, the distrust in experts and the desire for individual autonomy and agency characteristic of individuals in the risk society. However, the differences between medical, midwifery and lay understandings of risk reveal both the cultural and social constructionist nature of risk perception. Although the potential for pregnancy to pose a real risk for women exists the variable and often contradictory way in which women respond to these risks leads me to infer that much of Beck's and Giddens' thesis is overly simplistic as it fails to acknowledge the

complexity of individual responses to risk, particularly in relation to expert systems. The way in which an individual makes sense of current life events is determined by their past experience. Risk perception is dynamic, influenced by the health of the mother and baby as pregnancy progresses. It is also dependent on a variety of factors including individual characteristics, social and cultural practices and the degree of support available. How an individual woman is influenced by and makes decisions about risk in pregnancy is determined by how she makes sense of that risk and her lived experience of that risk. At times the decisions women make in the face of risk appear contradictory and non-rational to the professionals providing care. It is clear that women made decisions about their health in pregnancy and that of their baby using a variety of strategies which may include unconscious motivations, emotions, and intuition. The role of hermeneutics in decision making is thus under acknowledged by Beck and Giddens. Nevertheless, research on risk perception and reflexivity in pregnancy and childbirth is limited. My interpretation of how the 'risk society' impacts on women's experience of pregnancy and childbirth emerged more clearly as the research progressed, particularly during the stage of data analysis. In the next chapter I outline the methodology and methods I adopted in conducting this research. Although I did not enter the research field specifically to explore issues of risk, it quickly became apparent how the discourses of risk impacted on participants' experiences of pregnancy and childbirth. In the re-presentation of participants' narratives in Chapter 5, I embed a critical discussion of Beck's and Giddens' thesis of risk and reflexivity to underpin my argument that the risk approach of maternity services is influential in women's choice to use CAM during pregnancy and childbirth. In so doing I will also show the utility and limitations of Beck's and Giddens' thesis in understanding the meaning that participants ascribed to their CAM use.

Chapter 4. Methodology

4.1. Narrative inquiry - the importance of women’s stories.

Narrative research is an umbrella term that includes a wide variety of research approaches, which have at their heart individual stories (Elliott 2005). Frank (2000) uses the term narrative and story interchangeably arguing that people do not tell narratives, they tell stories. It is a genre within qualitative research which focuses on the meaning that individuals ascribe to life events (Riessman 1993, Czarniawska 2004). Engel et al. (2008) argue that understanding human behaviour is fundamentally a narrative activity and not a scientific endeavour. Therefore, through narratives it is possible to learn about the world of individuals, about their lives and their experienced reality. In choosing an appropriate methodology for my research, it is important for me to remain true to the philosophy of holism which underpins my practice as midwife, teacher and complementary therapist. Thus, like Rodriguez (2002), I chose narrative inquiry as a way of bringing humanity to my research, as an attempt to seek a more holistic interpretation of the world, and to understand why women use CAM during pregnancy and childbirth. Narrative research has taken a considerable hold in research on health and illness. This move is often cited as a resistance to the objectivity that medical science promotes at the expense of the subjective experience for the individual (Bury 2001). Indeed, Hurwitz et al. (2004) and others (Mishler 1984, Kleinman 1988, Bamberg and Andrews 2004) have found that personal perspectives on health and illness have been at variance to the professional narrative, the so called counter–narrative. There is however, little contemporary narrative research in relation to women’s experiences of pregnancy and childbirth, and none that I could find on women’s use of CAM in pregnancy.

The importance of narrative inquiry lies in the notion that story telling allows individuals to make sense of their world, and that this process is retrospective in nature. Providing the opportunity for participants to recount their stories may enable them to explore the meaning of this important life event and for me facilitate a greater understanding of why women use CAM during pregnancy and in childbirth. Pregnancy and childbirth are both intensely private and

public experiences thus there is the potential for a clash between cultural, personal and public narratives. The strength of narrative research lies in the ability to reveal contradictions between an individual’s experience and culturally embedded expectations (Somer 1994, Frank 2000, Mishler 1991, Reissman 2008). There may be some parallels between pregnancy narratives and those of illness. Becker (1999:2) suggests illness leads to narrative disruption, defined as a ‘period of limbo’ or life reorganisation. Pregnancy too is a time of transition, characterised by uncertainty and unpredictability and one could argue a period of living in limbo and preparation for the life reorganisation that inevitably occurs after the birth of a child. Becker (1999) argues that the telling of personal narratives enables people to make sense of their experience and develop a sense of continuity with the past.

As a midwife, a teacher and complementary therapist I have learned the best way to know those I care for comes from listening to their talk of experiences. Women tell stories instinctively to share their experiences, to express their emotional and spiritual needs, to learn and to make social relationships (Hall 2001). Freedman (1999) highlights the powerful and therapeutic nature of the stories women tell about birth. Indeed, Belenky et al’s (1997:35) seminal work revealed that pregnancy, birth and parenthood initiated an “epistemological revolution” in women’s ways of knowing, in that these events were considered by many women as the most important learning experience of their lives. Women seem to have a particular affinity for learning from stories and storytelling. Estes (1992) a clinical psychologist discusses how she taps into the power of stories to enable women to gain insight into their own situation and their own intuitive knowledge. Capturing this learning by listening to their stories offers me the opportunity to learn from women and understand their motivations in using CAM.

I also have a strong connection with stories. I have always loved a good story: those told by my parents, those I tell my own children and those I have been privileged to hear, told by the women that I have cared for in my professional life. I recognise in myself the claims made for narratives as a way of knowing, a way of learning, a way of making sense of the world and as a way of building

self-identity (Patterson 2008, Clandinin and Connelly 2000). I incorporate narratives in the form of stories, poetry and images in my teaching as a way of enabling students to learn the art and practice of midwifery and understand what really matters to women. I never tire of listening to women's talk of pregnancy and birth despite the many social occasions that have resulted in a story telling session. I value the social connection, the shared understandings and meanings that stories have the power to generate, their humour and entertainment value. Stories fire me, they keep me on tenterhooks, they have the power to generate a wealth of emotions. As Koch (1998) suggests a story gives context and detail, in attempting to create the mood and emotions of the setting, the experience comes alive. Women's stories of pregnancy and birth make me laugh and cry, make me feel proud to be a mother and a midwife but also make me embarrassed and ashamed of some practices women recount. Just by listening to stories I am imprinted with knowing and feeling about that experience. They inspire me with a desire to think about how I relate to women, to change midwifery practice and to improve the care offered to women. Indeed it is argued the compellingness of narratives is that they challenge us to think about our actions and how we might change them (Roberts and Holmes 1999, Gregory-Dawes 2001).

At the same time I am aware of the point Hendry (2008) makes that one can become so engrossed and intertwined in a particular narrative that it is impossible to see beyond it, to be constrained by it and to make connections where perhaps none exist. I recognise that narratives can be disconnected and incomplete and thus have their limitations in revealing the very essence of experience. I agree with Richard (1997) who suggests that not everything in life fits into a neat story line and that life is such a complex process that it can never be fully understood, never mind represented by another. A life in all its complexities and chaos cannot be contained within a straightforward framework and any attempt to do this is misleading. Life may be incoherent, full of confusion and contradictions, but I do not view narratives as having explanatory power to recount original experience. I accept Atkinson's (1997) assertion that any recounting of events is apt to change that experience. Hendry (2008) warns therefore that narratives should not be viewed as a

promise of describing a life in all its complexities. However, by acknowledging the social construction of the stories narrative research provides a methodology to consider the contextual, partial and contradictory aspects of life and storytelling. Ultimately narrative research cannot represent the truth but through the telling and listening to stories it is possible to grasp the meaning of those experiences. Most important of all, stories put our senses and emotions into knowledge, they bring to life dry words and phrases evoking images and emotions that we recognise and relate to (McHugh 2007).

Like Frank (2000) my methodological quandary lies in the limitations of my ability to enter into the life world of others or to make claims that I can reveal the truth of others’ stories better than they can for themselves. Rather I hope to provide my participants with the opportunity to speak for themselves and to make their stories accessible to others. My role as researcher is to provide a level of interpretation that aids understanding of the phenomena under investigation but also to stand back and allow the words to speak for themselves, for this is the power of the story. The potential of narrative research to influence professional practice is also fundamentally important to me. Narrative researchers of health and illness such as, Reissman (1993), Mishler (1984) and Frank (1995) have been successful in raising the awareness of the power of medical discourses and the impact of illness on the individual. This recognition, Charon (2006) argues is the first step towards change. Davis (2007) discusses how midwives can learn the practice of “mindful midwifery” through listening to women’s stories. Overcash (2003) argues that health care policy can be influenced through narrative research by providing insights into the lives of individuals most affected by those policies. This enables professionals to achieve a greater understanding of the physical, psychological and spiritual dimensions of the individual they care for. However, I am aware of the need to provide a research framework if I am to move beyond the mere collection of stories to demonstrate trustworthiness in the research process.

4.2. Trustworthiness and rigour in narrative research

There is considerable debate as to how qualitative researchers should demonstrate rigour and trustworthiness in their work (Koch and Harrington 1998, Long and Johnson 2000). Some argue that any endeavour to claim authoritative knowledge by the use of predetermined criteria is not warranted, as it is up to the reader to make that judgment (Polkinghorne 2007, Rolfe 2006). Others argue this fluid position is unacceptable, particularly for researchers who wish to disseminate their findings within the health care arena (Walsh and Downe 2006, Murphy et al. 1998). I aim to share my research with midwives and other healthcare professionals, thus it is appropriate to demonstrate my findings have been generated through a rigorous and trustworthy research process.

A number of quality frameworks have been devised for qualitative research but these have been criticised for their positivist focus, (e.g. see Mays and Pope 2000, Guba and Lincoln 1998, Sandelowski and Barroso 2002). Spencer et al. (2003) recommend a set of guiding principles which I have adopted as they serve a pragmatic approach to evaluating qualitative research. These include: the research should contribute to advancing knowledge, the design and methodological approach should be defensible and appropriate to fulfil the aim, it should be rigorous in conduct, demonstrate systematic transparent data collection, and interpretation and analysis of data should be credible by offering well founded and plausible arguments about the significance of the data generated.

Roulston (2010) argues that researchers must demonstrate the quality of their work in ways that are congruent with their epistemological assumptions. I do not advocate total relativism that views all narratives as texts of fiction. However, I recognise that narratives are not complete and accurate representations of reality. As Lieblich et al. (1998) suggest, stories are generally constructed around a core of facts or life events but these may be expressed with differing selection, additions or emphasis of meaning. The purpose then in the re-presentation of the narratives is to deepen the reader's understanding of the meaning of the story. Polkinghorne (2007) also suggests

that demonstrating rigour in narrative research is not a mechanistic process but one of argumentative practice. Knowledge claims made for narrative research need to be supported by strong and powerful arguments which allow for the presentation of meaning experienced by people.

The socially constructed nature of narrative research acknowledges that the researcher is embedded within their own research and that a story about the researcher is also being told (Steier 1991). Thus qualitative researchers are advised to incorporate a reflexive account into research reports, to unravel and reveal how their biographies intersect (Roulston 2010, Alvesson and Skoldberg 2000). Finley and Gough (2005:8) however, warn of the danger that self-reflection and introspection becomes little more than an 'opportunity to wallow in subjectivity'. Thus the researcher must move to a level of reflexivity which illustrates the researcher's awareness of their individual connection to and influence on the research process (Davies 1999). I acknowledge my biography, in particular my own experiences of pregnancy and birth, my CAM practitioner status and my role as midwife/researcher all impact on the totality of the research process. My personal philosophy was influential in the particular focus of this thesis, the methods I chose for data collection and analysis and in the way I chose to re-present participants' narratives. Therefore, I do not claim my research reveals the truth or even a level of certainty beyond that which is possible. Rather as Walsh and Downe (2006) suggest, I hope to ensure transparency of the research methods and convince the reader of the credibility and plausibility of my research findings.

Walsh and Downe (2006) also argue for ethical consideration in any judgement of quality: an ethical consideration which goes beyond adherence to ethical procedures, an approach which is more concerned with equality in the researcher/participant relationship.

4.3. Ethical issues in narrative research

Prior to undertaking the research I obtained ethical approval from the University Ethics Committee (see appendix 1). This involved the completion of standardised forms which set out how I would adhere to the ethical principles of non-maleficence, informed consent, confidentiality and anonymity (DOH 2005, ERSC 2005). However, Ellis (2008) highlights that these formal requirements are insufficient for what she refers to as 'ethics in practice'. Many argue that narrative research, by nature of its relational and interactional focus intensifies many ethical dilemmas and that decisions often need to be made on the spur of the moment (Boman and Jevne 2000, Deming et al. 2007). Guillemin and Gillam (2004) contend these 'ethically important moments' are significant for there is a possibility of harm or exploitation of participants. The issue of informed consent, the emotional potential of qualitative interviewing and appropriate boundary management became the most pertinent ethical issues for me during the research process.

Research governance demands that participants give informed consent to participate in any research study (DOH 2005). This normally takes place at the outset, an information leaflet is provided and a consent form signed. However, in narrative research gaining informed consent may be more problematic as individual stories are constructed during interviews, consequently neither the researcher nor the participants can anticipate what may be revealed (Miller and Bell 2000, De Laing 2000, Etherington 2007). Research such as mine, with prolonged or repeated interaction also poses a challenge as personal experiences and the meaning of these are divulged when relationships and feelings of trust develop over time (Birch and Miller 2002). Thus in narrative research the traditional approach to gaining informed consent is inadequate (Stuhlmiller 2000). Providing on-going information and adopting a process model for gaining informed consent is recommended as more relevant (Edwards and Mauthner 2002). Consequently, I re-negotiated consent at each and every stage of the research process and reiterated participants could opt out of the research at any time. One participant did indeed opt out citing the reason being she was not ready for her '*voice to be heard*'. During the first interview she disclosed she had a chronic illness and her unhappiness

regarding the care received from midwives: Thus, I returned her transcripts and reassured her that our interview would not be included in the study. I suggested a referral to the 'Birth Afterthoughts' service at her local Trust but this was declined.

The emotional potential of qualitative interviewing for both participants and researchers was highlighted when during my first interview with Stephanie, she became upset and tearful in recounting her experience of postnatal depression. I responded with what I believed was an empathetic and understanding manner, listening carefully and acknowledging her feelings. I was aware of my ethical responsibilities not to cause undue upset and wondered whether I should lead her quickly into another topic. However, I was also cognisant of the research literature which suggests participants often experience qualitative interviews as cathartic and therapeutic (Hallowell et al. 2005), so I encouraged Stephanie to continue. I experienced a conflict of emotions of whether I was doing the right thing but my approach must have given Stephanie legitimacy to continue as she progressed with a tragic story of how she and her son had been let down by the health system. Afterwards I felt uneasy, I was concerned I had caused Stephanie distress. I reflected on my ethical responsibility not to cause harm. I am comforted by the writings of other researchers who have reported similar feelings and on reflection realised I had not caused Stephanie distress but only provided her an opportunity to express it (Roulston et al. 2003, Hand 2003, Skene 2007). I had listened to her concerns without judgment and hopefully in this way provided support for her feelings and contributed to the therapeutic component alluded to by many qualitative researchers (Finch 1993, Murray 2003).

A further ethical issue relevant in narrative research is that researchers often experience tension between the role of the researcher and that of friend (Gilbert 2001). Sinding and Aronson (2003) argue there is the potential for manipulation and betrayal of participants because of the intimacy inherent in qualitative research. The techniques described as key to developing rapport such as allowing time to get to know participants, creating an atmosphere of trust and mutual respect, listening and empathizing, can lead the researcher

into potential ethical difficulties and the blurring of boundaries between rapport and friendship (Mauthner et al. 2002). Dickson-Swift et al. (2008) also found that researchers used tactics such as self-disclosure in an effort to enhance relationships, a strategy more akin to friendship. Before the interviews took place I considered how much I would disclose. This sharing is an important part of any reciprocal relationship and it is argued that self-disclosure is not only an effective strategy to enhance rapport but also shows respect for participants’ experiences (Oakley 1991). At the outset I told participants that I was a mother of 3 boys, that I was a midwife teacher and that I was a complementary therapist. As I reflected on my role in the interviews this definitely shaped the relationship I developed with participants and on many occasions we ended the interview with a general chat about children and the joys and challenges of motherhood. However, I did not feel as some have described that I was “faking friendship” in order to achieve a good rapport (Duncombe and Jessop 2002:115). I genuinely felt I could connect to the participants on a number of levels.

Friendships often develop from shared experiences, as my participants and I had much in common; being mothers and users of complementary therapies, the potential for friendship or the perception of friendship was real. At the completion of the fieldwork, I must admit to feeling sad that I would not meet my participants again. I had thoroughly enjoyed our interactions and I felt it was such a privilege to have the time to sit over a cup of coffee and listen to participants’ stories. The potential for harm arises if participants feel abandoned when contact ceases (De Laing 2000, Sinding and Aronson 2003). I followed Dickson-Swift’s (2006) advice to maintain contact. I kept in touch intermittently by email to let participants know how the research was progressing, to reiterate my gratitude for their time and prevent an abrupt ending to the relationship.

Although I experienced much soul searching as I progressed through the research in making decisions about the right thing to do, I am drawn to the views of Gilbert (2001) who believes it is impossible to see into the life world of participants from a purely intellectual level, instead research should also be

experienced from an emotional perspective, as this contributes to ethical practice.

4.4. Sample

Ensuring the appropriateness and ability of the sample to answer the research question is vital in any study (Blaikie 2000). A mixed sampling approach was used incorporating both purposive and snowballing strategies to identify a sample of women who had used CAM during pregnancy and childbirth, a technique recommended by Bryman (2004). At the outset of the research I approached one woman I knew personally and contacted an established network of CAM practitioners to ask for help in recruiting participants. I provided information leaflets to distribute to their clients and a flyer for display in their practice areas, (see appendix 1).

Within a few weeks 15 women contacted me and expressed a desire to participate in the study (one woman subsequently dropped out). Women were included in the study if they had used at least one CAM modality in pregnancy and childbirth. I felt it important that women needed some time for recovery and reflection following birth and therefore I decided not to accept any women whose baby was younger than 6 weeks. I did not set a limit on the length of time since women had their children given that pregnancy and birth memories are long lasting and imprinted into a mother's mind (Simpkin 1991, 1992, Beech and Phipps 2004).

I chose not to place any restriction on which CAM modalities women used. The information leaflet and flyer gave examples of many commonly used modalities and those classified as CAM by the House of Lords Report (Mills 2001), (see appendix 2). The decision making process with regard to the use of CAM has been found to be of a dynamic nature, in which people frequently change from one therapy to another which best suits their needs at a particular time (Gunnarsdottir and Peden-McApine 2004, Truant and Bottorff 1999). Consequently, to focus on a single modality or to constrain the choice of modality from the outset would deny the complexity of CAM users' beliefs and practices. The participants had used a total of 20 different CAM modalities

before, during or following pregnancy. The characteristics of the participants match the descriptors of those most likely to use CAM, found within the literature and discussed previously, (see appendix 3).

4.5. Methods of data collection: obtaining women's stories

The in-depth interview is the most frequently used approach within narrative inquiry. Robson (2002) claims the strength of interviews lies in gaining in-depth information of phenomena. Others highlight the importance of interviews in seeking understanding, and as a way of entering into the world of others, to understand phenomena as they experience them (Rubin and Rubin 1995, Nunkoosing 2006). These are ambitious claims and like others I questioned how well I could come to know someone just in the context of a research study (Wollcott 1995, Jarvinen 2000). Mason (1996) warns of the epistemological limitations of interviews to obtain data on peoples' experiences and feelings. Merely talking to people will not necessarily allow the interviewer to interpret and understand those experiences. However, as Bailey and Tilley (2002) highlight within a qualitative paradigm meaning rather than truth is the legitimate goal and particularly pertinent to narrative inquiry and the aim of my research. From this perspective, it is acknowledged that the role of the interview is to seek an understanding of socially constructed knowledge rather than a tool for obtaining factual objective truths. Thus the role of the researcher fundamentally influences the research process and the data that are gathered during the interview. This approach to interviews fits within the interpretative paradigm, in which reality is situational, culturally embedded and the generation of knowledge is dependent on social interaction (Gergen 1999, Watson 2006).

The emphasis in narrative research on allowing participants time to share their story led me to consider how many interviews would be required and their appropriate length. Riessman (2008) discusses how, given the freedom to talk, many of her participants talked for 6 hours. Although conducting multiple interviews does not feature in much narrative research, considering the needs of women with young children, I decided to conduct several shorter interviews on different occasions. This strategy proved to be very effective as I will

discuss shortly. Most interviews lasted about 1.5 hours, the longest 3 hours. I felt the participants appreciated when I recognised either they or their babies were tiring and in need of a break. Indeed, Caroline commented I had '*managed the boundaries of time well*'.

Mishler (1986) stresses that research which aims to seek meaning must be conducted within the social context of the individual. I gave consideration to the environment where the interviews should take place. The key priority was privacy but ultimately the choice was with participants. All but one of the interviews took place in participants' homes. This posed a number of challenges, as I was faced with many interruptions when the mother needed to attend to the baby or when we merely interrupted our conversation to engage with the baby. May (1991) discusses the unpredictability of interviews, therefore, part of the skill is being able to adapt to the situation and deal with the unexpected. Although the interruptions were not unexpected, I realised later, when transcribing, how these often altered the flow of the story and frequently changed the direction of the conversation. Nevertheless, I thoroughly enjoyed the presence of the babies and my interactions with them and feel they added to the development of my relationship with the participants. On one occasion the interview was interrupted when we found a two year old happily playing with dog food, transferring it back and forth between a bag, the water bowl and his mouth. Rather than this episode disrupting the interview it provided a serendipitous opportunity for my participant to express her views on how risk discourse impacts on parenting behaviour. One interview took place in a pub on a Saturday afternoon as privacy could not be protected in the home. Surprisingly this did not pose any problems. To the contrary it was a relaxed enjoyable interview as the pub was quiet and the background music ensured our conversation could not be overheard.

Interviews are said to require highly skilled and trained individuals (Rees 2003). Conversely, others suggest interviewing is an extension of everyday conversation (Rubin and Rubin 1995, Shottery 1993). However, this view underplays the complexity of the interview situation and as such may lead to

complacency and lack of preparedness. Indeed, Mishler (1986) warns us that the shared assumptions and cultural knowledge present in everyday conversation are not present when interviewing strangers. Rubin and Rubin (1995:10) suggest the skills differ in the intensity of listening, to both verbal and non-verbal signs. They advocate the term “conversational partner” as this highlights the active role of the interviewee in shaping the discussion. However, it can be challenging to encourage participants to open up and share their experiences. Burnard (2000) recommends a number of techniques which encourage participants to elaborate and facilitates information sharing. Conceivably, the most challenging is the task of remaining quiet and giving space for the participant to continue. Rubin and Rubin (1995:42) offer a useful framework for what they refer to as “keeping on target while hanging loose” to cope with this need for flexibility. I had prepared a number of questions for the first and subsequent interviews, however as the research progressed, I became more confident and began to think about what was important. I developed a number of probing questions that encouraged the development of the story, (see appendix 1).

Nevertheless, I recognised the danger of getting caught up in the skills of interviewing. Mishler (1986) warns that many interviewers suppress narratives by interrupting or by questioning in a way that elicits short answers. There is little in the literature that provides guidance for researchers in how to elicit narrative but I agree with Rubin and Rubin (1995) that understanding is achieved by encouraging people to describe their world in their own terms. ‘*Tell me how you first became interested in complementary therapies*’ was my opening question for each participant. For most women this was enough for them to reflect on their childhood or many years past and begin to tell their story. Occasionally they sought verification and my response was non-verbal such as nods, smiles and mm’s. I often signalled a desire to listen to their stories about pregnancy and birth by asking them directly to ‘*tell me about your pregnancy*’ or ‘*tell me about your labour and birth*’. Most, but not all of the women, completed their story to the present time in the first interview. The second interview served as an opportunity for women to either continue telling their story or for me to question and seek clarification. For one woman her

story telling continued to the third interview. Cox (2003) suggests that a flexible approach enhances trustworthiness as it encourages the participants to frame their own responses and focus on what is meaningful to them.

Two women began their story and completed it within a short time. Each of these interviews was punctuated by me asking many questions and requesting participants to return to specific events to gain a greater insight. My reflective journal indicates my feelings of inadequacy in my interviewing skills as they had failed to elicit depth of information or meaning. However, a comment from one participant revealed important insights about how much we can expect our participants to share. Rose reflected after the first interview that she was *'finding it hard to express my feelings'* and wondered whether it was because she *'wanted to erase pregnancy from my mind'* or she *'didn't want to look back as everything had moved on so much'*. The second interview was a completely different experience in that both women seemed to relax, chatted more readily about their experiences and disclosed meaningful insights, thus the value of the second interview was revealed. I agree with Pitts (2007) that developing a rapport with participants takes place naturally over time and cannot be coaxed or actively sought, an ethical, patient and sensitive approach is more important.

Miller (2000) also recommends that before returning to the second interview extracts from the first should be incorporated into the interview schedule. This reminds participants of what was addressed previously, allows for the development of emerging concepts and provides fluidity to data collection compared to a one off interview. I prepared the interview transcripts before the second interview and brought a copy with me. I found this approach useful, as in remembering details from the first interview, I was reinforcing to participants that I had listened and I was interested in their story to want to know more. The second interview also provided a number of challenges. Hollway and Jefferson (2000) suggest that a second interview enables the researcher to seek further clarification where contradictions, inconsistencies and incongruities are noted. Exploration of these tensions can then provide useful insights into concepts that individuals themselves have to grapple with

(Watson 2006). The second and third interviews also provided me with an opportunity to ensure that I had not imposed my personal and professional experiences, values and beliefs on the research participants. Gilgun (2006) argues that one way to ensure a better understanding of meaning is for the researcher to address contradictions and inconsistencies which emerge. However, my aim was not to ‘catch out’ participant’s inconsistencies or ‘smooth out’ contradictions as these do not limit the power of narrative reflections. Rather they reveal the complexity of human experience. I felt I could in the second interview gently challenge a number of participants when they had previously discussed apparently contradictory views. For example, Daisy expressed inconsistent views about the role of evidence in her beliefs about CAM. In the second interview I asked her to elaborate further. Daisy had also noted this inconsistency in her own reflections; a lively discussion followed which revealed insights into previously unexpressed ideas and assumptions. It is important therefore, to acknowledge the social construction of the narrative interview. Participants could have constructed different realities across the interviews. However, it is not the intention of narrative research to seek the truth or rely on completeness since the concern is with the interpretation of meaning.

The second interview created an opportunity for the production of shared meanings (Elliott 2005). The nature, conduct, and events of the 2nd or 3rd interview may have created the opportunity for participants to reveal and share a different or revised narrative from that which was originally recounted. It is inevitable that participants reflected on their accounts and on their performance following the 1st interview. Consequently, decisions about what they were prepared to share in subsequent interviews would have been made. None of the participants changed their accounts from the first interview. However, there were certainly many examples of participants reflecting on their stories told, of making active decisions to share particular events and of a different level of engagement with me in subsequent interviews. Nevertheless, I believe this enhanced my opportunity of reaching a level of interpretation that revealed the meaning of CAM use for participants rather than detracted from it.

Elliott (2005) also suggests that a way to activate narrative production is to pose particular positions or assumptions to participants with the aim of encouraging the exploration of meaning. Additionally, this strategy ensures the impact of researcher bias is attenuated. During the second interview I felt more confident to adopt this approach. I had developed a relationship of trust and one in which I believed a challenging question would not be perceived as a personal judgement. Thus I gently asked participants to respond to criticisms often cited, such as ‘CAM has no basis in science’ or that ‘gullible women are being hoodwinked’ in using them (Goldacre 2008). Despite my cautious approach, this was a successful strategy and yielded fascinating insights into women’s beliefs about CAM and biomedicine.

A threat to the credibility of interview data is that people generally attempt to present a positive image of themselves in social situations (Goffman 1959, Miczo 2003). Riley may have been concerned about revealing herself as ‘alternative’ in sharing her story which was essentially esoteric, a story that could be dismissed by many as nonsensical. Indeed other participants also referred to the notion that their stories could be perceived as ‘*out there*’ (Erin) or ‘*whacky*’ (Rachel) and at times showed some hesitation in revealing their extent of CAM use. Perhaps participants were concerned I would make judgements about them as individuals. Nevertheless, participants did share with me many experiences which would defy western thought or scientific evidence and therefore revealed they were confident I would accept their stories and understand their position without judgement.

It is also important to reflect on how participants may view the researcher and the position of power which is inherent in the relationship (Gilgun 2006). Oakley (1991) suggests this power may manifest in the way researchers gain access to individuals, glean information from them and give nothing or little in return. However, I did not consider myself powerful, I was reliant on the participants to be open and forthcoming. I was dependent on them for my research to be a success. I find Nunkoosing’s (2005) perspective more useful, he also acknowledges the power of the research participants in their ability to

give in to or resist our persuasion to share their stories. He refers to this as the ‘dance of power’. Throughout the interview the balance of power shifts from interviewer to interviewee and back again as they both vie for influence. He offers some suggestions to handle this issue, for example the importance of allowing time for relationships to develop and avoiding coaxing the interviewee into sharing what they do not want to tell. It is the responsibility of the researcher to maintain ethical conduct throughout the research process. Czarniawska (2004:48) also agrees that the “power of knowledge” lies with the narrators as they are the experts in their own lives and it is this that the researcher is interested in. She suggests that what researchers can offer in exchange is their “respectful and interested attention” and that this, in itself, offers what others often do not in providing an opportunity for expression of thoughts, feelings and opinions.

My experience has highlighted the intricacy, complexity and unpredictability of the interview in collecting and interpreting research data. I view the participants in my research as collaborators and my interview approach as one in which I strived not to dominate or control rather to facilitate the production of narratives. I believe the relationship I established with participants was one based fundamentally on equality, trust and a commitment to a joint construction of learning and understanding. More than anything I felt a connection with the women as a mother. We chatted and laughed most about our love for our children, our desire to do the best by them in the face of overwhelming and contradictory messages of right and wrong. We talked about the continuing and never ending challenges of motherhood and I revealed some personal stories of my children, good times and bad. Perhaps this approach encouraged the women to share honestly their experiences of pregnancy, childbirth and CAM, thoughts and feelings not often shared with professionals. I have reached a new level of understanding of the co-construction of narratives and the influence of the researcher in reaching shared understandings. I have witnessed how the relationship between the researcher and participants is paramount in shaping the nature of the interaction and the data collected. Indeed Oakley (1991) highlights the

unique characteristics of the relationships between female researchers and participants and Manderson et al. (2006) illustrates clearly how the characteristics of age, class and gender influence the interview process. This makes evident the social nature of the research interview and the acknowledgement that researchers and participants co-construct and co-create knowledge and interpretation. Therefore, each interview is unique and is a consequence of joint action shaped in the moment rather than either person’s prior intention (Shotter 1993).

4.6. Transcription of the interviews: recording and listening to women’s stories.

Within narrative research the content and meaning of data are important in knowledge generation so the data are transcribed verbatim with the aim of providing a full and faithful transcription of the interview. However, very soon I realised that this was rather a naive view as I had to make decisions about what exactly to include or omit. Tilley (2003) advises researchers to make informed decisions about how and what to transcribe and to give serious consideration to the choices they make, as this contributes to trustworthiness of research processes. I felt it essential to transcribe the data as fully as possible but to omit the interruptions for baby care and the baby talk that occurred around this time. I chose to record non-verbal details such as laughter, tone of voice, display of emotions and sighs as they add depth to the meaning of data (Bailey 2008). Oliver et al. (2005) also suggests that tokens such as a thoughtful ‘hm’ or a wistful ‘mm’ can be useful markers in speech indicating participant discomfort or other affective states, e.g. happiness, distress etc. In one recording I noticed how a participant laughed loudly every time she reached a point in her story of emotive and disrupted points in her life. I interpreted this as her way of making light of the situation or of being wary about revisiting distressing times but Mishler (1991) warns against making analytical assumptions such as this. During the second interview I asked the participant about her laughter at recalling distressing times. Her explanation, revealed an entirely different interpretation to mine as a response deeply rooted in her beliefs as a Buddhist.

That the process of transcription is an iterative and reflexive one was further highlighted as I revoked the decision not to include small talk. During one lengthy interview the participant chatted about a recent episode in her life which I felt was unrelated to the use of CAM. I omitted a 10 minute section from my transcribing. Later I realised what she was recounting revealed an important socio-cultural issue. I then had to revisit two recordings to ensure I had transcribed what I previously had omitted. I agree with Tilley (2003) that the view of transcription as revealing a truthful replication of the reality of the situation is not justifiable. The transcript serves only as a re-presentation of the interview situation and not the event in itself.

My initial thoughts of transcription as a rather mundane task to be completed as quickly and efficiently as possible were also revised as I found the process thoroughly enjoyable. The digital recording was of superb quality and I rarely had to play a piece more than once to hear what was said. As my typing speed is rather slow, I had time to really listen again to participants' stories. I found myself smiling when I reached the part of the interview where there was laughter or the feeling of a shared connection. I felt the emotion again where the story told of sad times or difficult decisions or just joyous mixed emotions that come with memories of pregnancy and childbirth. The added pleasure of listening to the baby's sounds and our talk and play with the baby revealed the interview process as alive and vibrant. However, like Reissman (2008), I found my transcriptions lacked life and the dynamism I had experienced during the interviews. I felt frustrated that the transcriptions lacked the power to portray these women's stories as I had experienced them. I provided a copy of the interview recordings on CD, and a copy of the interview transcript to participants so they too could recall our interactions if they wished. The feedback from participants led me to realise the value this had for women lies in the fundamental premise of narrative research, that individuals effectively make sense of their world through narratives or by telling their story (Bold 2012). Clarissa explains:

'it was helpful to reflect on my experiences and then read through it again. I have never spoken to anyone as long and only

about myself. That felt strange but helpful. It was right what you said in the leaflet it is good to talk things through’ (Clarissa)

My experience has highlighted the benefit for researchers of conducting their own transcription as this contributes to fuller engagement with the data. I realise now that transcriptions alone cannot represent all the details of the actual event. The decisions I made about significance of the data imply I had begun the process of interpretation. These interpretations are grounded in the context of the knowledge, experience and assumptions of the transcriber (Bird 2005). The possibility of multiple interpretations is also revealed and an acknowledgement that my interpretation may only serve as one of many. I can conclude as Davidson (2009) suggests that transcription is a process that is theoretical, selective, interpretative and representational.

4.7. Data Analysis: interpreting women’s stories

There is no single approach that defines narrative analysis and little guidance in the literature or a set sequence of procedures to follow (Elliott 2005). The premise of narrative research is that of multiple perspectives, there is no single truth and therefore no correct or incorrect way of analysing text. Holloway and Freshwater (2007) suggest the differing approaches depend on the interest of the researcher and the motivation for conducting narrative research. The aim in all approaches however, is to re-create the story as told with all its variations and to explore the meaning participants ascribe to their experiences. Differing approaches can be combined and are complementary, deepening the understanding of the data. I devised a framework by considering the key recommendations from the main protagonists of narrative analysis such as Reissman (1993, 2008), Lieblich et al. (1998), and Mishler (1995, 2009). These diverse approaches are without hierarchy and are not mutually exclusive. Indeed Holloway and Freshwater (2007) suggest they can be combined to form a creative and individual analysis not confined by structures or boundaries. Recognising the necessity of a multifaceted approach I have developed a model based loosely on Lieblich et al.’s (1998) 4 dimensions of analysis, (see appendix 4). Through a reflexive and iterative process the

framework was refined and developed further as I found different ways of viewing and interpreting the data which I will now outline.

4.7.1. Reading 1. Holistic content and holistic form

Lieblich et al. (1998) suggest the main purpose of this reading is to view the story holistically; the content is interpreted in the context of the narrative as a whole. The researcher is interested in the individual and their journey to the present day. Mishler (1995) refers to this as a semantic approach to analysis which produces a chronological account of events and serves an evaluative function which reveals the meaning of experiences in the lives of participants. I also noted the holistic form or genre of the narrative. Lieblich et al. (1998:16) suggest that identification of the genre, can reveal culturally sensitive meanings and that all narratives can be classified as 'progressive, regressive or static' in terms of a life trajectory. Frank (1995) has also identified a genre of 'restitution': one in which the individual projects a future of being restored to complete health and a 'quest' genre: one in which illness is understood as significant in terms of meaning. Both of these were apparent to some extent in participants' narratives. I wondered whether I would find elements of heroes and villains, or even a gothic genre of the dark side of biomedicine against the good of CAM. This was displayed, maybe not outwardly, but certainly in the form of a lack of trust or confidence that participants had in biomedicine. The genre of narrative disruption described by Becker (1999) as one which tells of disrupted lives was most evident in participants' narratives.

Narrative researchers are also advised to search for the plot and sub plots within a story. McAdams (1997) suggests that the plot can be interpreted as the story theme which illustrates a pattern of behaviour and is concerned with what the participants want and how they pursue their objectives. For all my participants the recurring plot was one of their desires for a normal birth, a fulfilling birth experience without the need for unnecessary medical intervention. Following this reading I created a memo for each participant within the qualitative data package Nvivo. I recorded my holistic

interpretation, the genre and plot of the narrative along with my impression of the participant, (see example in appendix 5).

4.7.2. Reading 2. Categorical content

This reading focussed on the content of the narrative but separate sections were analysed without consideration of the complete story. Reissman (2008) describes this thematic approach as an attempt to generate patterns and themes. The distinction between the content analysis of narrative research compared to other forms of qualitative data is how the stories are dealt with. The text is not reduced to words or single sentences, rather stretches of talk that take the form of narrative are analysed. Both Mishler (1995) and Reissman (2008) suggest the researcher works with a single interview at a time and after the process has been completed for all interviews, themes are identified for specific issues. At the completion of this reading I had generated a number of themes, sub themes and core narratives that I organised through Nvivo, (see appendix 6).

In this reading I faced a number of challenges, not least the decisions I had to make regarding which theme a particular section of text was most relevant to. In many instances the narrative section was entered across multiple themes. Clandinin and Connelly (2000) acknowledge the tensions that researchers face as they try to avoid reductionist approaches to analysis but suggest that researchers have to learn to deal with uncertainty. Nevertheless, following this reading I was still not convinced I had fully understood what I was looking for in the interpretation of meaning. Indeed there are recognised limitations of this approach. Little attention is paid to how the story unfolds or the impact of sociological influences on the narrative. The listener’s role in the co construction of the interview is not acknowledged and there is a danger in identifying core narratives that the voice and experience of the individual are lost. Thus with recognition of these limitations I decided to undertake further readings.

4.7.3. Reading 3. Categorical form

This approach focused on the analysis of discrete stylistic or linguistic characteristics of the narrative. Lieblich et al. (1998:154) suggest that features of narrative can yield insight into the emotional experience for participants and thus facilitate interpretation of meaning. The approach centres on reading for direct expressions of feeling or non-verbal behaviour that reveals emotion. Initially I had listened to the women’s stories and read the transcriptions with an interpretation of meaning that concentrated on positive aspects. However, I experienced an epiphanic moment of insight on reading Kleinman’s (1988) work on illness narratives. I realised that meaning can be interpreted as anything that helps an individual make sense of a situation and contributes to their way of thinking about themselves and their world. In my focus on CAM I had neglected the significance of preceding or concurrent life experiences for the individual. I noticed aspects which previously I had skimmed across. I searched for individual words which could provide clues or markers of the significance of the experience such as ‘suddenly’ or intensifiers such as ‘really’, or ‘very’. In addition, Elliot (2005) recommends looking for text that breaks chronological progression or provides detailed description, as this is relevant in the interpretation of meaning. These features were apparent in the narratives particularly of women who had more than one child. The criteria of recurrence, repetition and forcefulness can also be indicative of the expression of meaning (Overcash 2003). Examples include: how Daisy used the word ‘*really*’ 7 times in one short paragraph where she described how reflexology helped her cope with the stress of exams and Clarissa’s use of the word ‘*shock*’ which she used repeatedly to describe both physical and emotional aspects of her experiences. These only became apparent in this reading.

Mauthner and Doucet (1998:128) recommend a reading for ‘the voice of ‘I’’. It highlights where participants feel and speak about themselves and can provide insight into emotions and meaning. A focus on this revealed a huge amount of feeling words and emotive description of events. The use of metaphor can also provide an insight into the significance and meaning of

an event for the individual (Kleinman 1988). Becker (1999) suggests that metaphors may help to explain bodily distress and feelings which individuals may struggle to articulate. For my participants metaphors often signified the distress they experienced within the maternity services. Caroline described how she ‘*had to fight for herself*’ to get the care she needed on the postnatal ward. Metaphors were also used to express positive experiences of CAM use: Rose described shiatsu as providing ‘a *protective cocoon*’, to shield herself from life stresses, Alexandra portrayed yoga as her ‘*haven*’. Riley also used an analogy of a household burglar to express her views of the differences between the philosophy of western medicine and that of CAM.

Mauthner and Doucet (1998) also emphasise the relational component of women’s lives as important in terms of meaning. Thus this reading also paid attention to women’s talk of significant relationships. This confirmed my impressions created during the field work that relationships with midwives were not present in participants’ narratives. There was more evidence of significant relationships with their complementary therapist. I realised I had missed so much of this in the previous readings. I was amazed how this reading providing a different lens altering my perceptions of how I might interpret meaning.

4.7.4. Reading 4. Context: socio-cultural influences

Somers (1994) suggests the cultural embedding of narratives must be considered. Individuals make sense of their lives in relation to their social context, their individual history, past events, social relations and future hopes. Frank (2000) guides researchers to look for how the story represents a world view that is typical of some people in particular social situations. Certainly most of my participants exhibited a similar world view: one of holism and connectedness and a desire for autonomy, characteristics often attributed to CAM use (Lee-Treweek 2005a). However, individuals may have many narratives simultaneously (Holloway and Freshwater 2007). With respect to my analysis: the use of CAM, becoming

a mother and career changes, all with their own story but each impacting on the other.

Mauthner and Doucet (1998) advise researchers to listen for how participants describe the structural and ideological forces that enable or constrain them. Certainly participants discussed the advantages of using CAM very differently to the professional voice of safety, efficacy and effectiveness (Ernst 2006, Shang et al. 2005, Taylor 2008). The ideological context of motherhood and of CAM, as well as structural and political issues, were indeed evident in participants' narratives and illustrated the way in which women's accounts reflect the dominant or normative view of pregnancy and childbirth. Like Lavender (1998), I found through the process of listening to and reading women's accounts, the complex and contradictory nature of these discourses was revealed.

4.7.5. Reading 5. Narrative and the co-construction of the story

During the transcribing process and whilst conducting the previous four readings, I became aware of how some of the issues relevant to narrative methodology were being played out. I decided to undertake a 5th reading looking for evidence of methodological issues, in particular the interrelated concepts of the co-construction and the social performative function of narratives. In this reading I noted: my questioning style, how I led or facilitated the development of the story, how the story was interrupted as the baby demanded attention, how this altered the flow of the story, how at times I gave my opinion, how I offered reassurance but how most of the time I just listened. Even though participants knew I was a midwife, I gained the impression they were open and honest with me about their experiences, often they told me about their dissatisfaction with the system but still were able to highlight the strengths of western medicine and of particular midwives. I also felt some connection as a CAM practitioner. On more than one occasion I needed to reassure women that I understood their language, talk of holism, energy fields, vital force and ancestral connections. I felt intuitively this encouraged them to open up to me and describe their experience in a shared language; a language that often describes concepts

that are not congruent with western scientific thought and therefore frequently dismissed as nonsensical (Quah 2003). My role as an avid and interested listener is an inherent part of the interpretative process and I am fully aware that participants' accounts and my interpretations of these may be read by my audience as incredulous or whacky.

I also paid attention to the performative function of narratives. Goffman (1959) discusses how in everyday life we project identities of ourselves to others. Certainly, the women seemed to desire to portray themselves as active, responsible, in control, individuals who are in touch with their emotional selves. I also reflected on whether my participants told their story thinking something else was at stake in what they told me and their interpretation of what my purpose was in conducting the research. I explained to them that I hoped to be able to learn from their experiences to inform midwives and other healthcare professionals about what is important and significant to women and their motivations and experiences of using CAM. Indeed participants spoke of their motivations for participating in the research in order to share their story of the positive contribution that CAM made to their pregnancy and childbirth experience. Participants convinced of the role CAM played in contributing to a positive experience of pregnancy and childbirth wanted to share this with others as Caroline explains:

'I came forward (for the research) because I really believe in the benefits of complementary therapies to my pregnancy and the birth experience. It seems important to share the experiences which were so positive despite difficult circumstances in the hope that they might help other women choose CAM' (Caroline, e-mail correspondence following second interview)

I acknowledge that my participants may have constructed their accounts differently, in different circumstances with their peers or with someone who was not a mother, midwife or CAM practitioner. In the following chapter the

culmination of my data analysis process is revealed as I explain how I decided to re-present participants’ narratives.

Chapter 5. Findings, re-presenting participants' stories

Subsequent to the analytical approach just described I considered how best to re-present participants' narratives and my interpretation of these. Just as there is no single way to analyse narrative data there is no standard way of presenting the findings. I sought guidance from the literature and explored how other eminent narrative researchers had undertaken this task. I found a number of different strategies are often adopted. Narrative researchers must find a way of dealing with large amounts of narrative data, the desire to pay attention to individual narratives and the requirement to include different levels of interpretation. Some narrative researchers (e.g. Kleinman 1988), present their findings by telling a story using minimal quotes from participants. Others amalgamate participant's accounts by providing an exemplar narrative to illustrate the main findings (e.g. Hurwitz and Greenhalgh 2004). An alternative approach is to select only a subset of participants' narratives to share with the reader. This provides the opportunity to include large amounts of the original data in the form of quotes but against the cost of ignoring some participants' narratives. I rejected all the approaches described as I felt it essential to include all participants' narratives in some way as recognition of the time and effort they made in sharing their stories with me. I also felt it important to include direct quotes from participants as for me these hold the power of the story and ensure the reader has the ability to judge the trustworthiness of my interpretation. After much consideration I followed the advice of other prominent narrative researchers such as Lieblich et al (1998), Reissman (2008) and Holloway and Freshwater (2007) and adopted a thematic approach to the presentation of findings.

However, I also felt it important that the way in which I presented my findings was congruent with the philosophy of narrative research. Thus it was essential to acknowledge how biographical and socio-cultural influences impacted on participants' narratives. The concept of temporality i.e. an individual's past, present and anticipated future, referred to as "narrative diachronicity" by Bruner (1991) is also relevant to my interpretation. Although I do so only briefly, it is important to acknowledge participants' use of CAM both before and

following pregnancy. Prior to the presentation of the main themes and again at the end of this section I address the concept of narrative diachronicity. This allows me to illustrate how participants' previous biography influenced their choice to use CAM. Additionally, how the experience of CAM use in pregnancy is influential in future use of CAM and biomedical health services.

Nevertheless, most of my participants did not recount their story in a temporal fashion rather as Miller (2000) argues it is the sequence of stories where meaning is demonstrated. Therefore, presentation of the themes follows a framework where meaning is more important rather than a logical flow of CAM use through pregnancy, birth and the postnatal period.

In keeping the analysis faithful to narrative methodology my interpretation will also focus on the concepts of narrative genre. The concept of narrative disruption described by Becker (1999:2) as a 'period of life reorganisation' which leads to anxiety and a desire to create continuity with the past, emerged to a greater or lesser extent in all participants' narratives. I illustrate with quotes from participants how this disruption impacted on their experience of pregnancy, birth and motherhood and was influential in their use of CAM. The concept of narrative disruption is then interwoven throughout the themes. It was also evident how the various CAM modalities used by participants were instrumental in helping them cope with narrative disruption. I propose an apt description of participants' narratives is that of a 'transformative genre': one which displays the potential of CAM to facilitate a transformation of ideas or ways of being in the world and achieving ontological security. Becker (1999) suggests that in coping with narrative disruption individuals reach a turning point by regaining a sense of order and establishing a future direction. I will also reason that for participants, CAM facilitated this turning point. As a way of justifying how CAM contributed to this 'transformative' genre, I give examples throughout the presentation of the findings. I also end the thematic section with a summary of the different ways in which CAM transformed participants' experience of pregnancy and childbirth.

The overarching principle in presenting participants' narratives is to reveal the meaning of CAM use in pregnancy and childbirth and fulfil the aim I set for myself at the outset of this thesis. Consequently the emphasis in this re-presentation lies in the meaning participants ascribed to the use of CAM. Primarily women's stories were those of pregnancy and childbirth. The selection and organisation of the themes was a reflexive, iterative and creative process with the intention of revealing and interpreting the meaning of CAM use. The contribution CAM made to their experiences of pregnancy was summarised by one participant as being '*forewarned, forearmed and relaxed*' (Caroline). I use these words as a framework for my analysis and the re-presentation of participants' narratives, (see Table 1, Figure 1).

In the re-presentation of participants' narratives I also aim to explore whether women's use of CAM in pregnancy can be explained by or is a response to Beck's and Giddens' concept of risk. Of particular interpretative relevance is their theory of reflexivity and my analysis will centre on whether their concepts can illuminate women's decision making in choosing CAM during pregnancy and childbirth.

To ensure my interpretation is grounded in the data, the re-presentation of participants' narratives progresses alongside my theoretical analysis and discussion rather than in a separate discrete section. Participants chose their own pseudonyms.

Narrative diachronicity	'Forewarned'	'Forearmed'	'Relaxed'	Narrative Genre
<p>Engagement with CAM prior to pregnancy:</p> <p>Narrative Genre Narrative disruption, pregnancy and CAM</p>	<p>Pregnancy, the body and CAM</p> <p>Pregnancy, the emotions and CAM'</p> <p>CAM and negotiating contradictory discourses</p>	<p>CAM: dealing with uncertainty, strengthening the body</p> <p>CAM: as a backlash against routine medical intervention</p> <p>CAM: armed with confidence</p>	<p>Discourses of risk: CAM as antidote.</p> <p>Relaxation and stress relief in pregnancy</p> <p>Fetal subjectivity: CAM as a <i>'protective cocoon'</i></p> <p>CAM in labour: choice and control</p> <p>CAM: relaxation after birth.</p>	<p>A Transformative Genre</p> <p>Narrative diachronicity Engagement with CAM following pregnancy</p>

Table 1. Findings: Narrative diachronicity, narrative genre and thematic re-presentation of findings

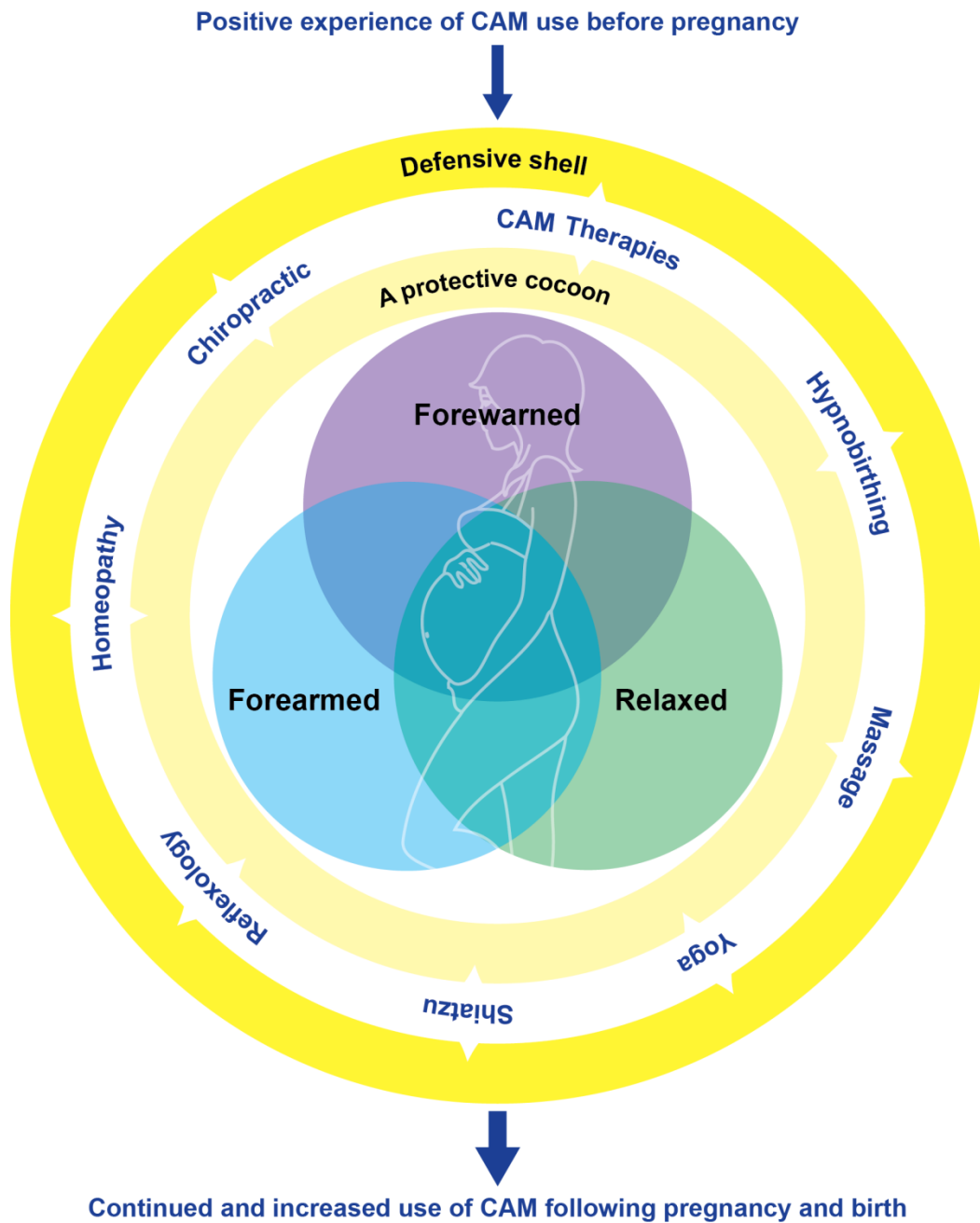


Figure 1. Diagrammatic representation of the meaning of CAM use in participants' narratives (see Appendix 7 for explanation)

5.1. Narrative diachronicity: engagement with CAM prior to pregnancy. *'I have been using therapies all my life' (Caroline)*

All participants had some experience of using at least one CAM modality before pregnancy. Their decision making with regard to choice of CAM mirrors those described in contemporary literature as complex and varied (Cant 2005). Many participants reflected on their childhood experiences as being influential in the development of their CAM practices and beliefs. Although not a consistent finding in the literature, a number of researchers have found CAM users are more likely than non-users to have a world view which supports an holistic orientation to health, interest in spirituality and personal growth (Testerman et al. 2004, Caspi et al. 2004, Saher and Lindeman 2005). Decisions to use CAM before and during pregnancy for these participants arose then as a result of deeply embedded cultural and lifestyle norms and values.

For many of the participants an episode of physical ill health or emotional stress triggered their use of CAM. A belief that CAM offered a solution to specific health problems, dissatisfaction with biomedicine or with the approach of medical practitioners were the prime motivators for use prior to pregnancy. As discussed in the literature review several sociological studies explain the increased consumption of CAM in relation to the limitations of biomedicine in relieving chronic illness and pain syndromes (Sharma 1992, Sirois 2008). Dissatisfaction was also linked to the lack of personal practices and the failure of biomedicine to take into account the lived experience of illness or pain as other research has confirmed (Foote-Ardah 2004). Participants did not conform to a dichotomous framework of biomedicine or CAM for managing their health and wellbeing, as Star suggested *'everything has its place'*. They adopted a pragmatic approach dipping in and out of a range of CAM practices and using biomedicine for what they felt appropriate. Faldon (2004) argues that this approach to healthcare suggests a 'domestication' of CAM: described as the process by which the *'foreign is rendered familiar'* such that many of the original differences between biomedicine and CAM have been abolished. However, participants in this study recognised and acknowledged the

differences between CAM and biomedicine. They expressed clear beliefs about the strengths and limitations of both and demonstrated how this influenced their choice of health care.

Erin described her use of CAM as '*being a life long journey*'. Star, Ladybird, Erin, Louise and Clarissa came to a career in CAM through personal experience of CAM use. Sointu (2006a) suggests it is often difficult to separate users from practitioners, as many users become practitioners and practitioners also embrace other CAM modalities in pursuit of health and wellbeing. Stephanie was the only participant to relate first CAM use '*in her journey to become pregnant*'. Thus all participants had experience of and a positive inclination towards CAM by the time they became pregnant. The metaphor of '*journey*' signifies that for participants their use of CAM is one of exploration, continued practice and the development of their thoughts and ideas about health, wellbeing, CAM and biomedicine.

5.2. Narrative Genre: Disrupted lives: '*now I feel more vulnerable than I have ever felt in my life*' (Clarissa)

Pregnancy for all the participants signalled a period of transition and although in a positive sense, a life disrupted. The concept of narrative disruption was evident to some extent in all participants' stories. Pregnancy, childbirth and motherhood were first experiences for Star, Caroline, Rose, Ladybird, Rachel, Clarissa, Alexandra, Daisy and Erin. All described how pregnancy impacted on their daily lives and sense of being in the world. Anxiety and worry seemed a central feature of participants' lives during these times. Individual circumstances then served to either ameliorate or heighten these feelings of narrative disruption. For example, Erin had not planned her pregnancy and faced difficulty coming to terms with her feelings around this and her ensuing troubled relations with her partner. Erin and her partner began hypnobirthing and received Theta DNA healing. Erin described this as '*more of a therapy session*' and '*a very empowering process*':

'It was a really difficult time. Having that space where we could talk about it and also a place of deep relaxation as well that helped us visualise where would we be when we had the baby. It sort of took us out of the situation we were in and gave us tools that we could use together. That was very transformative really' (Erin, 1st interview)

Erin uses the word '*transformative*' to illustrate the change in her relationship with her partner as a result of their engagement with CAM. A number of other participants referred to this notion of therapy as part of their CAM practices. Clarissa described her homeopath as '*also a psychologist*'. Rachel likened her shiatsu sessions to receiving '*counselling*'. Mackereth et al. (2009) found CAM practitioners in addition to providing their specific therapy, also create a therapeutic space which gives clients the opportunity to share their anxieties, and receive advice and support.

Even when pregnancy is planned, events may not unfold as anticipated. Alexandra struggled to deal with her feelings during pregnancy. She sought help from a hypnotherapist and began to practise yoga:

'I didn't think it (pregnancy) would be such a hormonal upheaval. It's just.... your resources are gone, you feel so exhausted with it. I really didn't expect that. I needed help, so I had hypnotherapy and I started yoga. I have never done yoga before I got pregnant ... I was more the aerobics type. Whereas, now I am the yoga fan (laughs). I couldn't imagine my life without my yoga'. (Alexandra, 1st interview)

A number of other participants talked about the unexpected impact of pregnancy on their emotions and shared their feelings of anxiety and vulnerability. Clarissa explains the origins of her vulnerability:

'now I feel somehow more vulnerable than ever before, about life and your whole existence and it's just ... all of a sudden, it wasn't just about me, it was about somebody else and you have to think about somebody else and what that means....yeh definitely nerve racking'. (Clarissa, 1st interview)

Even for second and third time mothers pregnancy was experienced as an anxious time. Norma, Caroline, Alison, Stephanie and Louise, described the emotional rollercoaster of pregnancy, birth and motherhood. The

equilibrium they had achieved following the birth of their previous children was disrupted. Riley described *'my hormones were all over the place, making me feel really vulnerable and emotional'*. Individual circumstances impacted on these feelings. Stephanie had not quite recovered from the traumatic events that followed her first son's birth and the lack of support she received with his medical condition. When she unexpectedly became pregnant for a second time she was *'terrified it would all happen again'* and on the advice of her midwife sought hypnotherapy to help her deal with her feelings.

These feelings of vulnerability match Giddens' (1991:131) description of 'fateful moments': as when 'an individual stands at the crossroads of his existence'. These fateful moments can precipitate a breach in 'ontological security'. Clarissa's comment *'that everything changes'*, the questioning of her *'whole existence'* and how she experiences having to *'think about someone else now'* signals the potential for pregnancy to threaten ontological security and to puncture the protective cocoon that usually filters out anxieties about risks and dangers.

This breach of ontological security could also be viewed as narrative disruption described by Becker (1999:2) as a 'period of life reorganisation'. This generates anxiety and stress and calls for a reevaluation of life as it is currently experienced, an apt description for participants in this study. Thus the imperative for participants in their actions was to fend off feelings of uncertainty and anxiety and seek a solution to the problems they faced. Taylor et al. (2000) propose that women manage stress by adopting strategies that protect their offspring and by seeking social relations particularly with other women. Participants sought this support, by seeking CAM, often in group settings. Erin the first of her peer group to become pregnant talked about the need to *'surround herself with other women'* who could support her through the process of pregnancy and childbirth, she chose hypnobirthing, healing and massage from female therapists. Despite Star's daily engagement with CAM, in her role as director of a natural health clinic, she *'needed someone to guide her, someone who knew about*

pregnancy and birth'. She sought this through attending a hypnobirthing class. Group practices which provide women with the opportunity to learn together and share information have been shown to increase confidence and ease the transition to motherhood (Demecs et al. 2011). As Becker (1999) argues people use cultural resources to make sense of their lives when a disruption happens. Indeed, the commercialisation of CAM has resulted in increased acceptability and availability. Participants made reference to the accessibility of CAM and also to the normative view of CAM among their peer group:

'My yoga class makes you feel you are not the only one and that it (CAM) is an acceptable thing to do in pregnancy. The yoga teacher was very good at saying have you tried chiropractic or the reflexologist. It was that kind of environment.' (Daisy, 1st interview)

Thus from early pregnancy many participants were immersed in a culture where CAM is viewed as acceptable. Participants' narratives of early pregnancy, their feelings of vulnerability and their decision to use CAM can only be partially explained by Beck's and Giddens' theories of reflexivity. As discussed above pregnancy signalled a narrative disruption, a breach in ontological security and therefore a time when reflexivity comes to the fore. Decisions women made became consciously orientated around their health and wellbeing and that of their developing baby. However, it was evident that the immediacy of risks in their everyday life took precedence over the more distant globalised risks described by Beck and Giddens.

Wynne (1996) argues that Beck's emphasis on the role of expert knowledge in reflexivity neglects the importance of an individual's life experiences. Certainly, participants made decisions to pursue CAM based on their previous positive experience and not just a weighing up of different expert opinions. Participants' experiences and beliefs in relation to CAM and biomedicine were influential in the choice of CAM. A desire for the holistic, more personal orientated approach of CAM led them to choose this option. This supports both Mythen's (2004) and Lash et al's (1996) view that an individual's values, world views and habits arise from their upbringing and

acculturation and that these are more important in decision making than conscious cognitive processes. I suggest CAM represented participants' attempts to re-establish the 'protective cocoon' and signified a turning point in their lives as they learned to cope with their feelings at this time. Additionally CAM served to *'forewarn'* participants about the potential impact of pregnancy on their physical and emotional wellbeing prompting further use of CAM.

5.3. The contribution of CAM to women's experiences of pregnancy and birth *'Forewarned, Forearmed and Relaxed'* (Caroline)

'Forewarned'

This section of analysis draws on participants' accounts of their subjective experiences of pregnancy and their responses to the emotional and physical challenges of pregnancy. Caroline's choice of the term *'Forewarned'* refers to participants' use of CAM as a way of alerting themselves to and coping with the side effects of pregnancy both from an emotional and physical perspective. The notion of *'forewarning'* also refers to participants' use of CAM as a way of negotiating between contradictory lay and professional discourses of risk surrounding pregnancy. An overarching thread within participants' narratives was that pregnancy was a prime motivational factor in their use of CAM. Riley recounted that pregnancy *'catapulted'* her to engage with CAM. Erin, already an avid CAM user described how pregnancy motivated her further and she described pregnancy as bringing about a *'crystallisation'* of her ideas about CAM.

5.3.1 Pregnancy, the body and CAM *'it just gave a sense of being in my body'* (Rachel)

All participants' narratives revealed how the physical changes of pregnancy disrupted their daily life or whole way of being in the world. Rachel's comment *'you are trying to deal with a lot of change going on in your body and each stage brings different kinds of feelings'* illustrates the change pregnancy brings to the physical and emotional body. Clarissa described

her '*whole body space being invaded*' and the development of new body awareness. Massage helped her cope with these changes:

'From the massage I felt I got a lot for me personally for my body to be treated and to remind myself that I had limbs and legs and to get myself moving and that here I am and it really helped with reducing fluid, stiff legs, aching legs and back.'
(Clarissa, 2nd interview)

Rose also found yoga was '*tailored toward all the structures in pregnancy*'. She reported feeling '*amazing*' by the end of her yoga sessions. A number of participants experienced distressing side effects of pregnancy, the so called '*minor disorders*'. This too provided the catalyst for some participants to seek CAM. Alison found much relief from her symptoms with reflexology, massage and chiropractic:

'It (massage) was so nice. I suffered terribly when I was pregnant, twitchy leg syndrome, twitches and twitches and there's sod all you can do about it and that really did help. I used to go for a full body massage but she would spend ages draining my calf muscles and thigh muscles and for the next couple of days it would be better. It was a murderous side effect of pregnancy. Then third pregnancy, oh my back was killing me. I developed appalling sciatica, my leg was such agony. So I went to see..... (chiropractor) and she cured my bad back and sciatica'. (Alison, 1st interview).

Participants judged the effectiveness and safety of CAM through their embodied experiences and relief from the discomforts of pregnancy. Stephanie used acupuncture for nausea and was convinced it had a '*real effect*'. Star gained relief from nausea and vomiting with reflexology and from headaches with cranio-sacral therapy.

It seems that women too were '*warned*' by their therapist of the risks of increasing discomforts as pregnancy progresses and further use of CAM rather than biomedical approaches were recommended. Star was informed by her cranio-sacral therapist that her pelvis had '*a slight twist*' and further treatment advised. CAM therapists recommended other therapists and often invited them to group sessions to share the benefits of their particular

therapy. These warnings that pregnancy poses a risk for the worsening of physical symptoms prompted the use of CAM as a preventative strategy and as a way of strengthening the body. Daisy, Rose and Clarissa, continued treatments throughout pregnancy and judged the worthwhile nature of this approach by making comparisons with other pregnant women:

'I went (to a chiropractor) quite a few times, a bit more regularly as I was getting bigger. Every time I went I felt a lot better. I never had to take any pain relief and I didn't have the backache when some of my friends in the yoga class were really suffering. A lot of them were saying they had really bad back pain. A few of us had been to.....(chiropractor) and we would be saying I feel a lot better you could really see the difference between people who were just having physio and not doing anything and people who were going to a chiropractor'. (Rose, 2nd interview)

Like other CAM consumers Daisy, Rose and Clarissa sought to gain mastery over their body. Baarts and Pederson (2009) argue this sense of mastery develops as individuals gain body awareness and through actively striving and taking responsibility for their own wellbeing.

The connection between bodily experiences during pregnancy and emotional wellbeing was also evident in participants' narratives. Rose described how constant back pain *'gets you down'* but with the help of chiropractic treatment she *'felt great during pregnancy'*. Rachel practised meditation and shiatsu to help her *'be aware of her body'* but recognised the impact these practices had on emotional wellbeing.

'I think because it's a hands on therapy, having that touch on the body helps you to be in your body. Often before a treatment I might have had lots of worries or concerns going on in my head so part of the shiatsu treatment definitely helped me to stay in my body rather than in my thoughts'. (Rachel, 2nd interview).

Participants intuitively sensed this connection between physical wellbeing and their emotions. They noted by attending and seeking help for their physical symptoms CAM enhanced their emotional wellbeing. As Daisy

suggested *'it (chiropractic) is the whole package'* or Riley *'it (acupuncture) ticked every box'*. Kamysheva et al. (2009) found clear correlates between depressive tendencies and the frequency and severity of physical symptoms in pregnancy. This was the case for Alexandra as her weight gain contributed to emotional distress. She sought hypnotherapy:

'The 5th month was really bad. I felt very low. I put on 5 stone in pregnancy, so I was a bit out of control. I wasn't used to that and felt really low and couldn't sleep anymore, I didn't think I would. I was really looking forward to being pregnant and when I had friends that were pregnant I would just love their tummy and think oh it must be so nice to be pregnant and then when it was my turn I just hated it. I was huge. I was so big, you can't move, you can't walk, you have backache and I couldn't turn over in bed, oh it was awful, I felt so low. I went for hypnotherapy and bought CDs. I listened to them every night and sometimes during the day. That really helped me get on top of those feelings' (Alexandra, 1st interview).

Alexandra's experience of pregnancy reveals a complex and contradictory ideology of pregnancy. Qualitative research confirms for many women pregnancy requires a significant adjustment to the way in which they view and accept their body (Clarke et al. 2010). Further evidence of a disrupted life is revealed when individuals cannot carry out their taken for granted daily activities. Alexandra's comment *'that she was not used to'* feeling out of control signifies a loss of a sense of self and anxiety that is characteristic of both narrative disruption and a breach in ontological security. In this scenario then the body becomes the primary site through which individuals strive to reorder their world (Becker 1999). Seeking CAM for the women in this study provided an on-going interpretation of bodily changes which helped them to make sense of their experiences and create continuity with the past. Becker (1999) would agree this signals a turning point in narrative disruption, and I also suggest the re-establishment of the 'protective cocoon'.

In a medicalized maternity service the physical safety of mother and baby is privileged over the lived experience. Women's subjective and embodied experiences of pregnancy and childbirth are not recognised as valid

concerns for professional consideration (Walsh 2010). Alexandra's experience highlights this point:

'The midwives they were often running late when it was my turn they are like, the blood pressure is OK, no sugar in your urine, right OK, is there anything else and you know they just want to hear no or fine and then you are out again. There were often times when I just wanted to talk to someone but never felt when I could because there was just so much time pressure on them.' (Alexandra, 1st interview)

People turn to CAM as a result of the recognition that practitioners place on emotional aspects of health and wellbeing and on their subjective experiences. Sointu (2006b) argues this recognition is important for understanding the appeal of CAM, as when listened to the individual is recognised as one whose experiences count. The limited advice and therapeutic options offered by health professionals left participants with little choice but to adopt self-help strategies to deal with their symptoms. Their concerns about the impact of pharmacological agents on their developing baby reveal a heightened awareness and sensitivity to risk, e.g. although Daisy said she knew that *'paracetamol was safe'* she *'did not want to take it'* for her back pain. Ladybird expressed a distrust of all mass produced products stating *'God knows what they put in them!'* Star's concerns epitomise Beck's thesis of distrust in institutions and science and the consequential 'reflexivity of uncertainty':

'You don't actually know all the side effects, (of drugs) you don't know the long term side effects and you don't know what goes with what. They have got their double blind trials and whatever they want to prove but I think there are lots of risks and side effects, especially in pregnancy, what do you consider safe?' (Star, 2nd interview)

Living in a world of manufactured risks, in this case both the known and potentially unknown side effects of drugs are evident in Star's narrative. As such all decisions are made with the knowledge that consequences are unforeseeable (Beck 1999). The 'precautionary principle' (Giddens 2002:32) adopted by both Daisy, Star and other participants, in their

avoidance of pharmaceuticals, is one way in which individuals avoid difficult decision making in the face of unknown risks. This precautionary approach was sometimes evident in participants' decisions to use CAM, for example, Daisy would not have used chiropractic unless it '*had been recommended by a midwife*' as she would have '*worried about it not being safe*' but few others questioned the safety of their chosen therapies. If participants did consider the possibility of the potential for side effects of CAM this was perceived as minimal, in keeping with Slovic's (2000) argument that individuals exhibit a greater tolerance of self-imposed risks compared to those imposed by others. Participants' previous positive experience of CAM was more influential in decision making than consideration of risks. For example, Ladybird was familiar with the side effects of aromatherapy oils but from previous experience she '*felt confident that it would be ok because my body is used to them*'. Taking a risk then is different to being subjected to risks by others (Lyng 2008), in this way women are exhibiting a desire for high levels of agency.

Seeking CAM as an alternative to biomedicine could be seen as symbolic of an individual's perspective of the location of risk in globalised pharmaceutical industries (Lane 2008:143). Their use could also be seen as a backlash against biomedicine and its dependence on pharmaceuticals and signify a return to what are perceived as more "natural" products (Mitchell and Allen 2008). Later I will argue that this perception of safety illustrates the role of trust in perceptions of risk and the complexity of and cultural influences on decision making.

The cognitive orientation of Beck's and Giddens' reflexivity emerges only to some extent in participants' narratives. I believe Lash's (2000: 53) notion of aesthetic reflexivity provides a deeper insight into participants' decisions to choose CAM. Aesthetic judgements according to Lash do not take place from given rules of logic, but are subjective, embodied and based on feelings and sensations. Feelings of pleasure, comfort and relief from the physical challenges of pregnancy were influential in choice, experience and continued use of CAM. As Slovic (2010) suggests perceptions of risk are

reduced when the benefits are judged to be high and the activity in itself is pleasurable. Participants' use of CAM during this time reveals participants' needs and motivation to deal with narrative disruption and the embodied experiences of pregnancy. There was an emotional imperative in participants' actions to deal with the physical challenges of pregnancy. However, there were many other factors which contributed to women's fears and anxieties in pregnancy.

5.3.2. Pregnancy, the emotions and CAM 'a dual edged happiness and most anxious time'. (Clarissa)

Clarissa referred to pregnancy as a 'dual edged happiness and most anxious time'. In this phrase she encapsulates the experience of pregnancy for many of the participants as a joyous occurrence but one which is tainted with anxiety and fear. Despite Alexandra's desire to have a child she had not anticipated the emotional impact it would have on her:

'I was desperate to have children. I got pregnant on the honeymoon so although I was incredibly happy it did all happen quite quickly. I had immediately horrendous nightmares of miscarriage, really, really bad, cried a lot, couldn't sleep, was tired all the time and that threw me. I didn't expect I would be so emotional. I had to wait 13 weeks to be scanned and only after that I calmed down a bit but obviously you hang on to the next one and what if something happens at the 20 week scan? I don't know perhaps my desire to have a child was so great that I just feared that it would be taken away from me'. (Alexandra, 1st interview)

The uncertainty and unpredictability of pregnancy contributed to Alexandra's emotional distress and led to her seeking hypnotherapy as a way of dealing with her fears. Women's worries and anxieties frequently relate to the uncertainty of pregnancy and childbirth, the fear of damage to their health or of abnormality in their baby (Maier 2010). Yet little is offered in routine care to help women cope with these feelings. Riley describes her feelings when she experienced bleeding in early pregnancy as *'the strongest anxiety I have ever felt'*. Riley expressed dissatisfaction with medical care, as a visit to her GP and an ultrasound scan which showed a viable pregnancy did little to relieve her anxiety. Riley sought support from

her kinesiologist who gave her a treatment, listened to her fears and reassured her that her body was '*strong*':

'she (the kinesiologist) was brilliant. She made me talk about what I was scared of, what might be happening and what that meant. I was sobbing because she made me face the worst possible scenario before she muscle tested me. Essentially she asked my body is this bleeding something to worry about? Is this a strong healthy pregnancy? Could this be implantation bleeding?, all those things.. She said look this is your body's response. I am not giving you any 100% answers we are just going to check in with your body and my body said this pregnancy is strong, it is going to be fine, it is implantation bleeding and don't worry. It was fantastic. I felt much relieved'. (Riley, 2nd interview)

Riley's bleeding settled and her pregnancy progressed normally. She concluded CAM got her '*though a very scary stage*'.

The context from which women came to know about pregnancy and childbirth informed their expectations, experiences, fear and anxieties. Childbirth did not hold any fear for Louise, Erin or Star. They spoke about early childhood experiences, in particular their own mothers' births, and how influential these were in giving them confidence in their ability to nurture and birth their babies. Conversely, Daisy's parents had lost two babies which she felt contributed to her feelings of being '*paranoid*' in pregnancy. Riley's first pregnancy was overshadowed by her mother's experience of traumatic and premature births. Riley herself had been born prematurely at 28 weeks gestation, and this had a significant impact on her fears:

'when I became pregnant I instinctively knew that all my traumatic experiences in my own birth were going to come up for me. The fact that I had spent my life hearing about my horrendous birth and the fact that I was so premature I am holding on to this very deep rooted fear that this baby is going to be premature and that terrifies me'. (Riley, 1st interview).

Within CAM philosophy there is an acceptance of the power of past events to impact on an individual's lived experience (Church 2007). Riley

subscribed to this belief and sought kinesiology as a way of dealing with her fear:

'During that session when he was doing the energetic bit I just got this incredible welling up of... it wasn't emotion, I wasn't going to cry. I almost thought I was going to be ill. I just felt really unsettled. I was also getting really hot and then really cold. I'd never had that kind of physical reaction to a treatment before and then it passed. He said 'I think your body has definitely released something'. I walked out of that room and I felt that a million tons was just out of me. It was incredible. He wanted me to be able to say I deserve to have a full term baby and for me to be strong and at the end of that session I was strong. I just stopped worrying; it was like the fear had really left me'. (Riley, 1st interview)

There is a recognised familial link with premature birth (Varner and Esplin 2005). However, western scientific acceptance of the primacy of DNA and genetic influences on health means there is little scope to influence the likelihood of these predetermined events occurring. CAM with its philosophy of vitalism and holism supports the theory of epigenetics: i.e. recognition that environmental factors are more important in health and healing than genetics, thus offering hope to individuals of breaking the science of pre determination (Lipton 2005). The congruence of CAM philosophy with Riley's individual experience provided her with a practice which had personal meaning and helped her make sense of and deal with her fear.

Shortly before Clarissa became pregnant she was diagnosed with coeliac disease. Although feeling very unwell she was reassured by her doctors that she would be 'fine'. However, she continued to feel:

'very stressed, really worried about the baby and just getting really paranoid about it. The nurses were saying there is nothing more we can do with you, this is just how it is and I had kind of just reached loggerheads with it' (Clarissa, 1st interview).

Dissatisfaction with what biomedicine could offer led Clarissa to CAM:

'at that point I started seeing a homeopath. It was just brilliant, a real turning point. I felt somebody would listen to me as opposed

*to being told well you know that's how pregnancy is. The first session was two hours, she looked at my whole personal history, how I had been brought up and illnesses I have had and looked at me being a coeliac because that was freaking me out. I know it's an autoimmune disease and I wasn't sure why it happened at that point in my life or what that means for me and so we talked a lot about things, which in itself was really helpful. Then she gave me a remedy and I just started to feel so much better within a month of seeing her. I mean, physically, mentally, everything started getting stronger so yeh seeing the homeopath was just **fantastic.**' (Clarissa, 1st interview).*

For these participants their family and personal history were significant factors in risk perception. Contrary to Beck's and Giddens' view that individual concerns are focussed on global dangers participants' perceptions of risk were situated within the context of their personal experience and daily life. The anxiety they experienced was multidimensional and influenced both by unconscious and conscious processes. Thus Beck's thesis of collective and universal anxiety is not confirmed.

The limitations of Beck's realist position on risk is revealed as the perception of risk displayed by these participants was highly variable and influenced by many factors. Psychological studies have identified that individuals overestimate risk if they can easily imagine it happening to them or is of high impact (Slovic 2010). Death or damage to the mother or baby during pregnancy would fit this category. Lupton (1999b:20) argues that in contemporary society increased expectations and advances such as genetic engineering mean the risk of anything less than the perfect child becomes unacceptable to society. This heightens anxiety for women who shoulder the burden of responsibility for the health of their baby. For participants in this study, science and medicine did not provide the certainty or reassurance they needed. Riley's lack of faith in the ultrasound which demonstrated a viable pregnancy, Alexandra's comment that ultrasound provided her with reassurance but only for a short period of time, and Alison's rejection of screening for Down's syndrome as she is well aware

'that no-one is going to come along with a white coat and tell you your baby is perfect' reveals a scepticism of science and technology.

Beck and Beck-Gernsheim (2000) argue that the debate over whether risks are real is not important; of more relevance is an individual's perception of risk and how it impacts on their life. As Riley's experience echoes, for her the risk of preterm birth may have been minimal but her perception of that risk was great. The uncertainty over the viability of her pregnancy was perceived as fear. Indeed, Smithson (2008:211) points out 'we do not just think about uncertainty we **feel** uncertainty'. Nevertheless, real risks can arise at any time in pregnancy or childbirth that could threaten the health of the mother and baby and this uncertainty played a significant role in generating participants' levels of anxiety.

For the women in this study the joy and positive aspects of pregnancy are negated by the physical challenges, the unpredictability and uncertainty of pregnancy and childbirth. The emotional roller coaster of pregnancy signifies narrative disruption and creates chinks in the 'protective cocoon'. The person centred approach of CAM provided participants with a way of dealing with their emotions. CAM also offered hope to participants by addressing emotional states and coping strategies that contribute to wellbeing (Zollman and Vickers 1999). Giddens (1991) suggests hope offers a protection against constant anxieties. For participants then the use of CAM facilitated a transformation in their levels of resilience during times of stress.

5.3.3. Negotiating contradictory discourses, '*they are an antidote to what is given to us*' (Riley)

Most of the participants viewed pregnancy and birth as a normal event in their lives, but experienced a medicalized approach to care. In contrast, CAM practices reinforced and supported their view of pregnancy and childbirth as a natural event.

'I don't think pregnancy is a medical issue. I don't think you are ill. I don't think it's a disease. I think that things can go wrong and you need to put on services as and when they do. You get monitored so closely in this country you can pull out what the issues are and try and deal with them but I think it seems to be taken over by the medical profession'. (Star, 1st interview)

However, some participants harboured a fear of childbirth and for these participants their beliefs in the normality of pregnancy and birth grew through their experiences with CAM. A childhood experience of a sex education video left Stephanie '*traumatised*' with a deep fear of childbirth. With the help of acupuncture, hypnobirthing and hypnotherapy Stephanie reviewed her beliefs about birth and came to a realisation that:

'I could be in control or I could be done to and I realised that if I went into hospital with everything I heard is that my labour would be managed and the intervention is there and you have no control in the matter'. (Stephanie, 1st interview)

Stephanie achieved a normal birth in a birth centre with both of her children. A number of other participants felt the media portrayal of childbirth contributed to their general anxiety and fears about childbirth as Daisy tells '*I have always been frightened about giving birth especially what you see on the TV and how it's a scary thing*'. Her attendance at antenatal yoga class introduced her to the concept of childbirth as a natural process. Below she explained the development of her beliefs in normal birth and the imperative to avoid medical intervention:

*'Just to be told, it doesn't have to be a medical event. It's a natural thing and your body knows what to do, it's a really good message. I think that really made a difference to my pregnancy. The class (yoga) I went to was very much about avoiding medical intervention when you can. If you get induced you are this more likely to have a medical intervention, more likely to have a caesarean that sort of thing. I hadn't really thought about it much. I **really** wanted to have a natural childbirth. I wanted to experience that for myself rather than having a caesarean, forceps all these sort of things'. (Daisy, 1st interview)*

For Stephanie and Daisy their subjective experiences of pregnancy were shaped by the social context of contemporary society which dramatizes

birth and assumes women are unable to cope with childbirth without medical intervention. For some of the participants CAM treatments provided them with an opportunity to review their fears and anxieties and come to an acceptance of childbirth as natural and one in which their body is entirely capable of achieving. Thus CAM discourses 'warned' participants of the risks associated with medical intervention. Riley summarised her belief in the role of CAM:

'they (CAM) are an antidote to what is given to us which is a lot of fear. If we didn't live in a world where it is suggested that you can't have a baby without an epidural unless you are mad then you probably wouldn't need all of those things. Most people think you are kind of crazy to have a baby without pain relief or it's going to hurt so you would rather have a c. section'. (Riley, 2nd interview).

There were many other examples of how CAM modalities supported women with negotiating contradictory discourses and in helping them pave their way through a medicalized system. Some participants actively avoided expert advice with its medicalized bias. Erin and Star made a conscious choice not to attend midwife led antenatal classes as they felt the approach was too medicalized:

'It was standard. It was what pain relief are you going to have? It already assumes that you need pain relief. I am not even convinced that most women didn't realise there is another way. If they had gone to their first antenatal appointment and NHS class and they said what pain relief do you want?, that's already set the route up, that's already gone oh I am going to need that, that and that and they haven't even considered it, and some of them give birth really easily and they haven't even considered the possibility they didn't need anything. They weren't offered that in the first place'. (Star, 2nd interview)

CAM practices such as hypnobirthing and yoga enabled participants to prepare themselves for labour and birth in a way that was congruent with their values and beliefs. As Riley explained CAM '*opens you up in a very powerful way to something that your body is capable of*'. Indeed the strategies used particularly in group CAM practices are those identified

by Nolan (2009) as that which would be considered best practice in antenatal education.

Other participants avoided hospital birth. Erin, Clarissa, Riley, Star and Rachel all planned a home birth. Stephanie chose to have her baby in a midwifery led birthing unit. Her fear of childbirth was exacerbated by stories she had heard about her local maternity hospital:

'the horror stories, managed labour, slicing and dicing. If you're in labour, if you don't give birth in 7 hours you will get a section and that you are forced into routes that you don't want to. Everybody I knew ended up with a section, absolutely everybody. I don't know of one person that has given birth naturally in the ...'(local trust). (Stephanie, 2nd interview)

Erin reflected on the fact that it is difficult for women to tell positive birth stories for fear of being '*smug or self-satisfied*' and that there seems to be '*something in connecting with other people through a shared trauma which means that those are the stories that get circulated*'. Becker (1999) would agree that distress seems to be the major organising factor in the way life stories are told. Pregnant women thus are exposed only to stories of difficult and traumatic births. Attendance at group CAM sessions meant women were in the company of other women with similar beliefs and desires to achieve a normal birth.

Participants' experience of these contradictory discourses contributed to their anxiety and a lack of trust in professionals. Beck (1995) acknowledges the role of the media in conveying risks to the public and heightening anxiety. In this way he modifies his realist stance to include a sociological perspective which recognises the cultural influences on risk perception. Participants' narratives however, reveal a more complex multi-layered and dynamic perception and response to risk. Participants' perception of risk was heightened by their life experiences, the media, by other women's stories and by the medicalized approach to care. These collectively serve to amplify the risks of pregnancy and childbirth. Conversely, engagement with CAM seems to ameliorate perception of risk. This transformation of risk

perception emphasises the essential dynamic and symbolic character of risk understandings and the transformative power of CAM.

The change in risk perception illustrated by some participants may not solely be attributable to individual reflexivity. It seems that when participants accessed group therapies such as yoga or hypnobirthing they became part of a reflexive community, such as those described by Lash (2000:47). It could be argued that group CAM practices constitute reflexive communities: encouraging their participants to critically engage and challenge institutional risk practices such as those of medicine and the maternity services.

Participants' actions, in opting out of NHS led antenatal preparation classes and avoiding hospital birth, constitute risk avoidance strategies. Their action is contrary to the view that risk avoidance strategies merely signify the 'fearful' and 'neurotic' response of individuals in the risk society (Beck 2009, Furedi 2004). Unlike others who give up their ideals and submit to the oppressive and controlling power of the institution and its discourses of risk (Edwards 2009), participants actively pursued their hopes and dreams through their CAM practices. As a result of engaging in CAM a transformation in participants' ways of thinking and beliefs regarding their ability to birth their babies without recourse to medical intervention emerged. This reflects the creative agentic individual described by Beck (2009). As Caroline suggested women's use of CAM served to '*warn*' them of the risks of medical intervention and thus '*to be forewarned is to be forearmed*'.

5.4. Forearmed: '*knowledge is power*' (Caroline)

As discussed in the previous section a philosophy of the normality of pregnancy and childbirth seemed to permeate CAM practices that participants engaged with in the antenatal period. A major underlying premise of this philosophy is that physiological processes work better if undisturbed. The avoidance of unnecessary use of technology or medical intervention is viewed as a significant risk reduction strategy. The social, emotional and spiritual

health of the mother are seen as important contributing factors to achieving a normal birth experience. In this section I will argue that for women the main tactic adopted in reducing risks and ensuring a positive birth experience focussed on preparing or '*forearming*' themselves with a number of tactics and tasks to help them achieve the birth experience they desired. Thus, use of CAM became a strategy by which they could symbolically '*arm*' themselves to fend off unwanted and unnecessary medical intervention and arguably, more importantly, defend themselves against the fear of such interventions.

5.4.1. CAM and strengthening the body: dealing with uncertainty, preparation for labour: '*you are never going to know what it feels like until you are actually in it*' (Erin).

With the exception of Norma and Alison the significance of CAM use centred on preparation for childbirth. Participants had high expectations for their births so the antenatal period became a time to prepare and strengthen the body in anticipation of labour and their hoped for normal birth. The uncertainty of how labour would progress and the inability to predict the outcome motivated women in their desire to be prepared and '*armed*' for what they may face, as Erin explained it is like '*stepping completely into the unknown*'. Riley's existential questioning reveals that for her pregnancy was as Giddens (1991) describes a fateful moment and one which has the potential to breach ontological security or contribute to narrative disruption:

'I was so clear what I wanted but also because you have no idea what is going to happen. Your body is about to go through something and you have no idea can it? will it?, will it go well?, will I be one of those lucky women who just breathe this baby out?, will I have some horrendous hospital experience?, will it be traumatic?, Will I be the same?, will I recover from this? I mean you go through every question in the world'. (Riley, 1st interview)

This uncertainty has a profound effect on women. The resulting fear and anxiety impact on their confidence to birth and prompted women to seek a range of CAM modalities which offered a sense of security and a way of influencing the future. A philosophy of active participation and preparation in order to strengthen the body, mind and spirit for the work of labour was

integral to all the therapies women engaged in. As Riley indicated '*all of it (CAM) was motivated by my desire to have a home birth and to have myself emotionally and physically prepared as possible*'. Ironically, although participants subscribed to the belief in the naturalness of childbirth, it was also seen as something that had to be anticipated, planned and prepared for. The effort women made in their preparations was enormous. Caroline viewed labour as a challenge:

'I felt it was a real challenge like running a marathon. It was something I was preparing for more mentally for 9 months and I wanted to do everything in my power to experience a natural birth'. (Caroline, 1st interview)

Practices such as yoga and hypnobirthing teach self-help techniques of breathing, distraction, visualisation, positions to adopt in labour and provide the opportunity to practice these techniques. Thus participants explored what labour may be like and how their actions could help them cope with the pain of labour. As Caroline explained '*it is like a rehearsal for childbirth*'. Clarissa found yoga prepared her for labour:

'fantastic preparation for labour. It helped me know how labour might be and what to expect from it, how long things might go on for and lots of practical tips like how you might use your body or if labour got too much to get into one position that could stop labour just to give you a bit of a breather. We practised different kinds of birthing positions. We practised some chanting which I thought at the time, this is ridiculous there is no way I am going to be chanting when I am in labour. I am going to be screaming like you do (laughs) but actually it was fantastic'. (Clarissa, 2nd interview)

The rehearsal for the event of labour gave women a sense of '*confidence*' (Alexandra) in their body and ability to birth. Clarissa found them '*so empowering*'. Caroline felt '*lucky*' to have practised these techniques as she believes they were instrumental in helping her labour to progress. However, despite all the preparations women undertook, there was always an undercurrent of fear and uncertainty that events may not go as expected. Participants turned to CAM to help deal with these emotions:

'I knew exactly what I wanted but it is also scary to know it might not happen. I know how easy it is not to happen and I didn't want to set myself up as horribly disappointed. I was investing a lot into how I wanted my labour to be. I was going to yoga every week, I was having acupuncture once a week and reflexology with a friend and then I saw this kinesiologist because I knew different emotional things were coming up.'
(Riley, 2nd interview)

Some CAM modalities prepared participants for the emotional and spiritual nature of childbirth. Therapists emphasised the importance of the individual, their desires and choices being central to their practice. Riley recounted the experience of inviting a herbalist to her home to discuss her preparations for birth:

'She said 'how do you want to bring your child into this world?' and I just started to cry. It was like 'oh that was up to me, I get to decide that' and it is so empowering and it is so powerful and she just talked to me for half an hour. It amazes me that nobody asks, nobody asks that question'. (Riley, 1st interview)

The potential for CAM in transforming women's experiences of birth is reflected in a philosophy which places the woman truly at the centre of care, where her needs and that of her baby transcend all others. CAM philosophy recognises the spiritual nature of birth and the significance of birth in women's lives. During the last 10 days of her pregnancy Riley described herself as being in '*major preparation mode*' for her anticipated home birth. A friend helped her prepare the birth room, cleansed it with sage and put crystals in each corner. Riley's use of sage and crystals symbolised a cleansing of the birth room and for her '*mindfully creating a place that is safe*'. This sense of safety in place of birth is vital for women to experience normal birth (Lavender and Kingdon 2006). Riley described feeling emotionally and spiritually ready for her birth only after she had experienced a form of visualisation meditation called shamanic journeying. On this shamanic journey Riley was to meet her '*spirit guide*' and she was to ask her spirit guide to '*show me the birth mother, show me the universal element of birth*'. She recounted the experience emotionally:

'I was needing her (grandmother) in order to have this baby and so that was just incredible like oh here you are, you are my spirit guide and then I was literally whisked out and we started to climb...so the next thing I know we are flying over the ocean and it was an amazing, amazing view of the ocean ... I was visualising the ocean spread out and then come in and spread out and come in and I realised that that is birth. That is the nature of birth, it surges and its waves and also the energy of birth is always there, it is essential to our existence. To have that energy you have to allow yourself to connect to that energy.

M. Did she talk to you?

R. No, not at all she was literally just showing me, she was like look at this. Then the music stopped, the drumming stopped. I just went right back the room and this whole time I wasn't emotional at all. I was just like wow and then I started crying like I had never cried in my life. It wasn't sadness. Like I don't feel sad now it's just the overwhelming emotion and it just took me over and I sobbed and then I started laughing (laughs), hysterically laughing. I went from crying to laughing to crying in their most powerful states. It wasn't like someone told me a joke it was like I was crying and laughing something out of me. I just felt like all this weight and tension was gone. I felt like my arms were touching the floor and I felt that way up until the day I had .. (baby). I felt that I released something so intense. I don't know what it was. It's not like there was something bad in me I just had this experience that really overwhelmed me and in a quite positive way. That journey needed to happen for me in order to have the labour that I had with him which was phenomenal. It was just..., I could not have had a better experience'. (Riley, 3rd interview)

The holistic nature of CAM is revealed in its focus on recognising the emotional and spiritual nature of birth and birth preparation. Riley's story would easily be dismissed by some as incredible. Yet for Riley her Grandmother had played such a significant role in her life this meeting of her in 'spirit' was a turning point in her confidence to birth.

The greatest challenge participants had to deal with was the uncertainty of labour processes and outcomes. The risks they faced were both inevitable, e.g. the pain of labour and potential, e.g. prolonged labour or fetal compromise. In this respect women's perception of risk differs from Beck's and Giddens' focus on manufactured risks. Nevertheless, for participants

both inevitable and potential risks create the desire to reduce and control uncertainty, and in seeking CAM they reduce the likelihood of these risks occurring and strengthen their ability to cope. Participants' struggle in dealing with uncertainty is evident. It could be argued their desire to seek such control over their labour and birth has led to a reliance on just another form of expert. These women display a knowing scepticism in obstetric science and believe the medical approach to labour management has created more problems than it has solved. Thus individuals are compelled to find different solutions to dealing with uncertainty. Both Beck (1999) and Giddens (1991) would agree that individuals still require and are increasingly dependent on expert knowledge to guide their daily lives. As discussed previously women acknowledge this need for guidance but CAM practitioners are a different kind of expert compared to those they encountered in the health service. Caroline '*didn't know anything about childbirth*' she consciously chose a yoga practitioner who had five children was '*very practical and knew a lot about childbirth*'. She reflected that '*probably in the past we would have relied on our mothers, now it is up to us to find that information*'. Participants demonstrate agency in seeking this support for themselves.

The focus on rehearsing for the real event is an attempt to make the uncertain more certain, the unpredictable more predictable, thus reducing anxiety and fear. Caroline reported '*without this preparation I would have been terrified*'. Women respond to the uncertainty of pregnancy and birth in a variety of ways, some abdicate responsibility for decision making to professionals, readjust their expectations or engage in preparatory activities (Dahlan et al. 2010). For participants in this study, engaging in CAM is their personal solution to dealing with the uncertainty of pregnancy and childbirth and provides solace in a way that biomedicine cannot. CAM offered a way in which participants gained a sense of control and mastery of their own bodies. This mastery extends to controlling the feelings associated with uncertainty and mobilising all their resources, physical, emotional and spiritual, in preparation for the event of labour. These desirable emotions of

control and agency empower women and contribute to a sense of psychological wellbeing.

Smithson (2008) argues without uncertainty there are no choices to be made, thus uncertainty about the future stimulates creativity and opportunity. For participants, the uncertainty of pregnancy and childbirth acted as a positive motivational force in seeking CAM. However, some would argue that participants' use of CAM, including Riley's use of herbs, crystals and shamanic rituals constitutes superstitious and non-rational practices (Beck 1992a, Goldacre 2007). Moore and McClean (2010) agree that such practices are often viewed with derision and suspicion having no place within a scientific paradigm. Giddens (1990) is not so dismissive, but suggests superstitious practices are secondary to rational decision making. Participants' spiritual practices illustrate their way of finding meaning and purpose to childbirth preparations, but represent a different way of seeing the world than Beck and Giddens describe. I agree with Heelas et al. (2005) and Baumann (2010) that superstitions and rituals may be more significant than we realise, providing a sense of security and perception of being in control, particularity over events which are essentially uncontrollable.

Women's decision making in seeking CAM as a response to the risk of childbirth are akin to Lash's (2000) aesthetic reflexivity. The transcendental questions that arise when individuals are faced with risk and uncertainty (e.g. those of Riley's) demand actions and decisions where meaning is more important than logically assigning simple good and bad associations to risk. The sense of safety and confidence participants develop as a result of their CAM practices results in feelings of ontological security. Thus women's use of CAM served as a meaningful strategy to defend against inevitable and potential risks and gave them the ability to '*arm*' themselves physically, emotionally and spiritually for the work of labour and birth.

5.4.2. CAM as a backlash against routine medical intervention '*gently bringing things on*'

Despite the extent of women's preparation for birth some participants found their plans and hopes for a normal birth thwarted before labour even commenced. Medical intervention offered routinely such as induction of labour for prolonged pregnancy was a significant source of stress for many women. Fear of induction was linked with the knowledge that, as a result of labour being '*forced*', there would be greater need for further medical intervention. Women were well aware of these risks: they had been '*forewarned*' of them by CAM practitioners and this procedure was seen as producing unacceptable risk for themselves and their baby as Clarissa explained:

'I suppose the threat of induction was fear about how induction can escalate into needing other drugs and things like that. That induction is forcing the body into something that it's not quite ready and that sets off a whole load of other problems, whereas going into labour naturally seems to be, well you are ready for it, baby is ready for it.' (Clarissa, 1st interview).

There is much debate in the literature about the risks of prolonged labour and the induction process itself. The evidence divides professional opinion which many of the participants became aware of in their consultations with doctors and midwives. However, what is missing in the scientific debates about induction of labour is how '*the threat of induction*' impacts on a woman's belief about her ability to birth. When Clarissa did not go into spontaneous labour and she was offered induction she began to question herself:

'I felt like I would have failed and I wasn't susceptible enough in my body or my body wasn't open, and under treat, under threat, that ... sort of motherhood thing, under threat, because I will leave.... (baby) open to things or somehow making me feel not like a woman. It was really stressful trying to work out if we weren't just avoiding induction just because of this.' (Clarissa, 1st interview)

The repetition of '*threat*' in Clarissa's narrative reveals the impact of medical discourses on her psyche, her femininity, as well as the concerns about

physical risks to herself and her baby. Given their continuing positive experiences of CAM, it is not surprising participants sought advice and support from a range of CAM therapists to help them achieve what they considered was a safer option for themselves and their babies. Like many other CAM users scientific evidence was not considered a priority (Foote-Ardah 2003, Evans et al. 2007). Participants did not seem to be concerned with the lack of research evidence or the lack of medical support preferring to accept the therapy based on their own risk assessment and subjective judgement of efficacy. Stephanie was '*absolutely convinced*' that acupuncture was successful in stimulating the onset of her labour. It seems for these women induction of labour has become the symbolism of inappropriate medical intervention which a philosophy of natural childbirth opposes. Participants felt this '*threat of induction*' and subscribed to the belief that it is better for labour to start naturally. Paradoxically they all took proactive CAM approaches in the hope of getting their labour started. Rather than questioning the need to induce labour beyond term women sought CAM as a more natural means of achieving the onset of labour. Women do not consider prolonged pregnancy to be a medical problem in itself but feel pressurised by maternity carers who must conform to policies and procedures (Westfall and Benoit 2004). In rejecting medical advice participants felt compelled to act as they took the weight of responsibility for their decisions and actions as Caroline explained:

'they (doctors) have to tell me what the risks are but it's my decision. They are not held responsible if I choose not to go with the induction and he is stillborn'. (Caroline, 2nd interview)

Thus for participants CAM also provided emotional support and a way in which the anxiety associated with this responsibility could be coped with. Below Clarissa described the support she received from her homeopath:

'I saw the homeopath a few days after he was due and we looked at why that might be, so we started on homeopathic remedies. I was in contact with her every other day and then it became every day, just gently bringing things on. Seeing the homeopath and being in constant contact with her coming out of that meeting (with doctors) and speaking with her. She was just

so encouraging with going along with how I felt as I was so scared to induce and then regret induction'. (Clarissa, 1st interview)

Pregnancy was not prolonged for Daisy, Alexandra, Stephanie, Ladybird and Riley. However, they accessed a range of CAM modalities such as reflexology, acupuncture and herbal products to support the onset of spontaneous labour and reduce the likelihood of induction. For this group of women choosing CAM modalities to support the onset of labour illustrates a backlash against routine medical approaches. Participants preferred to take control of the situation and be active managers of their own pregnancies rather than as Westfall and Benoit (2004) conclude 'disembodied subjects of medical intervention'. The discourses of medicalization and of risk are powerful, opting out or resisting the advice of medics causes anxiety, fear and guilt (Heaman et al. 2004). CAM became a strategy to help them cope. Feelings of guilt were assuaged by being proactive and also as Rose described, '*doing everything possible*' to achieve the desired result.

For other participants, their desire for a normal birth was curtailed by the routine medical approach to managing birth when the baby lies in a breech position. Alison, Caroline and Ladybird sought CAM when they found their baby was lying breech. Alison believed reflexology was successful in turning her baby and for Caroline acupuncture achieved the desired result. Ladybird had a successful external cephalic version (ECV) but attributed the success of this to her work with the acupuncturist.

When Rose's baby was discovered to be in a breech position she was devastated as she had planned a home birth. She was informed that *she 'would have to have a caesarean section'*. Rose's immediate response was to reject this advice. She reflected on this choice as '*obvious*' as she was firm in her belief that there would be '*another way to do it*'. Determined to do everything she could to ensure a normal birth she practised specific physical exercises designed to facilitate the turning of the baby. She used meditation

and visualisation: techniques learned from hypnotherapy and she sought treatment from an acupuncturist, an osteopath and a chiropractor but without effect. Subsequently an ECV failed and Rose later had her baby by caesarean section. There is little evidence of reflexive calculation in Rose's behaviour and a sense of desperation was tangible in her frantic attempts to try as many therapies as possible to help achieve the home birth she desired. Rose explains she would try *'anything if there was a chance it would help'*. Sharma (2003) also refers to this notion of desperation in seeking CAM. However this rather negative connotation to CAM seeking behaviour is ameliorated when users describe how their actions contribute to their internal sense of identity, of being proactive and in control individuals. Reflecting on her experiences of CAM Rose felt:

'It makes you feel better doing it, you are thinking if there is a chance that this could work you should try it. I felt like I had done everything that I could, everything in my power. There is a part of you that thinks it might not work. It's just if you don't do it then how can you even know?' (laughs). (Rose, 2nd interview)

The events playing out in their lives were of such significance, in terms of personal meaning, that frequently they were unable to see beyond these. Rose described becoming so *'fixated with 9 months of pregnancy'* that she found it was impossible to see beyond the pregnancy and birth and likened it to *'living in a bubble'*. This she felt was significant force driving her CAM use:

*"we get so engrossed in it that we are willing to participate in anything that we feel could be beneficial, including and especially complementary therapies. We think that anything we do has to be worth it even if we see a result or not. It's not that 'we'll try **anything**' as it's always with the best interests of the baby in mind.'* (Rose, 2nd interview)

Participants' rejection of induction and caesarean section because of the risks (NICE 2008b) is demonstrative of reflexivity described by Beck and Giddens. Women recognised the limitations of the 'scientific evidence' favoured by professionals. They appreciated the generation of scientific

knowledge did not take into account personal or cultural circumstances.

Caroline realised the impact of risk on professional advice:

'the culture of litigation is lurking there somewhere and they have to tell me what the risks are but it's my decision.'

(Caroline, 2nd interview).

Participants made reflexive decisions in a rational manner, weighing up the pros and cons of induction, reading widely, including accessing professional literature. Caroline, for example, knew the statistics for the increased risk of stillbirth in prolonged pregnancy. Participants also incorporated into their decision making strategies deeply held values and beliefs in relation, both to a scepticism of expert knowledge, and their belief and trust in their own bodies. Participants made decisions about CAM that were relevant to their social and situational context. In many instances their actions reflected a road less travelled by others or an outright rejection of standard care or medical advice. This is more reflective of the characteristics described by Zinn (2008b) as 'in-between' i.e. both rational and non-rational, strategies that people use in everyday life to make decisions in the face of uncertainty. A combination of both approaches to decision making is viewed by Zinn (2008b) as an important coping strategy, leading to more effective decision making. The social construction of risk is also revealed in that CAM practices too take place within a cultural context. The discourses of natural, the emphasis placed on listening to the body and the importance of 'being in control' all take place within the particular paradigm and epistemological beliefs of CAM. Adam et al. (2002:10) would argue risk is thus 'repositioned' within this framework. I suggest this 'repositioning' of risk illustrates the transformative power of CAM.

The pervasiveness of risk discourses entered these women's consciousness to compel them to act even though for some that risk was not a reality. For participants, the risks of induction and unwanted medical intervention were omnipresent, the possibility of induction or caesarean section was viewed as the catastrophic event to be avoided. It is the perception of risk that is viewed by Beck as threatening, as he suggests *'the*

staged anticipation of catastrophe obliges us to take preventative action' (Beck 1999:90). Beck (1999) suggests in this kind of scenario reactions frequently are of denial, apathy or transformation. However, participants in this study did not deny the risks or become apathetic instead they transformed their experience by seeking CAM.

Notions of agency are evident in the self-authorisation of participants as they seek a solution to their problem. Participants were persistent in their attempts to prevent unwanted medical interventions. However, the success of CAM in solving women's problems was not guaranteed. Rose described the stress and the financial cost of her efforts but doing nothing was not an option. As Lupton (1999b) suggests in the contemporary world fate has lost its power and is replaced by self-responsibility, planning and risk avoidance. Rather than allowing nature to take its course, seeking CAM is viewed as a way of taking this responsibility and being proactive in avoiding risk. Rose felt she had *'done everything in my power'*, so only then are the risks accepted as fate, the individual no longer in control of them.

Participants demonstrated the critical reflexivity that Beck and Giddens refer to. Their growing consciousness of the risks of biomedicine developed through CAM practice, aided by their high educational status and relative affluence facilitated their choices. Participants demonstrated their autonomy by actively pursuing CAM. Indeed, Pavey and Sparks (2008) highlight the contribution of autonomy to psychological wellbeing; hence the effects of ontological insecurity and narrative disruption are attenuated. Psychological wellbeing was also evident in women's expressed feelings of confidence in their decisions and choices.

5.4.3. CAM: *'armed'* with confidence and feelings of *'being in control'* (Rose)

Participants recounted how their CAM practices supported the philosophy of birth as a natural event: one which the female body is well designed to do. As a result of engaging in these practices a growing confidence and a transformation in their way of thinking emerged. Daisy recounted how a

serendipitous attendance at yoga classes because she thought it would help with her back pain became *'the single most valuable thing I did in pregnancy'*

*'That class was very much about pregnancy being a natural experience and not something to be frightened about and how it can be over medicalized. It took me from being frightened about childbirth to thinking of it in a completely different way'.
(Daisy, 1st interview)*

Stephanie who earlier I described as having an intense fear of childbirth, outlined a transformation in her thinking as a result of her engagement with hypnobirthing:

'I went from... I am going to have to go to hospital and have an epidural to actually there is no way I am going there to have this baby, there is nothing that would make me go. It was that big a swing for me'. (Stephanie, 1st interview).

Stephanie achieved her birth in a community birth centre and described it as *'just perfect'* and *'confident to do it all again'*. Engagement with CAM practices that espouse a philosophy of normal birth and active birth preparation seemed to enable women to reflect on their pre-existing beliefs and assumptions about medicine and childbirth. They came to a new acceptance of the naturalness of birth and an increase in confidence to achieve a positive birth experience at the same time as growing recognition of the limitations of biomedicine in supporting normal birth. Riley eloquently summarised her beliefs about the role of medicine in childbirth as *'science is our salvation and our destruction'*; this is the very core of Beck's and Giddens' thesis of the risk society:

'modern science reveals the role of chemicals and hormones and how the more you allow the body to do what it is capable of the less intervention you need. Science has discovered how the body works, so the less we need medical intervention. But technology provides so many possibilities and if it is there why wouldn't I use it? So there is a real tension between what science knows on a chemical level and what technology makes available to us'. (Riley, 2nd interview)

Confidence in their decision to use CAM was also reflected in that participants did not share their practices with midwives or doctors. Daisy thought '*it was none of their business*'. Those that did disclose their CAM use were often treated with derision. Erin asked her midwife not to use the word '*pain*' but the response was laughter and an unsympathetic retort '*don't be so silly, you are going to be in the worst pain of your life*'. Caroline mentioned to her midwife that she was using homeopathy and reflexology in an attempt to get labour started, she remembers '*a snort of derision*'. However, confident and convinced with their CAM practices participants, seemed immune to their criticism, as Riley explained:

'If somebody can't understand it, then it is their problem. You either have to open yourself up to these things or not and if you don't you are the one who loses out'. (Riley, 2nd interview).

A growing acceptance and confidence in CAM philosophy was also evident in participants' narratives. The benefits women experienced led to a transformation in their beliefs about CAM. Norma described CAM as '*the wisdom way of medicine*'. A number of participants like Alison described herself as initially '*very sceptical*' but because her therapy '*worked*' she became '*convinced*'. '*The proof of the pudding*' was a phrase used by many participants to indicate how they judged the benefits of CAM.

Various CAM modalities helped women become more attuned to their intuitive feelings. Practices such as yoga, shiatsu and meditation accentuate the connection between the mother and baby and emphasize the importance of intuitive knowledge (Yates 2003). The role of intuition is viewed as a legitimate way of knowing. This gave participants confidence to respond to their intuitive feelings. The significance of this for Clarissa is illustrated below when she talked about rejecting medical advice to have labour induced:

*'to me the way he was going to be born into the world was **really really** important, to them it doesn't matter much as long as he is born and is OK, that's their main emphasis. So seeing the homeopath really just gave me confidence in myself and*

*my instincts about trusting my instincts and do what I needed to do, so it was **really really** helpful in that way cause the medical profession think that instincts don't really come into it at all, that's the last thing they think about.... instincts can't be trusted'. (Clarissa, 2nd interview)*

Biomedicine was seen to be lacking as it offered solutions which were not in keeping with the individual's insights into their own condition. Although Caroline was not convinced that reflexology worked she gained support for her intuitive feelings that her '*body was just not ready*'. Caroline commented on her decision to reject medical advice for induction of labour as '*I was just doing what felt right*'. CAM '*armed*' women with the confidence to just '*listen to intuitive feelings*' (Ladybird, 1st interview)

There were other examples of how being '*forewarned*' as a result of CAM practices in the antenatal period '*armed*' participants with confidence in their own beliefs. Participants wanted to take control and make decisions that were right for themselves. They exercised their autonomy in a number of ways in choosing the CAM therapy and the choice of practitioner. Some participants were sceptical about particular therapies but accepting of others. Participants accepted therapies when they matched their existing knowledge base and their philosophical orientations. For example, Alison an aspiring garden designer and firm believer in the power and energy of plants and herbs was scathing in her description of homeopathy as '*airy fairy*', and '*bonkers*'. Congruence between the therapy and an individual's world view is important in choice of therapy (Robinson et al. 2009) and participants often illustrated this:

'The Reiki I really liked, but she wanted to go a deeper level. She did do some things with feathers and crystals and then some points on the head, shamanic points and then at one point she went into journeying but I just didn't feel....it felt a bit more witchy if you know what I mean and she was talking about how past lives and how my foot would have been like tortured in the past and I thought I don't really what to think about past lives (laughs). It was a bit full on and I felt I wasn't ready for it'. (Rachel, 2nd interview)

Sharma (2003) found that CAM consumers generally match themselves with practitioners whom they can connect with and whose approach they find acceptable. When participants did not benefit from CAM or did not like the approach of the therapist they withdrew their service. Rose changed her osteopath on a number of occasions until she found the one that was right for her. This consumer behaviour puts participants firmly in control of their choices. The desire to be in control was also prominent in their decisions to use CAM as Daisy explained:

'I think the whole induction thing... just they kind of, they think you're overdue and you need to be induced... this is how we are going to induce you and you have no say over when you come in, how long you are in for, whether your partner can be with you. So I thought I would try anything'. (Daisy, 2nd interview)

CAM provided them with this confidence to take control over events particularly in their interactions with medics. Additionally CAM fulfilled a role in providing information and empowering women to ask appropriate questions of medics. Clarissa reported that *'I didn't realise I had a choice'* about whether to accept induction until her homeopath suggested she did not have to accept medical advice. Clarissa talked about how her homeopath *'prepped'* her to deal with the pressure to conform to medical procedures. Without that she reflected:

'Otherwise, I would have probably been so shocked. I would have said OK fine let's do it but we (homeopath) had thought about it before hand and decided no, to just give it a bit more time because I was carrying on with the homeopathic remedies'. (Clarissa, 2nd interview)

Ladybird felt unhappy with the advice she received when her baby was diagnosed as breech, she *'felt everything had been taken out of my hands'*. The only option offered to her was to have a CS so she sought advice and support from an acupuncturist who gave her more options and techniques to practise at home, which she felt contributed to the turning of her baby.

Despite the confidence that participants gained from CAM their narratives were often infused with paradoxical and contradictory accounts which reveal both a reliance and at the same time a distrust of science, medicine and the expertise of health professionals. Erin, Star, Clarissa, Rose and Riley planned to have their babies at home but all other participants chose hospital believing this to be the safest place *'surrounded by people that were doing it all the time'* (Ladybird). Participants respected the expertise of medics and acknowledged that if the slightest thing were to go wrong they would want their input. At the same time they were very aware that the needs of the institution and the decisions of the experts take priority even without a clear medical need. This created further anxiety and a lack of confidence that their needs would be met. Thus preparation for labour with CAM approaches enabled participants to have the confidence to be in control, to question and challenge the professionals in order to achieve the birth they desired. Star experienced a great deal of pressure to conform to the routines of the institution. She attributed her strength to be assertive in labour to her hypnobirthing classes where she was coached on the questions to ask medics to help her decide whether intervention was required. Without this Star said *'it could have ended very differently'*:

'The hypnobirthing course was very good for educating the couples, just to allowing, prompt them to ask the question. They gave us sheets of why would I need this? or is my baby in distress? You know to ask those questions even under pressure'. (Star, 1st interview)

Star resisted the constraints of the clock imposed on the length of her second stage by challenging the doctor about the need for a ventouse delivery. She achieved a normal birth but under such pressure to deliver she was convinced her third degree tear ensued as a result. Star's narrative epitomises the tension between finding a personally acceptable and fulfilling experience of pregnancy and childbirth and the challenges of achieving this within the institution which upholds a biomedical view of childbirth.

The relationship participants developed with their CAM practitioners was significant in terms of the trust and confidence they had in accepting their

advice. Pregnancy and childbirth can be experienced as empowering and healing particularly when the quality of care is empowering, reassuring and emotionally supportive (Kirkham 2010). For participants it seems that this empowering, reassuring and emotionally supportive care was received from their CAM practitioners rather than midwives or other health professionals. Participants commented on the lack of a personal relationship with midwives. Many described feeling let down:

'I did actually feel a real lack from the midwifery team in the sense that I wasn't given any guidance on the experience of pregnancy and it was very routine'. (Erin, 2nd interview)

All the participants described the relationship of trust they built with their therapist. The personality and demeanour of the therapist was a significant factor in their experiences of CAM and the contribution it made to their pregnancy experience. Rachel described the special relationship she had with her shiatsu therapist:

'I saw her when I had a foot injury, the bereavement of my father and then being pregnant and then birth, so it has felt like quite a journey and we just seemed to really click. I felt nurtured, very open and very warm person and someone I felt I could trust. I felt like she knew me as a person. I felt really understood and she had seen me at times of real pain. I also feel like she had seen quite a change in me from when I first started seeing her right the way though in terms of being aware of myself and putting my needs first sometimes and how I am as a person becoming a lot more assertive, especially in pregnancy. I felt a definite connection in terms of understanding me as a person and my emotions and feelings'. (Rachel, 2nd interview)

Rachel attributed her developing self-awareness and assertiveness to her CAM practices and to the relationship she developed with her therapist. Rose felt her therapist did not '*judge her*'. Alison commented that her CAM practitioner was '*more interested in her*' and '*listened to her concerns*' compared to other health professionals. The therapeutic relationship is demonstrated when CAM practitioners value the client's perspectives and promote the active role of the client (Grace and Higgs 2010). The

relationship participants developed with their practitioners was highly valued and seemed to contribute not only to improvement in their physical symptoms but also to an overall reduction in their anxieties. Indeed, the benefits of CAM are often attributed to the therapeutic relationship that develops between therapist and client (Mitchell and McCormack 1998). Mander and Melender (2009) would agree that relationships of trust are vital if women are to make choices and assume control over their childbirth experiences.

I suggest a number of reasons why participants in their reflexive decision making were more likely to have confidence in their CAM practitioners than midwives or doctors. Firstly, structural forces are at play. A major impetus to women's use of CAM seems to be a lack of trust that their needs will be met by health professionals or will be subsumed by the needs of the institution. This confirms Beck's thesis that reflexive decisions are made within the context of distrust of experts and institutional practices. Interestingly, participants' counter narratives were not in direct opposition with the master narrative of pregnancy and childbirth as a medical event, thus they were not dichotomous entities. Instead participants demonstrated a sense of perspective over medicine and science by presenting themselves as knowledgeable and sceptical regarding the impact of medical intervention. However, they also acknowledged the expertise of doctors and the need for professional supervision in pregnancy and birth. Engagement with CAM gave women the confidence to be assertive in following their own desires but also to know if and when to accept medical advice and intervention. Participants displayed the characteristics of the contemporary individual described by Beck (1992a) and Giddens (1991) as one whose attitude towards science and expertise is often one of simultaneous acceptance and rejection, approval and disapproval.

I argue that the narrative disruption of pregnancy coupled with distrust in experts contributes to the breach in ontological security and provokes reflexivity as individuals are forced into facing their fears. As suggested by Giddens (1994), in order to achieve ontological security, individuals must

have trust in their social and material environments. This trust must be won and is open to continual negotiation. Since there was little opportunity for women to develop trusting relationships with health professionals it seems that women place their trust in CAM practitioners. Giddens (1991) believes the effect of trust impacts on risk perception and minimizes concern and anxiety. Feelings of trust are cultivated as the relationship between client and practitioners develops. Trust also develops when physical touch is experienced or a sense of belonging is achieved through CAM group practices. Thus participants choose to believe in their CAM practices and in the advice of their CAM practitioners. However, the constraints of the institution and the power of medical authority at times overwhelm participants' needs and they succumb to medical advice. Beck's notion of the agentic reflexive self is undermined as here structure is more influential in determining outcomes than individual agency.

Notions of agency are also illuminative in understanding women's actions. Medicalized and risk orientated approaches to maternity care undermine women's own confidence in their ability to birth without intervention (Downe et al. 2001). Participants were aware of the risks of such procedures and took active steps to strengthen their body and build their confidence in preparation for the birth they desired. The uncertainty that participants faced in deciding whether medical intervention was really warranted and the fear of risks mobilised them to action. Mythen (2004) argues that Beck's and Giddens' presentation of the reflexive individual does not take into account that many people lack the financial, social or intellectual resources to engage in reflexivity. Giddens (1991) suggests that material wealth does not restrict reflexivity but it must be acknowledged that participants in this study were all well-educated and had sufficient finances to pursue CAM. Nevertheless, participants described how they prioritised their spending to ensure sufficient money was available for their CAM practices.

Participants often analysed their own behaviour as a desire to be '*in control*'. In raising the consciousness of the individual to their own physical and emotional needs and encouraging the client to take responsibility for

their own wellness CAM contributes to a sense of empowerment (Braathen 1996). The paradox is that individuals in the risk society need to make choices and be in control but they are constrained against this by risk procedures within maternity services. Engagement with CAM allowed them to re-establish feelings of being in control. This confirms Beck's view of the potential for the individual to be liberated and active agents of their own biographies.

5.5. Relaxed: pregnancy and CAM as a '*protective cocoon*' Rachel

Caroline summarised the contribution of CAM to her experience of pregnancy and birth as '*forewarned, forearmed and relaxed*'. This signifies the importance of relieving stress and achieving a state of relaxation as the ultimate accomplishment contributing to a healthy pregnancy, birth and an emotionally fulfilling experience. Reducing anxiety and achieving a state of relaxation, became a further way in which participants could control and manage both the inherent risks of pregnancy and the fear of the potential risks of medical interventions.

5.5.1. Discourses of risk and CAM: '*It is a reward for being pregnant*' (Alison)

Participants' narratives of pregnancy were infused and tainted by feelings of fear, anxiety and uncertainty. They referred to '*stepping into the unknown*' (Erin). The potential for risk and for the development of unforeseen events was always considered a possibility. These risks cannot be avoided entirely, as Stephanie recalled '*one way or another baby has to come out*', and as such are not the types of risk described by Beck (1992a). The only way women have to control these risks is through their life style choices and as previously discussed by attempts to strengthen their body to ensure they are in optimum health to nurture and birth a healthy baby. However, it is impossible to disentangle women's fears and anxieties in this respect from those generated by the discourses of risk medicine. The medicalized approach to care, the focus on risk and health messages from professionals were significant factors contributing to their worries and anxiety.

Many women commented on the medical approach to the care they received in pregnancy. Although some women felt apprehensive and confused being '*bombarded with advice*' and the '*forever changing advice about what to eat and drink*' (Daisy) they believed these recommendations were in the best interests of the baby. Alison, with children aged 23, 16 and 7, was well placed to reflect on the impact of risk reduction strategies and the changes she had experienced in the maternity services over the years. Below she reflected on how massage and reflexology in pregnancy countered the risk approach to pregnancy management:

'I find it really hard work since they have medicalized it so much. When I had my first child (23 years ago) no one told you what to eat, what to drink and what to do. They were quite keen on giving up smoking, which was all they were worried about. By the time I was pregnant with ... (daughter age 16) you were not allowed to eat God knows how many different thing, liver, cheese, pate, no this, no that and then when I was pregnant with (son age 7) it was just even worse, you can't do this, you can't do that. I mean my Miriam Stoppard Mother and Baby book says relax in the evening with a glass of wine but by the time I had.... (son) if you had been drinking a glass of wine whilst breastfeeding the police would come in the door practically or they say there is a .0001% chance this might happen so don't eat tuna, it's all risk'. (Alison, 1st interview)

Alison's narrative reveals the pervasiveness of risk practices in current maternity services. Public health discourses such as those described by Alison, construct risk as a consequence of individual responsibility and life style choice (Gabe 1995). In following medical advice the health of the baby takes priority and women's needs become subsumed by that of their fetus, as Alison suggests '*you are sacrificing yourself on the altar of this potential child*'. There was absolutely no suggestion that this advice would not be followed as Alison reflected on how '*guilty*' she would feel or as Rose thought '*God forbid if anything were to happen to the baby*' as a result of her decision making. CAM provided a '*reward*', a '*treat*' to make up for the hardships of pregnancy and for the lack of recognition of women's needs when the focus of care is on the wellbeing of the fetus:

'I think you have so much more need for that feeling of doing something for yourself because all the things that you used to do nice for yourself you are not allowed to do anymore because you are sacrificing yourself on the altar of this potential child. It's just nice to go off and have a massage. I think it's a reward for just being pregnant'. (Alison, 1st interview).

The medicalized approach to care heightened women's fears and provided no outlet for their anxieties. As Rachel described the focus is *'on the physical: blood tests, blood pressure, listening to the heart'*. Alison experienced great anxiety when doctors could not agree on the best course of management when a complication arose in her pregnancy; she described the effect as *'they freak me out with their panics'*. Any opportunity for women to discuss their concerns was curtailed by the emphasis on physical wellbeing of the mother and baby and temporal pressure as explained by Rachel:

'When you see the midwife they listen in and they check the heartbeat but there isn't so much time to talk about what you might be worried about. I understand that they are busy. They focus on the physical; I mean its blood test, blood pressure, and then listening to the heart. I felt like you could maybe talk through one or two things but you couldn't go into a lot of detail, obviously they have so many people to see'. (Rachel, 2nd interview)

Participants' anxieties and fears result from the uncertainty of pregnancy outcomes, the inevitable risks of pregnancy and birth, and the potential risks of medicalized interventions. Their actions and behaviours in seeking CAM cannot be described by either risk or uncertainty alone. Although Beck (2009) distinguishes between risk and uncertainty the impact and consequences on individuals are similar. Potential dangers involve both an element of risk and an element of uncertainty, but the open and unpredictable nature of future events, and of the outcome of decision making, serves as a common denominator (Arnold 2009). The focus on the assessment and management of physical risks of pregnancy to the mother and baby contrasts sharply with the risks self-defined by women as lying within their emotional reactions and social domain. This highlights the

disparity between professional and lay notions of risk, the contested nature of how, and by whom risk is defined and operationalized. Finding a way to address these feelings became an imperative for participants' action in seeking CAM

5.5.2. The need for relaxation and stress relief in pregnancy 'yoga was my haven' (Alexandra)

In participants' talk of stress and anxiety there is evidence of narrative disruption, a breach in ontological security and an expressed need to re-establish the secure feelings of the 'protective cocoon' described by Giddens (1991:40). With the failures of contemporary maternity care, participants found alternative ways to deal with their anxieties by seeking the relaxing effects of CAM. Louise found shiatsu gave her '*a sense of peace and harmony*' and Rachel described shiatsu as '*it took my mind off all the worries and helped me to stay as relaxed as possible*'.

Participants recognised the factors contributing to their emotional and physical wellbeing and took active steps by engaging with a variety of CAM modalities to deal with their stress. Rachel described the continued effect of shiatsu, meditation and self-hypnosis as providing her with a '*protective cocoon*':

'You have a cocoon around you, so you are aware of your emotions, you are aware of any fear but you learn to acknowledge that, not to push it away or keep busy. It really helps you to be aware of yourself and develop as a person. A protective layer, yeh a protective cocoon and time for you and obviously I was still going to work and that brought some sort of strains but I felt I was able to close the door on that and concentrate on myself and it was lovely feeling'. (Rachel, 2nd interview)

Participants sought support from therapists and found solace in the company of other women by attending hypnobirthing and yoga classes. Alexandra described her pregnancy yoga class as her '*haven*':

'my pregnancy yoga class was very very nice especially because there were so many other pregnant women there and I didn't feel so huge. That class was my haven because I could still not sleep well and when she did her final relaxation at the end where we were all lying down she always had to wake me up at the end. She always went through the body parts and I am sure she got from the head down to the chest and that was it I was gone, so relaxing'. (Alexandra, 1st interview),

The metaphor of *'haven'* signifies a refuge, a place of safety, a place of protection where Alexandra found release from her anxieties and fears, if only on a temporary basis. Becker (2010) suggests that discourses of stress have achieved cultural pre-eminence. Within the domain of CAM, stress is perceived as having a negative impact on emotional and physical wellbeing, and a pathway to ill health (Pert 1997, Church 2007). Individuals are advised to take control of their lives and health, by reducing stress. They are exhorted to adopt a vast array of stress relieving and relaxation strategies. Within this 'fear inducing' rhetoric the double edged phenomenon of CAM is also revealed. The onus of responsibility in dealing with the causes of stress is placed heavily on the individual (McClellan 2005). Scott (2002:33) argues contemporary society should be known as the 'angst society' since this individualisation of risk forces individuals to be reflexive and personally responsible for all decisions. The affective term 'angst' recognises the emotional impact of risk on individuals. Certainly this descriptor would fit participants in this study. Furedi (2004) also argues the perception of psychological vulnerability in itself, can lead to both emotional and physical ill health. Beck's realist view on risk assumes that those at most risk perceive higher levels of risk. However participants' health status and biographical details reveal most probably very low levels of risk. I therefore concur with Scott (2002) that Beck's view of risks as objective facts ignores the interpretation of risk by individuals and communities.

I also see evidence of Lash's aesthetic and hermeneutic reflexivity in participants' decision making and use of CAM. Lash (2000) suggests that this aesthetic or hermeneutic reflexivity reveals itself in taste and style, consumption and leisure activities. Rather than seeking further medical

advice or pharmacological treatment for anxiety, engagement in CAM reflects this aesthetic and hermeneutic reflexivity. Other researchers have found too that the most valued elements of CAM relate to aesthetic elements of comfort, touch, connection and caring (Smith et al. 2009). Hermeneutic reflexivity also involves emotion, intuition and imagination based on culturally acquired understandings. The role of imagination in decision making may be particularly pertinent for pregnant women. Participants, having no other way of connecting with their baby, imagined the risk that their anxieties and fears may place on their wellbeing. However, this in itself became another concern. Participants worried about the effects of their mental state on the growing baby and perceived a need to protect the baby from stress and anxiety.

5.5.3 Fetal subjectivity, protecting the baby from stress. *'I really wanted it to be a safe place for my baby'* (Erin).

The belief that negative emotions could somehow be transmitted to the fetus and impact on their wellbeing was common. Thus participants' concerns to manage their emotions were not limited to relieving their own anxiety but also out of concerns for *'creating a safe place for the baby'*. Rachel explained this in physiological terms:

'Any anxiety or worry obviously increases your heartbeat and your cortisol, and that will have an impact on ... (baby) in terms of her heart beat and wellbeing. I suppose because you don't want any kind of ill effects. I didn't want those feelings to be passed on to her so you very aware and obviously with your hormones racing you get some quite strong emotions, but you de-channel, any strong emotions you feel like they are really channelled in a healthy way because you don't want them to turn inwards'. (Rachel, 2nd interview).

Erin worried her negative emotions, about unplanned pregnancy and the ensuing conflict with her partner, would impact on the baby. She described *'wanting to compensate her baby for those feelings'* and found that through her use of massage, acupuncture and hypnobirthing she could let her baby know that she was *'loved, her birth would be rejoiced and she was in a safe place'*. Erin recounted this experience as *'transformational'*:

'Having that space where we could talk and also a place of deep relaxation helped us visualise where would we be when we had the baby and it sort of took us out of the situation we were in and also gave us tools that we could use together. I think that probably was the thing that influenced our pregnancy the most'. (Erin, 1st interview)

In her first pregnancy Riley was concerned that emotional issues from her past would impact on the health of her pregnancy and, in her second pregnancy she carried a number of fears from her first birthing experience. She was determined *'to protect the baby from those fears'*. Notions of fetal subjectivity create a moral obligation for women to engage in appropriate maternal behaviour and comply with medical advice (Kaplan 1994). Besset (2010) argues that a contemporary view of good mothering is based on sacrifice for and identification with fetal interests.

In contemporary discourses it is also viewed as morally reprehensible for women to allow themselves to become stressed. Emerging research confirms that in utero fetal exposure to stress can have both immediate and long term negative effects on the health and wellbeing of the child (Glover 1997, O' Connor et al. 2002). The women in this study were imaginatively and intuitively aware of the impact that their worries and anxieties may have on their baby. Thus, with the wellbeing of the baby the primary concern, pregnancy legitimises the expense of CAM as Rachel expressed:

'Before I was pregnant you feel you have to justify it (her shiatsu treatments) almost, like when I was pregnant I felt like that was to keep me healthy in pregnancy and you get your grant so you think I can spend that money but afterwards you feel can I justify that money. I think it is money well spent really. It's quite refreshing looking after yourself eating well, exercising to the right level and relaxing and having the treatments'. (Rachel, 2nd interview).

I accept Zinn's (2008b) assertions that intuitive responses are often the most appropriate. A number of CAM modalities have been found to reduce anxiety and biological markers of stress in pregnancy (Burns et al. 1999, McNabb et al. 2000). In this way engagement with CAM promotes reflexivity

and critical health literacy which contributes to a sense of control over life events (Long 2009). CAM then becomes a means by which women can apply the public health discourses to themselves in pregnancy.

Many CAM modalities aim to develop the mother's bond with her unborn baby. Mother and baby are seen as inextricably connected physically and emotionally. Daisy and Clarissa described the practice of vibrational breathing practised in yoga:

'We used to do this vibrational yoga thing where you had to make a noise that the baby would be able to hear. When the baby is born if you do that it will help the baby to settle. She talked about a link between your heart and your womb. Everyone would sit there and do this vibrational sound and almost meditate, thinking about your baby and that was really nice for bonding'. (Daisy, 2nd interview)

Clarissa found her homeopath concerned herself not just with how she was dealing with the emotional aspects of pregnancy but also gave consideration to her baby's feelings:

*'The other thing she did that was **brilliant** was talking through connecting with S. which no one had really said. We think a lot of how we are going to get through labour but not really think about the baby and talk to the baby and connect with the baby. That was something really overwhelming, when I was pregnant thinking about the journey that he would have to take. (Clarissa becomes emotional and cries a little here). That really makes me feel, it's just an incredible thing and you know that I wanted him to know that I was there for him because OK it was painful for me but for him it was this unknown thing him coming into the world. So she was really supportive of that and helped me form my ideas about what to do with those feelings and how to connect and what I could do to help him, as he's labouring and that was brilliant'. (Clarissa, 2nd interview)*

Women particularly enjoyed the element of CAM therapies that promoted the connection between mother and baby. However, the emphasis on fetal subjectivity places the arduous task of stress reduction on women. Thus it seems that CAM too has the potential to increase anxiety. Lupton (1999a) agrees that the strategies individuals use to contain and manage risk often

have the opposing effect of amplifying their intensity and increasing fears and anxieties. I am not sure that my participants would subscribe to this belief though. Technological interventions such as ultrasound have also contributed to the view of fetal personhood and have had a profound effect on the way in which women view and feel about their unborn baby. However, unlike CAM these technologies do not offer a way for the mother to actively connect with their baby or deal with their anxieties.

I have argued thus far that reflexive decisions are embodied and contextual. As Adam et al. (2000:4) point out risk definition and perception is also 'positional'. Participants' world views reveal the positional influences that Adam et al. (2000) refer to. However, an aspect that comes to the fore in this theme is that in voicing their position women reveal a moral imperative to do the best for their baby. Beck (1992a) neglects specific socio-cultural factors which impact on reflexivity and decision making, but the role of values in decision making is at the core of cultural approaches to risk. Douglas' (1992) perspective on risk highlights that perception and response to risk depend on the values of particular cultural groups.

Participants also demonstrated Beck's (2009:118) concept of 'unknown and unknowable' risks as Erin revealed '*who knows what effect it (stress, anxiety and negative feelings) will have on her (the baby)*'. There is a growing body of evidence to suggest that depression and anxiety in pregnancy can influence fetal growth and increase the risk of prematurity (Alder et al. 2007). However, there is limited scientific evidence available to fully understand either the short or long term effects on the baby but women intuitively sensed a deep connection between themselves and their baby's emotional wellbeing. It seems participants adopted the 'precautionary principle' described by Giddens (2002:32) as a way of dealing with uncertainty and manufactured risks. Giddens (2002:34) believes this may be an appropriate way of decision making as risk should not be ignored while definitive scientific evidence emerges. Participants felt the burden of responsibility and acted in the only way they knew how to diminish the potential effects of stress by seeking CAM. Certainly, early studies do show

that the fetus responds favourably when the mother adopts even simple relaxation techniques (Fink et al. 2010). A vital task for women then is to reduce stress and protect the baby from negative emotions thus demonstrating to themselves and to others responsible motherhood. Hence, for participants, the anxieties generated by the uncertainty of pregnancy, the fear of manufactured risks and worry about the impact of these emotions on the baby become their motivation for seeking CAM.

5.5.4. CAM and relaxation in labour '*you can choose to be relaxed and calm*' (Daisy)

The work of CAM in emotionally preparing women for birth in terms of reducing fear, giving them confidence in their ability to birth and providing them with strategies to use in labour was tested in their ability to relax and allow labour to happen as nature intended. Relaxation was viewed as essential to promote normal progress in labour and to enable women to cope with the pain of childbirth. Participants attributed their ability to achieve a state of relaxation in labour to their various CAM practices. Techniques of breathing, visualisation and positive affirmations were commonly taught as part of a number of CAM modalities as self-help strategies. Star explained '*you need a tool box of all the different things you can pull on (in labour) without it being a medical thing*'. Participants found these techniques very useful and this antenatal preparation had a significant impact on their birth experiences.

Since participants, particularly those having their first baby had no way of knowing how labour would be or how they would cope they prepared a range of CAM practices for use in labour. The uncertainty of labour, a fear of inherent risks of the labour process and a fear of the manufactured risks of medicalized care led participants to prepare this tool box of different things that Star referred to. Ladybird made ready a number of essential oils and briefed her partner on how to use them when she was in labour. Louise, Erin and Clarissa used homeopathic remedies to help deal with a

range of emotions they experienced during labour. As Riley explained the principle behind the use of these therapies in labour is to help the individual relax, and in the reduction of fear, allow labour to progress:

'CAM therapies really support that process of letting go of the fear and to give your body a fighting chance not to be overcome by the fear'. I made this list from aromatherapy to herbs, to acupuncture points, to homeopathy to Bach flower remedies, everything. I had divided into the stages of labour. If this happened at this stage try this. I found that to be incredible. My labour was intense because it was posterior but I had him in the water at home in my living room in 6 hours which is pretty remarkable for first labour'. (Riley, 1st interview)

This toolbox made it possible for participants to anticipate and prepare for every potentiality. It offered them a way of being in control of the uncertainty of labour and enabled them to have confidence to deal with a range of situations or their own reactions. For most of the participants, labour went according to plan; they used their strategies to achieve the birth they anticipated. Most managed without pharmacological analgesia and those that resorted to medical intervention were satisfied that this was appropriate given the circumstances. Alexandra practised hypnobirthing techniques in labour and was convinced this contributed to her positive birth experience:

'It was so easy during labour. It was a bit like fleeing into that other world which was full of calm and serenity. I just didn't have to think about the labour at all, about the pain, it was just not there really. I was so calm'. (Alexandra, 1st interview)

Caroline attributed the ease of both her births to techniques of breathing she learned in yoga as she believed *'it was all about the breathing'*. Erin reported her labour as *'really enjoyable'*. Below she described the use of positive affirmations and the state of relaxation she achieved:

'My contractions were strong and regular ... the midwife came out and checked and I was about 4 or 5 centimetres dilated I was listening to the hypnobirthing CD, being very relaxed and breathing through my contractions and being in the pool and it just felt..., it was great. I was just enjoying it and ... (partner) was in the pool too and we were really enjoying it and going with it. I was quite trancy. I was really deeply relaxed. I kept

falling asleep between my contractions and just drifting off. I did feel very in my body and I guess the thing that was guiding me through them (the contractions) were the affirmations that came with the hypnotherapy, things like the idea, it can't be bigger than me because it is me and so I can handle all of this'. (Erin, 1st interview)

Erin's use of the word 'trancy' describes the altered state of consciousness that women often experience in labour (John 2009). It is argued that this loss of awareness of their immediate surroundings is essential for normal progress in labour. The potential for CAM to contribute to transforming birth experiences also revealed itself in participants' narratives. Alexandra reflected upon her belief that maybe without the hypnotherapy she would not have achieved such a positive birth experience:

'I was so at ease within myself and I was thinking I will be able to do this, I believe in my ability to give birth without having all those other things. I did it all by myself, just the breathing, just the concentration and everything. Without the hypnotherapy I would have definitely felt more out of control and a lot more scared and not so confident in my own abilities'. (Alexandra, 1st interview)

Stephanie also discussed how breathing and relaxation techniques she learned from hypnobirthing contributed to a very positive birth experience.

'it (labour and birth) was very easy. I was doing all the breathing and I think that was why I was so calm and quiet. It was just perfect. It was lovely and it was very positive and I have a warm glow about it and it certainly left me, the birth left me quite happy I would do it all again'. (Stephanie, 1st interview)

Given that earlier Stephanie had talked about being terrified of birth and initially wanting an epidural, her narrative illustrates the transformative power of CAM. Caroline also impressed the midwives with the ease of her two births and attributes this to her breathing and relaxation. She bemoans the fact that midwives do not have the skills or the time to teach women the techniques of breathing and relaxation. Daisy had a long labour but achieved a normal birth without any pain relief. She remembered it being quite traumatic at the time because the unit was busy and they did not have

a room for her. The skills she learned from yoga were instrumental in helping her cope and in establishing an identity that moves from a 'stressy' person to one of being calm and controlled as she explains below:

'The yoga class and the breathing... one thing she (yoga teacher) used to say was whatever happens, even if you are having an emergency caesarean, you can choose to relax and you can choose to be calm. That's the one thing I can remember during labour: I am choosing to be calm and I am not going to panic and that was really helpful. I amazed myself because I am quite a stressy person. So going to that class really helped'. (Daisy, 1st interview)

The holistic nature of CAM, the acknowledgment of the emotional component of childbirth and strategies to reduce fear and promote relaxation were more attractive to these women than medical interventions. This state of relaxation enabled participants to feel a sense of control over their labour. The spiritual and healing dimension of childbirth is demonstrated when women describe the pregnancy and birth in terms of a re-assessment of themselves and their capabilities in the light of their childbirth experiences (Milan 2003). All participants attributed their positive labour and birth experiences to the use of breathing and relaxation and the various CAM practices they had engaged with. Both Slovic (2000) and Furedi (2004) agree that a perception of risk is sufficient in itself to pose risks. The negative impact of fear and anxiety on the physiology of labour is well documented (Alehagan et al. 2005, 2006, Fenwick et al. 2009). For participants in this study, CAM offered a way to conquer their fears regarding the uncertainties of labour. The reduction of fear and anxiety and the state of relaxation they achieved had a positive influence on labour outcome both from a physical and emotional perspective. The medical model with its reductionist view of discrete internal physiological processes of labour fails to recognise women's emotional and subjective responses to labour as significant. Yet participants' analysis of their emotional status as relaxed and calm was seen as contributing to the progress of labour. Participants' determination to deal with their anxiety and fear are well founded. Fear and stress can have an impact on the outcomes of

pregnancy such as a lack of confidence in the ability to give birth naturally and an increased likelihood of preterm labour, prolonged labour, forceps delivery, and caesarean section (RCOG 2001, Saisto et al. 2001, Johnson and Slade 2002, Van der Bergh et al. 2005). Lash (2000:15) believes that decision making in the face of risk and uncertainty is inextricably linked with emotions and the world of imagination. Indeed, Alexandra told me of her frequent daydreams in which she laboured quickly and easily at home. The imagination is powerful in pregnancy as women project their hopes and dreams for an easy birth and towards their future with a healthy baby. Many CAM therapies use visualisation methods as a way of encouraging people to tap creatively into the world of imagination to influence health and wellbeing (Gawain 1995, Payne 2000).

Women sought CAM in order to find a solution which had meaning for them and contributed to their desire for a natural birth. This desire for a natural birth was seen as important in reducing risk to themselves and their baby both from the known risks of labour and birth and the known and unknown risks of medical intervention. Their positive birth experiences indicated the success of their decision making strategies and support Zinn's (2008b) belief that decision making is more effective when taken with both rational logic and non-rational strategies including, emotion, intuition and imagination.

5.5.5 CAM, stress and the need for relaxation after birth '*the importance of being a relaxed mum*' (Rachel)

Women also attributed the sense of calmness and relaxation they achieved during pregnancy and birth as contributing to their baby's emotional state after birth. Frequently participants referred to their baby as '*very chilled out*' (Ladybird) or '*a really contented baby*' (Rose).

'All that relaxation worked. I mean even in pregnancy, just the time I was spending doing it was calm time, time for me and he was getting the benefit, he wasn't in distress, he came out fine. I think it did, he's really calm, he sleeps all night. I don't know, you don't know what links to what but he's.... I used to listen to

the CDs at night before going to sleep, it seems to be a really nice rhythm and he was very calm with it'. (Star, 1st interview)

Most participants continued with CAM treatments following birth. The emphasis continued on '*the importance of being a relaxed mum*' (Rachel). Some extended their CAM practices to include the baby. Techniques to help a stressed and crying baby were taught at baby yoga and baby massage sessions. Star felt her baby was stressed following her long labour as he cried every time she put him to the breast. A cranial osteopath gave him two treatments which Star felt helped enormously:

'The cranial osteopath reported a huge amount of cranial tension and jaw tension from the birth, she relieved most of that and general birth tension and then at least when I was putting him to my breast he wasn't screaming. It calmed him down a lot, he stopped crying, at least I could put him to the breast.' (Star, 1st interview)

Participants also described the importance of relaxation and stress relief following birth as they came to terms with their new role of motherhood. Following the birth of her third child Norma developed postnatal depression. She described herself as feeling '*very stressed*' with concurrent events in her life, and '*crying all the time*'. Norma sought help from a cranio-sacral therapist and a homeopath who helped her deal with her '*terror*':

*'I went to see (homeopath) and I told her my whole spiel. She listened to everything I said. She gave me a remedy and one to take the next day. I went off to the train station with this little remedy under my tongue thinking, oh well, I and just sat waiting for the train. The train must have taken about 20 minutes to come and in that 20 minutes I had dissolved into a puddle I was just a mess. It wasn't like little tears like sniff sniff, I was just like **everything** just fell out of me. I went home and I went to sleep. I woke up the next day and I just felt really safe and happy and warm and I never felt like that again. I never felt that depression. I just never had it again. I just never ever felt like that again, it was like it was over so that was really amazing'. (Norma, 1st interview)*

The narrative repetition indicates a transformational experience for Norma. Stephanie too developed postnatal depression, when her newborn son cried constantly as a result of oesophageal reflux. She described her '*life as*

hell' but received little advice or support from health professionals who she felt labelled her 'as a neurotic mother'. Stephanie, sought help from a hypnotherapist who was instrumental in helping her to deal with stress and transforming her outlook:

'she took me through all the experiences that I had and then under hypnosis she gave me some strategies to be able to deal with it and keep those bad things out, tamed, blocked up and outside and got me to build a different outlook. She taught me how to do self-hypnosis and how to relax. I became much more positive to everything being good this time. The hypnotherapy really helped it really made me feel completely different, really restored the energy levels and I was able to carry on'. (Stephanie, 1st interview)

The postnatal period and early parenthood can also be a physically and emotionally challenging time for women and their partners. New mothers often experience emotional distress and feel the need for additional support. For many this additional support came through their CAM practices, particularly group sessions and those which included the baby. Both Norma and Stephanie rejected pharmacological treatment on the basis it did not offer a solution to their problem. I suggest the strategies participants adopted are a search of one's own life in the 'runaway world' described by Beck and Beck-Gernsheim (2002:22) and Giddens (2002). Participants made reflexive decisions between conflicting discourses. In so doing they create their own life trajectories. CAM facilitated this process, transformed beliefs and experiences and provided them with a range of strategies to live in this runaway world.

5.6 Narrative Genre: Transformative 'life dramatically and fundamentally changed' (Riley)

The transformative genre of participants' narratives is one which displays the potential of CAM to facilitate changed perspectives, a transformation of ideas or ways of being in the world. Within the concept of disrupted lives, Becker (1999) suggests that individuals reach a turning point in dealing with adversity by regaining a sense of order and establishing a future direction.

This arguably is representative of a transformational experience and the use of CAM may provide this turning point. Riley's comment that following her first experience of receiving acupuncture '*life dramatically and fundamentally changed*' illustrates this point.

Whether it is for a first or subsequent child, pregnancy is a time of transition, as women prepare for and experience a momentous life changing event. For the women in this study the use of CAM contributed to a positive experience of pregnancy and childbirth facilitating personal growth, fulfilment and recognition of the emotional and spiritual aspects of pregnancy and childbirth. In the risk society Beck (1992b:21), argues individuals in making reflexive choices often seek self-transformation by acquiring new knowledge and skills. The following discussion coalesces some of the participants' narratives that illustrate and justifies my argument and proposal for the transformative genre

In some instances CAM facilitated transformation in participants' beliefs about pregnancy and birth. As discussed before all the participants expressed a desire for a natural birth with minimal medical intervention. However for some the belief in their ability to achieve this was undermined by their personal experiences, by the media portrayal of childbirth or by medical and scientific discourses. Daisy and Stephanie, in particular talked about their deep inherent fear of childbirth. They recounted how CAM supported the philosophy of birth as a natural event, one in which the female body is well designed to do. As a result of engaging in these practices a transformation in their way of thinking emerged, a belief in the ability to birth their baby without recourse to unnecessary medical intervention. Daisy's ability to cope during labour with yoga was influential in transforming her self-belief from a 'stressy' person to one of being calm and controlled. Stephanie too outlined a transformation in her thinking as a result of her engagement with hypnobirthing. Her change in attitude led to a reversal of the decision to birth in a major obstetric unit to achieving a normal birth in a community unit with no pain relief. She described her experience as '*just perfect*'. Use of CAM also transformed women's experiences of birth. This was revealed in

Alexandra's narrative. Alexandra described herself as having quite an anxious personality but with the help of hypnotherapy she experienced a very positive birth experience:

'Without the hypnotherapy I would have definitely felt a bit more out of control and a bit more scared and not so confident in my own abilities' (Alexandra, 1st interview)

A number of participants recognised the transformational power of positive birth experiences. Both Riley and Alexandra commented on their feeling of empowerment which resulted from a sense of achievement. Riley's comment encapsulates this belief *'wow if I can do that I can do anything'*. Alexandra talked about having a better relationship with her son, more confidence as a mother and desire to have a home birth with a subsequent pregnancy:

'because I had such a good birth experience, I felt because I had been able to give birth to him that well that I am a good mother in some way. That I am this earth mother and it is in my blood. I felt instantly connected with him. Perhaps also because he just fell out and he didn't cause me so much pain. Perhaps I am not having any grudge towards him. I don't think gosh I wish I hadn't had you or perhaps I would have done it differently and I don't have that feeling. It was perfect in every way and I definitely think I have a much better relationship with him because it was so nice'.
(Alexandra 2nd interview)

Alexandra's words reveal how the spiritual and healing dimension of childbirth is demonstrated when women describe the pregnancy and birth in terms of a re-assessment of themselves and their capabilities in the light of their childbirth experiences (Milan 2003).

Participant's use of CAM following birth also revealed transformational experiences, sometimes of an extraordinary nature. For example, Norma described how she developed postnatal depression following the birth of her third child. Norma was recommended by a friend to see a cranio-sacral therapist. She described the treatment she received as follows:

'I lie down on this table and she just put her hands on me and I kind of relaxed. Then the weirdest thing happened, she put her hands on my chest, behind my head and on my pelvis. I just remember really really clearly all the blood in my body had changed direction, it was really weird like it had been off in the first place and then it was going in the right direction, then I just fell asleep. When it was over she said you are fine you can get up when you are ready. I noticed my kids were sound asleep and she said you know 'you just had this connection with these kids and there were really feeding off you' and she said 'I just needed to do some work on them through you I hope you don't mind' and I was like oh oh OK. They were just knocked out all 3 of them like beautiful little dolls. In that 45 minutes I don't know what happened but the kids were sound asleep so I had to wake them all up and then we all trudged back home on the train it was amazing they were so much more calm and I was really able to kind of focus whereas before I still felt quite not in my body but I did not feel, there was a kind of terror, you know I was always crying but there was a kind of terror, I don't know I just felt really terrified but the terror was gone so and the crying was basically gone'. (Norma, 1st interview)

Coupled with homeopathic treatment Norma found a way to relieve her postnatal depression. Homeopathy became Norma's first approach for managing her health and that of her family.

In participants' accounts, I found evidence that many of their transformational experiences seemed to arise from the connecting relationships they developed with their CAM practitioners. Participants experienced empowering, reassuring and emotionally supportive care from their CAM practitioners. Clarissa described the relationship she developed with her homeopath during pregnancy:

'we kind of built up this relationship and we would talk about how she would help me with the birth and we did one session completely with the birth and how I felt about the birth so it was brilliant preparation getting strong helping me connect because I think at that point I was a bit scared to connect with the baby'. (Clarissa 1st interview)

Rachel talked about how her shiatsu practitioner made her feel:

'I felt nurtured. I felt I could trust her, I felt like she knew me as a person and she felt like a friend as well. I felt really understood I felt a definite connection in terms of understanding me as a person and the emotions and feelings'. (Rachel, 1st interview)

Rachel attributed her developing growth as an individual and her ability to assert herself to ensure her needs were met to the support of her therapist.

Rose too recounted the therapeutic nature of her treatment encounter:

'The osteopath I saw was very reassuring, she was absolutely lovely, she was so lovely in fact I think I burst into tears the first time I went to see her afterwards. I had so many problems with my back and it was really getting me down I mean I cried when I left her because it was such a sense of relief that she understood that I was in pain and that she was going to help me the way I wanted to be helped'. (Rose, 1st interview)

Mitchell and McCormack (1998) suggest these kinds of connecting relationships are fundamental to achieving positive outcomes and improvements in health and wellbeing. As discussed previously these relationships form the basis of trust. Giddens (1991) believes trust can develop from reflexive calculation or from choosing to accept or believe in an individual or institution. This choice was determined by dissatisfaction with the support offered by the maternity services and contrasting experiences of that offered by CAM practitioners. Beck and Beck-Gernsheim (2002) suggest a relationship of choice depends on mutual commitment and trust. Trust enables mutual disclosure which facilitates on-going relationships and makes it possible for both parties to work together. Rachel and Stephanie both commented that their therapists let them *'into their lives'* and through their personal disclosures a mutual connection was developed. Thompson (2005) refers to this as *'recognition of authenticity'*. In her narrative Alison reflected on why CAM therapists seem genuinely to have an interest in and care for clients' subjective experiences

'I think they just consider things more. They are more interested in what you have to say, they are more interested in hearing you, they want to listen to you. I mean I think they go into it because they are like that. Their communication skills are better. I think they have much less from the receiving end. You are talking to your peers when you are talking to people like that. They take you seriously as a person. You are not talking to someone who just sees you as 'a patient'. I suppose the sheer volume of what professional health care people deal with you must eventually start seeing people less as individuals. No they like doing it, they like

the whole thing. They have got it nice. They are not working in a horrible over pressurised NHS facilities where they can't really do their job properly. They probably pick and choose their clients from the kind of people they got. The clients come from the polite, pleasant, articulate middle classes who don't give them a really hard time, it's just a better transaction isn't it? Of course they are interested if you have something wrong with you because you are paying them by the hour. There is a transaction. They are delighted just to get your money? (Alison 2nd interview)

Alison alluded to the consumerist nature of the relationship between CAM practitioner and client. Although some participants had reciprocal arrangements with friends all paid for CAM services from professional therapists. Participants exercised their consumer tendencies by shopping around to find the right therapy and therapist to best meet their needs. For participants in this study, relationships with CAM practitioners were valued highly compared to the medicalized midwifery encounters they experienced. These relationships were significant in transforming participants' perceptions and experiences. Giddens (1990:78) argues that without this trust people could not take the 'leap of faith' that is required in taking advice based on expert knowledge which they may have little comprehension of. Thus even though some participants were initially sceptical of the underpinning belief systems of CAM the relationship they developed with CAM practitioners allowed this 'leap of faith' described by Giddens to take place. Subsequently a transformation in their own beliefs and values took place and this impacted on their behaviour and further CAM consumption. The concept of narrative diachronicity is thus revealed.

5.7. Narrative Diachronicity: Transformation in future health care practice: strategies for living life in a runaway world: *'once you have learned those skills it is for life'* (Star)

For many of the participants, engagement with CAM became a journey of continuing use and a transformation in their values and beliefs about CAM and biomedicine. Interestingly, some of the participants were initially sceptical about CAM but this belief changed to one of confidence and faith through continued use. Other research supports this phenomenon.

(Cartwright 2007, Baarts and Pedersen 2009). This may represent part of the reflexive project of the self, described by both Beck and Giddens (Beck et al. 1994) as a desire to achieve personal growth. Furedi (2004) argues that the individualism of contemporary western culture forces people to rely on their own inner resources. In making choices self-understanding is required. Therefore individuals develop a distinct sense of self through reflection. The need for self-understanding promotes the belief that the self is continually open to improvement and self-development. This is also a dominant discourse within CAM. The concept of journey signifies participants past, present and anticipated use of CAM. Initial use and positive benefits experienced by consumers of CAM leads to further exploration.

The positive benefits participants attributed to CAM during pregnancy had a profound impact on how they plan to manage their own and their babies' health care in the future. Clarissa first began using homeopathy during pregnancy but has continued post-birth to support her own health and that of her baby's. Rose, Star and Daisy both talked about how they would use CAM again in a future pregnancy, potentially commencing them earlier than they had with the most recent pregnancy. They also projected the desire to use a wider range of therapies should the need arise e.g. Daisy felt she would '*definitely use moxibustion*' if her baby was in a breech position.

As a director of a natural health clinic, Star's world revolved around CAM. However, a less than ideal experience of maternity services and her own use of CAM during this time have proved transformational in her career. Star has devised an innovative pregnancy programme of CAM therapies which she hoped to make accessible to many women via a social enterprise scheme.

A number of the participants talked about how the skills they learned and the strategies they developed as a result of their CAM practices gave them a set of life skills they could use in other circumstances. Star explains that '*once you have learned those skills it is for life.*' Stephanie too talked about how she has adapted the skills she learned from hypnotherapy to deal with a dental phobia:

'I was a phobic. I can now go to the dentist. I used to wake up on the day before and I was highly anxious, even before I got close to the dentist I was in tears and they couldn't do anything because I was just crying the whole time but using the techniques that the hypnotherapist taught me I was able to have all the treatment without the tears. I could never ever have done that before.'

(Stephanie, 1st interview)

CAM for these women becomes a life choice: a choice which confirms their sense of identity as active, empowered and responsible agents and a choice which provides a sense of achievement and self-fulfilment. In order to survive the pressures of everyday life individuals need to be resourceful, actively paving their own path in creating their own biographies, the 'do it yourself biography' or the 'risk biography' referred to by Beck and Beck-Gernsheim (2002:24).

5.8. Implications for Midwifery Practice.

Midwives did not feature highly in participants' stories of pregnancy and childbirth. However, it is possible to identify some implications for midwifery practice from the findings of this study. Most of the participants did not discuss their CAM use with midwives. The motivation behind participants' choice of CAM reveals much about their physical, emotional and spiritual needs during pregnancy and childbirth. Thus there is a lost opportunity for midwives to understand the individual needs of their clients or fulfil their role in its entirety of providing woman centred care. A lack of shared dialogue means midwives have lost a learning opportunity to enhance their knowledge and understanding of CAM and be in a better position to advise and support those who use various modalities. Those that did disclose their CAM use to midwives or other health professionals often received disparaging or dismissive comments. Both non-disclosure and participants' perception of a lack of support for their CAM use perhaps illustrates midwives lack of knowledge on CAM. Alternatively, it could be a reflection of the inconsistent advice that originates in policy such as the NICE guidelines (NICE 2006, 2008a). Nevertheless, the Midwives Rules (NMC 2004) are clear that midwives should respect women's wishes to use CAM.

Midwives could learn from CAM practitioners about the power of the therapeutic relationship and its contribution to positive outcomes. Midwives also place great importance on developing supportive relationships with women. Despite long standing government policy promoting the need for continuity of care and improved mother-midwife relationships few women in the UK have the opportunity to benefit from such a relationship with their midwives (Kirkham 2010). When midwives work within systems constrained by obstetric ideology and risk dominated policies they find it impossible to develop connecting relationships with women. They no longer have the option or the time to provide individualised care (Kirkham 1999, McCourt and Stevens 2009, Wilkins 2010). However, by analysing the characteristics, behaviour and demeanour of CAM practitioners and how these contribute to supporting relationships midwives may find ways of improving their ability to develop trusting relations with women, despite the constraints of resources and time. I would argue that the same characteristics of choice, mutual benefit and emotional communication evident in the relationship between CAM practitioners and their clients are also fundamental to midwifery practice. Indeed, Nicholls and Webb (2006), found good communication, compassion, kindness, caring and supportive were seen as essential skills of a good midwife.

That midwives wish to improve their relationship with women is evident in the increasing number of midwives who engage with CAM. Midwives can expand their scope of practice to include CAM, provided they receive education and training and it is in the best interests of women in their care (NMC 2004). Daisy, Erin, Rose and Alison sought CAM from midwives with qualifications in chiropractic or acupuncture for their treatments. They particularly valued their dual qualifications as Rose explained:

'It was brilliant, to know that she was a midwife as well and to know that she sees it from that angle. It definitely sealed, confirmed my trust in it and it was nice. It made her feel very connected with my pregnancy and it was nice you know. There was the kind of compassion about her. I don't know, there was just something very nice about the way she would kind of feel the position of the baby and just that kind of confidence in her touch

around the baby and the abdomen. It was really nice and very reassuring so yea I enjoyed it. It was like going to see the midwife but having that extended level of care. It did, it was lovely, it wasn't the deciding factor but it was very nice that she was trained'.
(Rose, 2nd interview)

Lane (2008:143) refers to the 'happy marriage of midwifery and CAM', since the 'woman centred' philosophy of midwifery practice is congruent with the values of CAM. Midwives cite the same reasons they work with CAM as participants in this study: to support normal birth, to provide alternatives to medical intervention and to facilitate the provision of holistic care (Mitchell and Williams 2007). However, none of the participants accessed CAM through the maternity services. While the medical model of maternity services remains dominant, the challenges may have been too great for these midwives to integrate CAM into midwifery practice. For women then CAM may provide an alternative approach that supports a more holistic and social model of care in pregnancy and childbirth than that which they receive in the maternity services.

Despite the congruence between CAM and midwifery there is little evidence that professional bodies, expert advice such as that issued by NICE (2006, 2008a, 2008b) or midwifery educational curricula have embraced CAM. Midwives are cautioned to avoid recommending CAM on the basis of a lack of knowledge, conflicting information and ill-advised restraint on the grounds of safety (Tiran 2006, Lane 2008). Concerns about the safety of CAM should never be dismissed but it is clear that for the participants in this study such guidance had little impact on their choice to use CAM during pregnancy and childbirth. A more satisfactory approach would be one in which there is open dialogue between midwives, women and CAM practitioners on how best to meet individual needs. When medical professionals work in a collaborative and inter-professional way with CAM practitioners, when their skills and expertise are valued research has found this has contributed to patient safety, more effective use of resources and improved patient satisfaction (Grace and Higgs 2010). Perhaps such a model may be the key to the development of maternity services of the future. At the very least midwives should be open

mindful about CAM and adopt a questioning, enquiring approach rather than dismissing CAM without foundation. In asking women to share their stories, midwives could not fail to recognise the significance of CAM use for women in their experience of pregnancy and childbirth, as I have done in this thesis.

Chapter 6. Conclusion

In this thesis I have explored the experiences of women who have used CAM during pregnancy and childbirth and sought to understand the meaning they ascribe to such use. In the conclusion I revisit the aim of this thesis, highlight my key findings and place them within the context of CAM and the conceptualisation of risk.

Although other research has explored prevalence and women's experiences of CAM during pregnancy these studies have mostly adopted a positivist paradigm which has limited the opportunity to explore individual and complex motivations. This study is unique in that my concern has not been with the extent of CAM use but of women's experiences within their socio-cultural context and the meaning they ascribe to their practices in relation to CAM. It has also provided insights into women's beliefs and values in relation to biomedicine and how the risk orientated approach of the maternity services impacts on women's experiences of pregnancy and childbirth.

Although each participant's story had its own particular nuances, crises, turning points and climax, a number of core narratives emerged. For every woman their central narrative was one of pregnancy, birth and of their baby. Narratives of CAM were always set within the context of their individual experience of pregnancy and childbirth. It is important to acknowledge that all participants experienced a normal course to their pregnancies, despite most suffering 'minor disorders'. Some participants experienced medical complications such as breech and prolonged labour. All participants made a good recovery from childbirth and had a healthy baby during the research timeframe.

Firstly, I argued that for all participants, pregnancy precipitated a narrative disruption or a breach in ontological security. Dissatisfaction with the medicalized approach to maternity care, the lack of opportunity to develop trusting relationships with health professionals and a perceived lack of support were influential in participants' choice to pursue CAM. The most important

factors in participants' decisions to seek CAM were their previous positive experiences and the congruence between CAM philosophy and their personal values and beliefs. CAM provided a way of creating continuity with the past as participants sought to achieve both the physical and emotional equilibrium they had experienced prior to pregnancy, thus minimising the effects of narrative disruption.

The overarching storyline was participants' desire for a healthy pregnancy, a 'normal birth' and an emotionally fulfilling experience. Their CAM practices facilitated the achievement of their hopes and dreams. CAM use was thus self-described by participants as one of transformation. I have thus defined the narrative genre as transformative. By this I mean that participants' positive experience of CAM facilitated a transformation of their ideas, beliefs or ways of being in the world. Qualitative research on CAM use during times of illness has also documented the potential for CAM to be transformative, facilitating personal growth and fulfilment (Willison 2007). However, my analysis provides a new perspective in defining the genre as transformative, not described before in narrative or CAM research.

The meaning that participants ascribed to their CAM use was summarised by Caroline as one of being '*Forewarned, Forearmed and Relaxed*'. Other writers including myself have highlighted women's use of CAM in pregnancy and childbirth as assisting in preparation for childbirth (Tiran and Mack 2000), offering alternatives to routine medical intervention (Mitchell and Williams 2007, Mitchell and Allen 2008), for pain relief (Cyna and McAuliffe 2004) and as a way of experiencing a degree of control over birth experiences (Steen and Calvert 2007). However, in deconstructing participants' actions by exploring the meaning of CAM use, this study enhances understanding of the increasing prevalence of CAM use in pregnancy and childbirth by exploring what is under the surface of women's motivations and experiences of CAM. This perspective contributes new knowledge on CAM use in pregnancy and during childbirth.

For some time I resisted advice to consider a theoretical framework to underpin my research. Reflecting on my reasons for this resistance revealed a desire to enter the field with openness and a concern to allow theoretical assumptions to emerge from the data rather than be predetermined. I did not want to be bounded by a framework that would inevitably pre-empt the questions I would ask as Green (2009) highlights this is a limiting factor in much risk research. I began the field work with a conviction that I was being faithful to the philosophy of narrative inquiry by not posing any constraints on participants in the telling of their stories. Nevertheless, in listening to women's stories I came to a realisation that participant discourses and practices in relation to CAM had a resonance with concepts of risk. I made the decision to choose risk as a theoretical framework with the belief that this provided the potential for a fruitful interpretation and a way of making sense of women's use of CAM in pregnancy. Additionally, I identified a gap in the literature as I could not find any published work which had explored CAM use in pregnancy through a lens of risk. Indeed, Zinn (2009) argues it is more worthwhile to study risk by exploring every day phenomena than framing research questions from the outset within a risk paradigm. This I believe is a strength and original feature of my research.

This research both supports and refutes some of Beck's and Giddens' concepts of the risk society. Participants experienced a pervading need to reduce feelings of uncertainty and strengthen themselves, physically, emotionally and spiritually for the tasks of pregnancy, birth and motherhood. In their preparations for childbirth women hoped to reduce the need for unnecessary or routine medical intervention with its associated risks. Women's practices in using CAM, whether as a response to the uncertainty of pregnancy and childbirth or as a defence against manufactured risk, both take place against a background of coping strategies which transform an unpredictable and unmanageable future into one which is more predictable and manageable. The common denominator is uncertainty rather than risk. In this respect I agree with Zinn's (2009) argument for a shift from risk and uncertainty to uncertainty and risk: when risks are unpredictable or uncontrollable uncertainty assumes priority. It is the stress and anxiety

associated with uncertainty which has to be dealt with. Indeed, the uncertainty women experienced had a profound impact on the emotional experience of pregnancy. Discourses of stress, the imperative to reduce fear, anxiety and achieve a state of relaxation and feelings of wellbeing were a common feature in participants' narratives. Their CAM practices helped them to achieve this desired state and provided what they felt was a safe environment for their baby.

The risks that women faced during pregnancy and birth are both real and socially constructed. Although this may seem contradictory, participants' narratives of risk revealed risk perception as a hermeneutic activity described by Lash (2000). Despite the fact that participants experienced normal pregnancies they were very aware of the risks pregnancy may pose to both physical and emotional wellbeing and that of their baby. They were also very aware of the 'manufactured' risks of medical interventions but their interpretation of these risks as dangers was based on their personal values, beliefs, hopes and dreams. The net effect of the uncertainty of pregnancy outcomes and the fear of 'manufactured risks associated with unnecessary medical intervention was a escalation of worry and anxiety.

Participants' decisions to pursue CAM demonstrated the type of cognitive reflexivity described by Beck and Giddens, but more importantly reflexive decisions were based on emotion, intuition and aesthetics. The social and cultural factors which influenced their decision making included the accessibility and acceptability of CAM, their relative affluence, high levels of education and dissatisfaction with the medicalized approach of maternity care. Thus both Lash and Douglas's sociological approach to understanding risk perception and response are more illuminative in understanding participants' motivations in using CAM during pregnancy. Zinn's (2008a) amalgamation of both rational and non-rational means to decision making, his description of these 'in-between' strategies for decision making in the face of risk and uncertainty is also apt. The strategies that individuals develop to manage risk and uncertainty include, building relationships, paying attention to emotions and intuitive feelings and, for my participants, the use of CAM as a readily

accessible resource. Notions of trust and distrust are also pertinent in participants' decision making (Alaszewski and Coxon 2008) but in a rather more complex and interrelated way than Beck and Giddens suggest. Participants' choice of CAM was both underpinned by trust, for example, in the development of relationships with CAM therapists and distrust, for example, the avoidance of medical advice and intervention. A factor that is underplayed by Beck and Giddens is the role of an individual's past experience in determining risk perception, illustrating the importance of an individual's personal biography in meaning making and in risk perception. The role that family history plays in risk perception is under acknowledged in Beck and Giddens work but also by other risk theorists adopting more sociological approaches. Even in the absence of personal experience, family events such as stillbirth and premature birth like those described by Daisy and Riley impacted on the perception of risk and generated anxiety. A heightened perception of pregnancy and birth as risky is thus transmitted through the generations. The opposite was also true in that some participants described their belief in the normality of pregnancy and birth emanated from their own mother's beliefs and experiences.

It is important to acknowledge that the risk society thesis developed by Beck and Giddens is only one approach to understanding risk. All theories and concepts highlight specific aspects of social phenomena and neglect others. Beck's and Giddens' closely aligned concepts of risk are just one way of viewing the phenomena under investigation. Although differing somewhat in their theories about the role of trust and expert systems they are in agreement about cognitive nature of reflexivity and the agency of individuals in shaping their life course. Other theoretical perspectives such as cultural and psychological approaches to understanding risk have different emphases, values and complexities. Zinn (2009) critiques much risk research for conflating these concepts and suggests it is important the risk approach is differentiated. By focussing on Beck's and Giddens' influential theses I believe I have avoided this pitfall.

Since the 1990s government policy has been to encourage women to assume control over their birth experiences including the right to make choices, but the reality has not matched the rhetoric (Manders and Melender 2009). As Zinn (2009) suggests every risk is accompanied by a chance: a chance to ameliorate or avoid risk and dangers. Unlike others, participants in this study did not sacrifice their chance of achieving a healthy pregnancy, a normal birth and a fulfilling experience by acquiescing to the power of medical discourses. With the help of CAM and the support they received from their CAM practitioners they achieved their desires, hopes and dreams. As Douglas (1992) suggests rejection of technological approaches reveals not only the fear of risks that Beck suggests but also fear of oppression and disempowerment. Thus of equal importance is the contribution that the sense of control, of taking responsibility and making active decisions had on their wellbeing. Even when events did not play out as participants hoped or when they did not achieve the normal birth they desired, they were happy with the decisions they had made in seeking CAM. Indeed, being content and satisfied with decisions contributes to psychological wellbeing (Slovic 2010).

Participants' group CAM practices such as yoga and hypnotherapy played the role of reflexive communities akin to those described by Lash (2000). This role of CAM in actively coaching women to be assertive, to ask appropriate questions of professionals and to defend themselves against routine and unnecessary medical intervention is neglected in the literature. Concepts of risk have provided a critical insight into both cultural and agentic behaviours. Beck's and Giddens' view of the power of agency and the creative potential of individuals is supported. Andrews (2004) suggests that when individual experiences do not match those of the dominant cultural storylines they are challenged to make sense of and find meaning in their experiences. Thus engagement with CAM signifies a resistance, a counter narrative to the normative ideologies of pregnancy and childbirth and a way of locating themselves within an alternative cultural practice of CAM. However, the inconsistencies and contradictions within participants' narratives revealed the extent to which the dominant paradigm and medical view of pregnancy and birth influenced their beliefs at an unconscious level. The narrative approach

to my research facilitated the identification and understanding of the impact of the risk approach to maternity care on participants.

My first experience of narrative research has fulfilled my expectations of it. It has allowed me a way of understanding the meaning women ascribe to their CAM practices during pregnancy and childbirth, a way that not only acknowledges the complexity of individual lives and experiences but also acknowledges the importance of the social context and the role of the researcher in the co-construction of knowledge. It has been fascinating witnessing the unfolding of narrative concepts as my research progressed. I agree with Andrews et al. (2008) that the strength of narratives lies in their ability to reveal different levels of meaning, often contradictory in a way in which the individuals and society can be better understood. The concept of narrative diachronicity described by Bruner (1991) has been so relevant to this study: the criterion of continuity is vital in narrative research as experience grows out of other experiences and always leads to further experiences. A woman's previous life, experiences of pregnancy and childbirth and use of CAM significantly influence not just future birth experiences but approaches to motherhood and child rearing practices and have major significance for individual biographies.

Harter et al.'s (2005) warning that a coherent chronology of events should not be expected was also relevant. Many of the participants' stories were complex, discontinuous and sometimes contradictory. As Miller (2000) suggests it is through narrative construction and reconstruction that individuals make sense of their world and meaning is created. This highlights one of the fundamental tenets of narrative research: that the construction of personal stories is recognised as important for meaning making, as individuals make sense of disruptive or transitional events in their lives. This sense making is a retrospective process requiring time and the telling and retelling of stories, thus my decision to conduct two and sometimes more interviews was appropriate. This proved invaluable in both helping me and my participants to clarify and reflect on the meaning of their stories and is a further original aspect of my research approach. Of particular interest was participants'

capacity to recall events in great detail, it seems that as Simpkin (1992) suggests that pregnancy and birth memories are etched into mothers' minds.

It is vital to acknowledge that, although stories are universally accepted as a way of attributing meaning to individual lives and phenomena, the way in which stories are told and heard differs significantly between cultures (Traher 2008). Stories are therefore influenced by social, cultural and historical influences and therefore cannot be seen as portraying simple or unproblematic truths. Such fundamental difference in story telling means that interpretation is always uncertain, this Clandenin and Connelly (2000) believe is a further distinguishing feature of narrative research. As a midwife, mother and complementary therapist I recognise my interpretation is only one possible way of understanding and that I am inextricably linked and connected to the knowledge generated from this thesis. I recognise this as a limitation of my research. The field of CAM is complex, opinions are polarised, beliefs accepted or dismissed and much of CAM practice is hidden from view. I have taken the advice of Gough (2003) and incorporated my reflexive observations throughout this thesis. These serve to highlight how my assumptions, beliefs and behaviour impacted on the research process and reveal the inter-subjective dynamics between myself and my research participants. Gough (2003) suggests this introspection can yield insights which strengthens the work and provides the basis of a more credible understanding and interpretation. The characteristics of the sample must also be considered in considering the trustworthiness and transferability of research findings. The 14 participants of this study were self-selected and all avid CAM users. Some expressed the reason they came forward for the research was to share their positive experiences with others and to advocate the use of CAM during pregnancy and childbirth. Indeed, CAM users have been noted to become strong advocates for CAM embracing to varying degrees the underpinning philosophies and then often projecting their world view into social activism (Goldner 2004). It is not surprising therefore, that participant accounts were predominantly of a positive nature. Their stories revealed the meaning of CAM use in relation to

perceptions of being in control, making active choices and defending themselves against the uncertainty of pregnancy and childbirth and the risks of unnecessary medical intervention.

Nevertheless, findings confirm that the extent of participants' use of CAM challenges the assumption that a western biomedical system of maternity care characterises women's health choices and practices during pregnancy and childbirth. It is difficult for a single model of health care provision operated by the maternity services to meet individual needs, therefore CAM addresses a demand not met by biomedical care in including a different perspective on health and illness, treatment and preparation for childbirth (Sharma 2003:221, Willison et al. 2007). Far from being the gullible consumers of CAM, women were knowledgeable and confident in their choices and beliefs. In making decisions to choose CAM, in particular which therapy was right for them participants displayed the characteristics of individual reflexivity described by Beck (1996b). As such they are discerning consumers, people who make choices based on a range of information and beliefs rather than relying on others to make decisions for them, proactive individuals rather than compliant patients. The findings can assuage the concerns of those who cite CAM as disempowering (Leap 2000, Robertson 2002). To the contrary, CAM use transformed women's beliefs in the normality of birth, taught them practical strategies to use as a defence against unnecessary medical intervention, but more importantly put them in control over their birth experiences.

I suggest that participants in this study accomplished the critical reflection, self-confrontation and self-transformation that Beck (1996b) argues is characteristic of reflexivity: through the use of CAM and by adopting different ways of viewing and being in the world, by achieving stress relief and the ability to relax. As Adam et al. (2002) point out that when risk is not amenable to control the imperative is for individuals to find new ways of relating to risk, it seems for the women in this study CAM is their way. Participants' response then is like that which Alaszewski and Coxon (2009) have identified as a growing resistance to expert definitions of risk and to expert solutions for managing it. Unlike the medical approach which calls for more science and the

application of further technology to deal with risks, women in this study desire a return to a more natural and social model of maternity care, with CAM supporting physical, emotional and spiritual processes in the transition to motherhood. This finding highlights the need for profound cultural change within the maternity services. As Becker (2010) says gaps in maternity service provision cannot be resolved by women themselves no matter how much they utilise CAM. The findings of this research are relevant to midwives. The care and support offered by CAM practitioners enabled participant's physical, emotional and spiritual needs to be met. Midwives should ask and be interested in their client's use of CAM, since a shared dialogue may enhance midwives knowledge and understanding of CAM. The elements of CAM practice and the characteristics of CAM practitioners that contribute to a therapeutic relationship could be explored and applied to midwifery practice. . A relationship of kindness, caring and empathy, one in which there are mutual benefits but fundamentally one in which the woman feels as if her experiences count.

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Glossary of Terms

Acupuncture: a component of Traditional Chinese Medicine which involves the insertion of needles into the body to treat a range of problems (Heller, T. Lee-Treweek, G. Katz, J. Stone, J. Spurr, S. (2005) *Perspectives on Complementary and Alternative Medicine* Abingdon: Routledge)

Aromatherapy: the use of essential oils derived from plants for therapeutic purposes (Worwood, V.A. (1990) *The Fragrant Pharmacy*, London: Bantam Books.)

Bach Flower remedies. Bach and other flower remedies are prepared by infusion. Flower heads are placed on the surface of pure spring water and left to infuse in direct sunlight. The water is retained and preserved in alcohol. The remedies are used for the treatment of a range of emotions (Woodham, A. Peters, D. (1997) *The Encyclopaedia of Complementary Medicine*, Dorling London: Kindersley Books

Biomedicine, a term most commonly used in CAM literature to refer to the tradition of western medicine (Quah 2003). Biomedicine is based on scientific method, in that its beliefs and practices are determined by empirical observation, and the generation of universal laws to explain the natural world and the origins and management of health and illness (Seale and Pattison 1994:7).

Breech Presentation: a baby is said to be lying in a breech position when the buttocks are lying in the lower pole of the uterus. Babies may lie in this position for a number of reasons but often it is unexplained. Delivery of a baby with a breech position is associated with a risk of number of complications for the mother and baby.

Complementary and Alternative Medicine (CAM) is defined as “ a broad domain of healing resources that encompasses all health systems, modalities, and practices and their accompanying theories and beliefs, other than those

intrinsic to the politically dominant health system of a particular society” (Cochrane Library 1998).

Caesarean Section: A caesarean section is an operation to deliver a baby by making an incision through the abdominal wall and the uterus. It can be performed as an elective or emergency procedure. Usually a caesarean section is performed when a vaginal birth places either the mother or baby at risk.

<http://www.nhs.uk/Conditions/Caesarean-section/Pages/Introduction.aspx>

accessed 31/08/2011)

Chiropractic: Chiropractic specializes in the diagnosis, treatment and management of conditions that are due to problems with the joints, ligaments, tendons and nerves, especially related to the spine. [www. http://chiropractic-uk.co.uk](http://chiropractic-uk.co.uk) accessed 31/08/2011)

Cranio sacral therapy: is a method some osteopathic physicians use to restore health by adjusting the bones of the skull and sacrum. <http://www.ebm-first.com/craniosacral-therapy.html> accessed 31/08/2011)

Dilated e.g 4-5cms: refers to dilation of the cervix that occurs in the process of labour. The cervix is said to be fully dilated when it has reached 10 cms dilated, after which the baby is ready to be born.

Discourse: ‘a bounded body of knowledge and practices’ provides a cultural insight into ways of giving meaning to reality via words and imagery. Through discourses an individual perceives and understands their social, cultural and material world. Discourses may have the effect of either limiting or making possible human agency (Lupton 1999:5).

Evidence-based medicine (EBM) defined as “the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients” (Sackett, D. Rosenberg, W. Gray, M. Haynes,

R. Richardson, S. (1996) Evidenced-based medicine: what it is and what is isn't *British Medical Journal* 312. pp. 71-72)

Epidural anaesthesia: often referred to as an **epidural**, is an injection into the back that numbs the lower half of the body and stops any pain. Often used in labour to control labour pain. It is associated with a range of complications for mother and baby. (<http://www.nhs.uk/conditions/epidural-anaesthesia/pages/introduction.aspx> accessed 31/08/2011)

Holistic: the belief in the interconnectness and interdependence of mind, body, and spirit for health and wellbeing.

Homeopathy: An entire system of healing based "let like be cured with like".

The law of similars: medicines are chosen on the basis of their similarity between their pharmacological effects and the symptoms of the disease.

Homeopaths claim the remedies work by providing an energetic stimulus to the body which promotes self healing. **The law of potencies** states that minimum doses are more effective (Vickers, A. (1999) ABC of complementary medicine: homeopathy *BMJ* 319 (7217), pp.1115-1118.)

Induction of labour: the stimulation of labour by surgical or pharmacological methods. It recommended when continuing the pregnancy could pose additional risks to the mother and/or baby. It is associated with a number of risks for example the need for emergency caesarean section is increased and it has an impact on the birth experience of women. In the UK approximately one in five labours are induced (NICE 2008).

Herbalism or Herbal medicine, is the use of plants, in a wide variety of forms, for their therapeutic value. Herb plants produce and contain a variety of chemical compounds that act upon the body and are used to prevent or treat disease or promote health and well-being.

Hypnobirthing is a complete antenatal education intended to help women achieve a natural childbirth using easily-learned self hypnosis and breathing techniques. (<http://www.hypnobirthing.co.uk/> accessed 31/08/2011)

Hypnotherapy a form of deep relaxation in which a Hypnotherapist helps people to make changes in their behaviour.

Kinesiology: a CAM modality which uses muscle testing to assess all bodily processes for optimal functioning from both a physical and psychological perspective. If problems are found the kinesiologist uses a variety of strategies such as nutrition, massage or counseling to rectify the issue.

Massage: a touch therapy in which the skin and deep tissues in the body are manipulated for therapeutic effect. There are many different traditions included western methods, eastern methods and non touch methods called therapeutic touch. (Woodham, A. Peters, D. (1997) *The Encyclopaedia of Complementary Medicine*. Dorling London: Kindersley Books)

Meditation: a state of profound relaxation. Various techniques are used to induce this state but all involve focussing the mind on a particular object, word, activity and avoiding distractions. (Woodham, A. Peters, D. (1997) *The Encyclopaedia of Complementary Medicine*. Dorling London: Kindersley Books)

Moxibustion: Moxibustion is a treatment used in Traditional Chinese Medicine to encourage cephalic version of the breech. It involves burning of the herb moxa to heat the acupuncture point Bladder 67 on both feet. Studies suggest heating this point for 10-15 minutes daily for 7-14 days increases the version rate of breech to cephalic presentation (Cardini, F, Weixin, H. (1998) Moxibustion for correction of breech presentation *JAMA*. 280, pp. 1580-4)

Naturopathy: also known as natural medicine, naturopaths believe use diet and non invasive therapies to promote self healing of the body (Woodham, A.

Peters, D. (1997) *The Encyclopaedia of Complementary Medicine*. Dorling London: Kindersley Books)

Normal birth: normal birth defined as 'spontaneous in onset, low risk at the start of labour and remaining so throughout labour. The infant is born spontaneously in the vertex position between 37 and 42 completed weeks of pregnancy. After birth mother and infant are in good condition (WHO (1999) *Care in Normal birth a Practical Guide*. Report of a technical working group WHO Geneva).

Osteopathy: an approach to diagnosis and treatment that originated in America in the 19th century. Practitioners use touch and manipulation of the musculoskeletal system as treatment (Woodham, A. Peters, D. 1997 *The Encyclopaedia of Complementary Medicine*. Dorling London: Kindersley Books)

Placebo: means 'I please' : a positive therapeutic outcome that can occur after the administration of an inert substance or intervention by initiating a physiological or psychological response. Placebo effects contribute significantly to treatment outcomes. In CAM the term placebo includes the broad array of non-specific effects of a therapy including the patient practitioner relationship, expectations, empathy, reduction of anxiety and increase in self awareness. (Peters, D. (2001) *Understanding the placebo effect in complementary medicine*. Edinburgh: Churchill Livingstone)

Reflexology: a complementary therapy in which 'reflex' points in the feet, hands and sometimes ears are stimulated by specific massage techniques. It is thought that each area of the body including specific organs can be accessed through these reflex points. The stimulation of these points can improve health in various parts of the body improving the circulation, removing waste products and balancing energy flow.

(<http://www.internethealthlibrary.com/Therapies/Reflexology%20.htm#top> accessed 31/08/2011)

Reiki: a form of touch therapy which originating from Japan. 'Reiki means 'universal life energy', the energy which surrounds all living things. The therapist can facilitate healing through the laying on of hands or by distance healing. The universal energy is manipulated by the therapist to create a balance of energy in the recipient's body (
<http://www.internethealthlibrary.com/Therapies/reiki.htm>.accessed 31/08/2011)

Relaxation: "a state of consciousness characterised by feelings of peace and release from tension, anxiety and fear" (Payne, R. (2000) *Relaxation techniques: a practical handbook for the health care professional*. Edinburgh: Churchill Livingstone)

Risk. Zinn (2008a) draws attention to the plethora of ways in which the term risk is alluded to in interdisciplinary risk discourse. The terms risk, catastrophe, threat, hazard and danger all refer to unwanted effects or negative outcomes. In a realist perspective risk also refers to the notion of risk calculation and the probability of the negative outcome occurring. Risk and uncertainty are also often used to denote the same concept. Beck (2009:9) differentiates between risk and danger or catastrophe: risk signals the potential but not the actuality of catastrophe thus 'risk is the anticipation of catastrophe'. Beck (2009) believes it is this anticipation of catastrophe that is omnipresent in our lives. In everyday language 'risk' can also apply to the notion of positive risk taking which belies Beck and Giddens assumption that risk always leads to avoidance or reduction strategies (Lyng 2008). In the maternity services risk is defined usually in terms of ' the likelihood of an adverse outcome for the baby which is greater than the incidence of that in the general population (Fleming 2006)

Shamanism and Shamanic journeying: 'a way of healing and providing spiritual guidance that involves going into a trance. A shaman describes some one who is able to 'journey' to and commune with the spirit world' (Woodham, A. Peters, D. (1997:190) *The Encyclopaedia of Complementary Medicine*. Dorling London: Kindersley Books

Shiatsu: a form of Japanese massage which involves finger pressure on specific points on the body to diagnose and treat physical, emotional or spiritual ill health and promote wellbeing. It is based on the principle of that life energy circulates around the body through meridians and that if this energy flow is disrupted ill health may occur. (Woodham, A. Peters, D. (1997) *The Encyclopaedia of Complementary Medicine*. Dorling London: Kindersley Books)

Theta DNA Healing: is a set of techniques which work to help an individual identify and work on their thought and behavioral patterns to promote healing. Reprogramming of thoughts and behavior is possible by addressing largely subconscious beliefs. It is said to promote healing as once beliefs have been changed it is possible to alter the influence of DNA.

Therapeutic relationship: the relationship between a client and doctor/therapist that contributes to positive outcomes for the client (Mitchell, A. McCormack, M. (1998) *The Therapeutic Relationship in Complementary Health Care*. Churchill Livingstone)

Traditional Chinese Medicine: an ancient system of Chinese healing. It is based on the principle of that life energy (chi or qi) circulates around the body through meridians and that if this energy flow is disrupted ill health may occur. It covers a wide range of therapeutics from herbs, acupuncture, to movement and massage.

Ventouse delivery: a birth that is expedited by traction applied to a suction device applied to the baby's head

Visualization: an active and deliberate thought process of improving a situation or resolving a problem. It is based on the assumption that by repeatedly experiencing an outcome in the imagination the likelihood of it taking place in real life is increased (Payne, R. (2000) *Relaxation techniques: a practical handbook for the health care professional*. Edinburgh: Churchill Livingstone).

Vitalism: the philosophy of CAM which supports a belief that a vital force distinct from physics and chemistry powers the human body. This vital force is usually described as energy and the flow of this energy is vital for the maintenance of health and wellbeing.

Yoga: a form of exercise consisting of body postures and breathing techniques. It has been practiced for thousands of years in India for health, wellbeing and spiritual development.

Appendix 1 Ethics Forms:**FACULTY OF HEALTH AND SOCIAL CARE
FACULTY ETHICS SUB-COMMITTEE APPLICATION
FORM**

All students and staff intending to undertake a research project with human participants need to gain ethical approval for their proposed study before the research begins.

NB: If the proposed research involves NHS patients, patient tissues or organs, NHS staff, NHS premises, NHS data, you should NOT use this form. Please contact Leigh Taylor, Ethics Sub-Committee administrator for further details.

Please provide all information requested and justify where appropriate. Use as much space as you need – the sections expand as you type. Use crosses [X] in the boxes that apply. Please use the guidance notes to help you with your application.

Your application needs to be filled in electronically and emailed to Leigh.Taylor@uwe.ac.uk. A paper copy with signatures should be sent to Leigh Taylor, Room 2B24, Post Station 3, Glenside Campus within 3 days of sending the electronic version

Please indicate here that you have included the following with your application:

- **participant consent form(s)**
- **participant information sheet(s)**

- **interview schedule (if appropriate)**
- **questionnaire (if appropriate)**

- **observation schedule (if appropriate)**
- **letter of permission (eg from a workplace)**
- **other (describe)**

For further guidance, please contact Leigh Taylor, Leigh.Taylor@uwe.ac.uk, 0117 328 8833 (Faculty Research Ethics Sub-Committee administrator) or Simon Evans Simon.Evans@uwe.ac.uk (Chair of the Faculty Ethics Sub-committee)

Faculty Research Ethics Committee APPLICATION FORM

Part A: Section 1 Details of Research Project

A1. Name of researcher

Mary Mitchell

A2. Contact address

Faculty of Health and Life Sciences
University of the West of England
Glenside Campus Rm 2A.06
Blackberry Hill
Bristol BS16 1DD

A3. Email address (if available)

mary.mitchell@uwe.ac.uk

A4. Contact telephone number and whether work or home

work: 0117 3288892

A5. Is the research being undertaken as part of an educational course or degree?

Yes

**Give name of the course/degree or details of how research fits within the Faculty
e.g. small grant, scholarly work**

Professional Doctorate

A6. Name of supervisor/mentor

Dr David Pontin

A7. Title of research

A narrative exploration of women's past experiences of using complementary therapies in pregnancy and childbirth

A8. Anticipated start date

June 2009

A9. Anticipated completion date: September 2012

A10. Other key investigators/collaborators applicable **Not**

Name:

Organisation:

A11. Other Research Ethics Committees that will be approached? applicable **Not**

Give details

A12. Where will the research take place?

Give details

The interviews will take place at a location convenient to the participants. I anticipate that in most circumstances this will be in participant's homes. However, if the participants prefer to meet elsewhere the criteria of privacy will dictate location. The analysis of data and the writing of any work may take place at Glenside Campus or in the home of the researcher.

A13. Has funding for research been secured?

Yes

If yes, give details of funding organisation(s) and amount secured

University of the West of England has funded the Professional Doctorate

A14. Has the funder of the research agreed to act as sponsor as set out in the Research Governance Framework? (see note 1 below)¹

Yes

A15. Has the employer/supervisor of the researcher agreed to act as sponsor of the research? (see note 1 below)

Yes

Give details of the organisation who will act as the sponsor of the research:

Dr David Pontin/University of the West of England

Organisation:

¹ In student research the supervisor normally acts as the sponsor
 In unfunded staff research, the University acts as the sponsor
 In funded staff research, the sponsor might be the funder or the University but this must be clearly stated
 If unsure, seek advice from Leigh Taylor (Faculty Ethics Sub-Committee administrator)

Part A: Section 2 The Proposal

A16. What is the principal research question/objective?

Research aim: to explore women's past experiences of CTs during pregnancy and childbirth and the meaning ascribed to their use.

A17. What are the secondary research questions/objective?

Sub aims

- To explore the reasons women give for using complementary therapies during pregnancy and childbirth
- To explore the experiences of women who use CTs in pregnancy and childbirth in relation to:
 - a) their personal history of CT use
 - b) their pregnancy and childbirth journey

A18. What is the justification for the research? What is the background? Why is this an area of importance?

The last decade has witnessed an enormous and unpredicted growth in the use of complementary therapies (CTs) in the UK and worldwide (Ernst and White 2000). Complementary therapies are defined as "a broad domain of healing resources that encompasses all health systems, modalities, and practices and their accompanying theories and beliefs, other than those intrinsic to the politically dominant health system of a particular society or culture in a given historical period" (Cochrane Library 1998). Women are more likely to use CTs than men and there is a suggestion that the use of CTs is increasing during pregnancy (Tiran 2005). This is despite the recommendation from the National Institute of Clinical Excellence (2004) that discourages women from using CTs and midwives from recommending them due to a lack of research evidence. A study from the USA reported that one third of women used CTs during pregnancy (Ranzini et al 2001). However, no studies have addressed this issue in the UK. The growing popularity of CTs in pregnancy may reflect a growing disillusionment with conventional medical practices and the biomedical model on which the maternity services are built or the desire for a more holistic approach centred on the experiences of the individual (Mitchell and Williams 2007), but there is little empirical evidence on which to build this supposition.

Pregnancy and childbirth are normal physiological events but represent a time of social change and psychological adaptation that can pose additional challenges for women. Tiran and Mack (2000) suggest that the use of CTs may help women cope during this process. In addition, the use of CTs may offer women the opportunity to gain an insight into the spiritual and empowering aspects of childbirth which the medical model does not often address (Mitchell et al 2005). Many midwives have embraced the use of CTs as the philosophies and principles of complementary therapies fit well with the fundamentals of midwifery care,

which emphasises the link between the mind, body and spirit (Tiran 2005). Midwives also claim that in providing CTs to pregnant women they are supporting normal birth and the development of maternity services which focuses on the provision of a woman-centred, holistic and social midwifery model as opposed to the biomedical model of care which is currently prevalent (Williams and Mitchell 2007). However, this view is not universal, attitudes to CTs are not always favourable and some midwives suggest that use of CTs may prevent women from utilising and developing their inner resources and coping strategies (Leap 2000). There has been no research from a woman's perspective to claim or refute these suggestions. Attitudes to the use of CTs vary enormously. Within the medical and scientific community these are particularly polarised and CTs are often dismissed as "nonsensical", ignored by medical practitioners (Bagley 1999) or described as implausible by western science (Quah 2003). Despite such divergence of feelings on the value of complementary therapies there is a growing body of evidence to support improved subjective feelings of health and wellbeing with CT use but mostly within the context of chronic illness (Graham 1999).

Despite the controversies, there is evidence that CTs are being integrated into the maternity services (Mitchell et al 2005). Nevertheless, these CT services are often provided on an ad hoc basis, are often under threat of withdrawal and are open to criticisms by the medical profession (Williams and Mitchell 2007). This also leads to a lack of opportunity for evaluation, audit and research on the use of CTs during pregnancy and childbirth, hence the dearth of empirical evidence in relation to CT use during pregnancy and childbirth. Women who use CTs during pregnancy and childbirth are more than likely to be accessing services outside of the NHS. Since the use of CTs is often not disclosed to health professionals (Ranzini et al 2001) little is known about women's use of CTs during pregnancy and childbirth.

In addition, there has been little attempt to explore the experiences of women who use CTs in pregnancy and childbirth, to discover the value they place on their use and how CTs contribute to the overall experience of pregnancy and childbirth. Yet this information is vital for midwives if they wish to provide services that meet women's needs and are congruent with the rhetoric of women-centred care, as espoused clearly in the political agenda for maternity services provision (DOHa 2004). If midwives are to truly fulfil their remit of being "with woman" it is important to learn through women's experiences. In developing midwifery practice it is vitally important that midwives understand women's reasons for using CTs in pregnancy and the meaning they attribute to their use. The findings of this research would add to the limited evidence base on women's use of CTs during pregnancy and childbirth, bring to light their experiences confirming or refuting midwives views and contribute to policy and practice development within the maternity services. This research may also be influential in providing insight into the meaning that women ascribe to the use of CTs during pregnancy and childbirth that may encourage professionals to reflect on their attitudes to CT use.

A19. Give details of methods and overview of the planned research. Where appropriate a flow chart or diagram could be submitted separately. *(It should be clear exactly what will happen to the research participant, how many times and in what order.) Include a copy of the interview schedule/questionnaire/observation schedule as appropriate.*

Methodology.

Narrative inquiry is a qualitative research approach with the underlying premise that individuals effectively make sense of their world through narratives or by telling their story (Riessman 1993, Czarniawska 2004). Lieblich et al (1998) suggests that through narratives it is possible to learn about the world of individuals, about their lives and their experienced reality. Narrative researchers do not seek to uncover “truths” rather they accept that stories are constructed around events allowing the narrator creativity and freedom of expression in recounting those events. The narrative approach assimilates the philosophy of midwifery practice and that of CTs in the need for a holistic research approach.

Research Methods

As fitting with narrative inquiry, face to face in-depth interviews will form the main method of data collection. At least two interviews will be carried out. The purpose of the first meeting would be to develop a rapport with the participant, provide an opportunity for the participant to ask questions and begin a preliminary discussion about participant’s use of complementary therapies. The second meeting will provide an opportunity to further explore issues raised during the first interview and discuss specifically about use of complementary therapies during pregnancy and childbirth. Each meeting would last about an hour, but shorter or further meetings could be arranged to suit the needs of the participant. A schedule will act as a loose structure to guide the interviews. No fixed boundaries will be set at the outset of the interview as women will be asked to recount their personal stories of CT use during pregnancy and childbirth. However, key words and prompts may be utilised to facilitate ongoing dialogue and to ensure all aspects relevant to the study are included. The interviews will take place at a time and location suited to the participant. Due regard will be paid to ensuring privacy. The interview will be audio-recorded. In keeping with my holistic philosophy if participants desire to tell me their stories via alternative sources such as diaries, poetry or visual material such as photographs these would also be relevant to narrative inquiry (Kendall and Murray 2004, Herxheimer and Ziebland 2004, Boynton and Auerbach 2004) as they are infused with the life experiences of the individual.

Data Analysis

There are a variety of approaches to the analysis of narratives (Riessman 1993, Lieblich et al 1998, Mishler 1986). The process involves reading and rereading the narrative. Initial and global impressions are identified, exceptions, contradictions or incongruence noted. The main focus of the story and themes to emerge are identified. Overcash (2003) recommends that the criterion of recurrence, repetition and forcefulness should be applied across two levels i.e. intrathematic, where themes are identified for a single narrative and interthematic to aid analysis across narratives., Geanellos (2000) suggests the researcher should explore the language of the narrator to generate greater insights into the meanings individuals ascribe to events. Recognising the necessity of this

multifaceted approach I have adapted the model used by Bleakley (2005). This is based on Lieblich et al's (1998) 4 dimensions of analysis, focusing on particular episodes and a holistic approach which considers the story as a whole. The research approach of in-depth open ended interviewing and engagement with participants in the process of data analysis will contribute to demonstrating trustworthiness and consistency. Participants will be sent transcripts of the interviews if they wish and encouraged to comment on them to aid my understanding of their meaning. All decisions regarding return of transcripts will be guided by participant needs and desires. My work will be subject to a review process via the supervision team.

A20. How has the quality of the research been assessed? (Select all that apply)

- Through the UWE project approval process (PA1)
- Through the Faculty Small Grant Scheme (staff)
- Internal review (e.g. involving colleagues, academic supervisor)
- Part of assessment
- Through Research Degrees Committee

A21. How is it intended the results of the study will be reported and disseminated?

- Peer reviewed journal
- Internal report
- Conference presentation
- Other publication
- Written feedback to research participants
- Presentation to participants or relevant community groups
- Dissertation/Thesis

Part B: Section 1 Recruitment of participants to your study

B1. How will potential research participants in the study be (i) identified, (ii) approached and (iii) recruited?

Include inclusion/exclusion criteria and give details for cases and controls separately if appropriate.

Sample

The population of interest is women who access complementary therapies through private services. in the Bristol and Bath area. A mixed sampling strategy will be used incorporating both purposive and snowballing strategies to identify a sample of between 10-15 women who have utilised a range of CTs during pregnancy and childbirth, a technique recommended by Bryman (2004). As a complementary therapist I have a network of contacts that will facilitate recruitment of the sample. As I am module leader for a Complementary Module for Midwifery practice on the pre-registration programme I have personal knowledge that some midwifery students have used CTs in the past during pregnancy and birth. Recruitment will not take place through any NHS service provision.

Should the need arise a suitable mechanism of advertising would be through the free publication Bristol and Bath "Folio", delivered to all households in the Bristol and Bath area. The inclusion criteria are that women should have used at least one CT in a past pregnancy and childbirth experience, women should not be currently pregnant or be within 6 weeks of having given birth. For pragmatic purposes women will be excluded if they are not fluent in English and because of difficulties in gaining consent if they are under 18 years of age.

B2. Will any research participants be recruited who are involved in existing research or have recently been involved in any research prior to recruitment?

Yes

No

Not known

If yes, justify their inclusion in your study:

If midwifery students are involved in the study I will ensure that they are not involved in any other study. However, it may not be possible for me to know in advance if other potential participants are involved in other research prior to the first contact.

B3. How are participants informed that withdrawal is possible?

The participants may withdraw from the study at any time. This is clearly written into the information leaflet and will be addressed verbally prior to the participant signing the consent form. A technique of "process consent" will be used, i.e. at every stage of the research process consent to participate will be renegotiated and participants reminded of their rights to withdraw

Part B: Section 2 Consent

B4. Will the participants be from any of the following groups? (select all that apply)

- Children under 18 (16 in Scotland)
- Those with learning disability
- Those who are unconscious, severely ill or have a terminal illness
- Those in emergency situations
- Those with mental illness (particularly if detained under Mental Health Legislation)
- People with dementia
- Prisoners
- Young Offenders
- Adults in Scotland who are unable to consent for themselves
- Healthy volunteers
- Those who could be considered to have a particularly dependent relationship with the investigator, e.g. those in care homes, medical students
- Other vulnerable groups

None of above

B5. Will informed consent be obtained from the research participants?

Yes

Give details of how consent will be obtained and by whom. Give details of any particular steps to provide information (in addition to a written information sheet) e.g. videos, interactive material. If consent is not to be obtained, please explain why not.

If participants are to be recruited from any of the groups in B4, give details of particular steps taken to protect individuals

Women will initiate contact with the researcher if they wish to participate or they wish for further information. The information leaflet includes the contact details of the researcher including postal address, telephone contact and e mail address. In addition a tear-off slip will be included in the covering letter which participants can return if they wish to be included or desire further information. Participants must be able to read and converse in English to be included in the study. The study will be explained in full. An information leaflet will be provided for them and an information sheet will be made available to their complementary therapist, if recruitment is via their therapist. At the first meeting further information or explanation will be provided and a consent form signed. A technique of "process consent" will be used: at every stage of the research process consent to participate will be renegotiated and participants reminded of their rights to withdraw.

B6. How long will the participants have to decide whether to take part in the research? (days, weeks?)

2 weeks

B7. Will a written information sheet be given to research participants?

Yes

Attach a copy of the information sheet to be used

If answer is no, please justify.

B8. Will a signed record of consent be obtained?

Yes

Attach a copy of the consent form to be used

If answer is no, please justify

B9. What arrangements have been made for participants who might not adequately understand verbal explanations or written information given in English? (e.g. translation, use of interpreters etc.)

Not applicable

B10. Is subsequent withdrawal of data possible if a participant withdraws?

Yes

Please describe/justify

If a participant chooses to withdraw after the first interview and they do not wish the data from the first interview to be used then this can also be withdrawn

Part B: Section 3 Care and Protection of Research Participants and Researcher

B11. Will group or individual interviews/questionnaires identify any topics or issues that might be sensitive, embarrassing or upsetting? Is it possible that criminal or other disclosures requiring action could take place during the study? *(eg recounting of upsetting experiences, admitting to illegal drug taking)*

The principles cited in Research Governance (DOHb 2004) and in Research Ethics Framework (ERSC 2005) which concern the rights of individuals will be adhered to. These are: the right not to be harmed, informed consent, voluntary participation, confidentiality and anonymity. Women will be informed about their role in the research, that participation is a choice and they have the right to withdraw at any time (DOHb 2004). Ethics approval will be obtained from UWE. Although it is possible that when women recount their pregnancy or birth experience they may become emotional the opportunity to express their thoughts and views, to have a listening ear may prove beneficial and contribute to emotional well being (Finch 1993). The researcher, an experienced midwife will be alert signs of distress or unwillingness to continue. If this occurs the participants will be encouraged to seek appropriate professional advice. Information on a range of local agencies and services will be available, e.g. the Birth Afterthoughts Service in North Bristol NHS Trust and a similar service available in Bath.

B12. What is the potential for pain, discomfort, distress, inconvenience or changes to life-style for research participants as a result of their participation in your study? How will this be dealt with?

Setting aside time for the interviews may inconvenience some women. However, the researcher will be alert to this and ensure flexibility in arranging times, dates and locations of interviews to suit participants. Although it is envisioned that 2 interviews will be required of up to one hour in length, it is entirely feasible for shorter or further interview times to be arranged. I have informed women of this on the information leaflet

B13. What is the potential for benefit for research participants?

I anticipate that participants will volunteer from an altruistic perspective as much research has suggested (Carter et al 2008). Although a primary purpose will not be to provide a therapeutic scenario, research literature suggests participants often experience qualitative interviews as cathartic and therapeutic (Finch 1993, Murray 2003) allowing a re-evaluation and changed perspectives on their experiences (Jack 1999, Serrent-Green 2005). Other research indicates that people volunteer for research because of a desire to that as a result they feel their experience and views help others and are valued and they gain a sense of being part of a wider community (Carter et al 2008).

B14. How will any problems identified by the researcher during the study be referred onwards or dealt with eg helpline numbers given, counsellor available?

The researcher is an experienced midwife who will be aware of the signs of emotional distress or emotional ill health such as postnatal depression. If such a situation arises a suggestion will be made that the woman contacts the GP in the first instance. Contact details for a range of local support services such as Birth Afterthought Services, the NCT or other support groups for mothers will be available.

B15. Describe what steps will be taken to protect the researcher? e.g. take mobile phone, whereabouts known by third party, staff nearby, regular supervision, etc.

Prior to engaging in field work the researcher will record whereabouts with a third party either at home with next of kin or with the Department Admin support. A mobile phone will be available and a satellite device will be used to ease transport in unfamiliar geographical areas. Supervision and support will be provided by the researcher's supervision team and other experienced colleagues in the Faculty.

B16. What health and safety aspects have been considered in this proposal?

As above

Part B: Section 4 Community and Confidentiality Issues

B17. How will the results of research be made available to research participants?

Transcripts of the first interview will be available to participants at subsequent meetings and can be sent to them at completion of the interview process if they desire. If the participant wishes the results of the study can be made available in summary form or a copy of any publications to arise from the study can be forwarded to them at a later date. An e-mail contact will be retained to inform participants when the study is completed.

B18. Will the research involve any of the following activities at any stage (including identification of potential research participants)? (Select all that apply)

Transfer of data by floppy disc - No

Sharing of data with other organisations- No

Use of personal addresses, postcodes, faxes, emails or telephone numbers-Yes

Publication of direct quotations from respondents. Yes

Use of audio/visual recording devices- Yes

Storage of personal data on any of the following:

Manual files

NHS Computer

University Computers: Yes

Home or other personal computers: Yes

Laptop computer: No

B19. What measures have been put in place to ensure confidentiality of personal data? Give details of whether any encryption or other anonymisation procedures have been used, and at what stage?

The researcher has considered the guidelines from the Data Protection Act 1998 and the HSC draft guidelines on Data Management. I will ensure the following:

Personal data will only be held for the specific purposes of the research study.

Personal data and any transcripts of interviews will only be stored and accessed through password protected computers in Glenside Campus and in the researcher's home. Both computers are protected by a firewall. There will be no movement of computers between sites

All participants will be allocated a pseudonym. All data will be anonymised and the code to identify participants will be stored separately from the main data and details of the participants.

All digital recorders or manual files will be kept in a locked filing cabinet in the researcher office 2A06 which is also capable of being locked.

All audio recordings will be destroyed at the completion of the study but research records will be retained for a period of 12-15 years by the Faculty Research Office as recommended by UWE.

Movement of data between sites will take place only by e-mail in a password protected file.

Movement of data between personnel (e.g. for transcription purposes) will only take place face to face

B20. Who will have access to the data generated by the study?

The researcher and the researcher's supervisors will have access to the data. Interview transcripts will be available for the participants if they wish. If transcription of the tapes is required this will be done through the Faculty Research office.

B21. Who will have control of, and act as the custodian, for the data generated by the study?

Mary Mitchell and the Faculty Research Office

B22. Where will the analysis of the data from the study take place and by whom will it be undertaken?

Analysis will take place in the researcher's office, Glenside Campus or the researchers home.

B23. For how long will data from the study be stored?

Months **15** **Years**

Give details of where they will be stored, who will have access, and of the custodial arrangements for the data:

The researcher will store the data for as long as employed by UWE. The Faculty Research office will be provided with the anonymised data for archiving for a period of 15 years.

B24. How will the data be destroyed and by whom?

The audio tapes will be taken to The Teaching and Learning Support Unit for clearing by the researcher.

Part B: Section 5 Declaration

- The information in this form is accurate to the best of my knowledge and belief and I take full responsibility for it.
- I undertake to abide by the ethical principles underlying the Declaration of Helsinki, and Good Practice Guidelines on the proper conduct of research.
- If the research is given a favourable opinion, I undertake to adhere to the study protocol without agreed deviation and to comply with any conditions set out in the letter sent by the University/Faculty notifying me of this.
- I am aware of my responsibility to be up-to-date and comply with the requirements of the law and appropriate guidelines relating to security and confidentiality of personal data, including the need to register when appropriate with the appropriate Data Protection Officer.
- I understand that research records/data may be subject to inspection for audit purposes if required in future.
- I understand that personal data about me as a researcher in this application will be held by the Faculty Research Ethics Sub-Committee and that this will be managed according to the principles established by the Data Protection Act.

Signature of the Researcher:

_____

Date: April 2009_____

FOR STUDENT APPLICATIONS ONLY

- I have read the ethics application form and support this submission to the Faculty Ethics Sub-Committee. As supervisor, I understand my responsibilities as a sponsor of the student research.

Signature of the Supervisor: Hard copy signed by Dr David Pontin_____

Date: _____

Covering letter

Please respond to:

School of Nursing and Midwifery

Mary Mitchell

0117 3288892

Email mary.mitchell@uwe.ac.uk

8th September 2009

Dear Complementary Therapy Practitioner

Re: a research study on women's past use of complementary therapies in pregnancy and childbirth.

I am a Senior lecturer, a midwife and a complementary therapy practitioner undertaking a research study as part of my professional doctorate. I would like to request your help in recruiting women to the above study. The aim of my research is to explore women's experiences in using complementary therapies during pregnancy and childbirth in order to learn from women and to contribute to midwifery knowledge. Please take the time to read the enclosed information sheet which details the study. If you are willing to help I will send coloured copies in the post to you. I would be grateful if you would then distribute the information leaflet to women that you know have used complementary therapies in the past during pregnancy and childbirth. Then if the woman is interested in participating she can contact me directly. Please note that women if currently pregnant should not be considered for the research. The study is fully supported by the University of the West of England and has received ethics approval. If you have any queries or would like further information please do not hesitate to contact me. Many thanks in anticipation of your help.

Yours sincerely

A handwritten signature in black ink that reads 'Mary Mitchell'.

Mary Mitchell (Senior lecturer, Midwifery)

CONSENT FORM

Title of Project: A narrative exploration of women's past use of complementary therapies in Pregnancy and Childbirth.

Name of Researcher: Mary Mitchell

1. I confirm that I have read and understand the information sheet dated

for the above study

2. I understand that my participation is voluntary and that I am free to withdraw at any time.

3. I agree to take part in the above study.

4. I agree to the interview being audio recorded

5. I agree to the use my anonymised data in publication or other outputs.

Name of participant

Date

Signature

Researcher

Date

Signature

Interview schedule**A narrative exploration of women's past use of complementary therapies in pregnancy and childbirth.**

Procedure: welcome, thank you for attending. Review of participant information sheet. Give opportunity for questions. Complete consent form.

Interview 1:

- Can you tell me how you first came to use Complementary Therapies?
- What influenced you to choose a particular therapy over another?
- Tell me about your experiences of using these therapies?
- What were the benefits of these therapies?
- Did you have any worries or concerns about these therapies?
- What were your family, friends, and health professional's reactions to you using these therapies

Interview 2 and/or 3.

Procedure: welcome, thank you for attending. Review of participant information sheet and recheck consent. Give opportunity for questions. Revisit interview 1 and ask for further explanation if necessary

- Can you tell me how you came to use Complementary Therapies during your pregnancy, childbirth or postnatal time?

- What influenced you to choose a particular therapy over another?
- Tell me about your experiences of using these therapies?

- What were the benefits of these therapies?

- Did you have any worries of concerns about these therapies?

- What were your family, friends, and health professional's reactions to you using these therapies

- Tell be about your future plans to use complementary therapies for yourself or your family.

Additional probing questions will be used by the researcher in order to elicit more in-depth answers

What are the possible disadvantages?

It is possible that when you remember and tell me about your experiences you may find it emotional or upsetting. However, sometimes this is good as we can talk it through but I will also discontinue our discussion if you wish.

What if I am not happy with the conduct of the research?

If you encounter any problems in relation to the conduct of the study, I would like you in the first instance to discuss this with me. If you wish to complain about the way you were approached or treated in the study, please contact David Pontin, e-mail David.Pontin@uwe.ac.uk or telephone 0117 32 88503.

What will happen to the results of the study?

I will write the results in the form of a thesis. The work will also be published and presented at conferences.

Who is organising and funding the research?

The study is part of a Professional Doctorate Degree supported and funded by the University of the West of England, Bristol.

What happens next?

Take some time to think about if you would like to be part of the study. If you would like to take part, please contact me or tell the person who gave you this leaflet and they will contact me with your details.

For further information

Mary Mitchell
School of Health and Social Care
Glenside Campus
Blackberry Hill, Stapleton
Bristol BS16 1DD

E-mail Mary.Mitchell@uwe.ac.uk
Telephone 0117 32 88892

A Research Study

A narrative exploration of women's past use of complementary therapies in pregnancy and childbirth



You are invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. This leaflet tells you the purpose of the study and what will happen if you take part. Take time to decide whether or not you wish to take part. Please contact me if you would like further information.

What is the purpose of the study?

The study aims to explore women's experiences of complementary therapy use during pregnancy and childbirth.

In recent years there has been a tremendous growth of complementary therapies worldwide and in the UK, particularly among women. There is very little information on why women chose to use complementary therapies, particularly in pregnancy and how they experience these therapies. Many midwives have also embraced the use of complementary therapies in an effort to enhance the pregnancy and childbirth experience for women. However the Department of Health does not recommend or actively support the use of complementary therapies in the maternity services, citing the lack of research evidence as the main reason for this. It is important for midwives and the maternity services to understand why women use complementary therapies and how they contribute to the pregnancy and birth experience if they are to provide services to meet women's needs and meet the Department of Health's goal in providing a quality service to all women.

Why have I been chosen?

As someone who has used complementary therapies during pregnancy, birth or afterwards your views, opinions and feelings are valuable and it is important to learn from your experiences. There will be approximately 10-15 women invited to take part.

What do you consider a complementary therapy?

For this study complementary therapies are: any therapy or practice you have used to enhance your health or wellbeing during pregnancy and childbirth that was not provided by the NHS

Maternity Services, for example reflexology, massage, homeopathy, herbal remedies, acupuncture, yoga, shiatsu, chiropractic, osteopathy and many others.

What will happen if I take part and what do I have to do?

I would like to meet with you at least twice. First we would get to know each other, it would be an opportunity for you to ask any questions and then I would begin by asking you to tell me about your experiences of using complementary therapies. The second meeting I may ask you to explain further some of the things we discussed the first time and we could continue discussing your experiences. Each meeting would last about an hour, but I understand you may be busy and I am happy to be flexible and arrange shorter or further meetings if necessary. I would like to audio record our discussions to help me remember. We could negotiate the location of our meetings, wherever is more convenient for you, but it should be private. Everything you say will be confidential. When I write the study, I will ensure that you will not be identified and if you wish I can make sure you see what I write. All the tapes and records will be kept in a locked cupboard and when the study ends they will be destroyed.

Do I have to take part?

No, it is up to you to decide whether or not to take part. If you do you will be given this information sheet to keep and be asked to sign a consent form. If you take part but later change your mind, you can withdraw at any stage and this will have no impact on any further care you receive or my relationship with you. You do not have to give me a reason.

What are the possible advantages of taking part?

Many participants in research of this kind find getting to know the researcher and talking to them over a period of time enjoyable and say it is good to have the opportunity to talk about their experiences. Being part of a study like this can also help you reflect, remember and make sense of your experiences.

A Research Study

A narrative exploration of women's past use of complementary therapies in pregnancy and childbirth

- Would you like to take part in a research study?
- Would you like to contribute to the development of new knowledge on complementary therapies?
- Have you used any of the following complementary therapies during pregnancy, labour or after your birth? Acupuncture, Aromatherapy, Chiropractic, Herbal remedies, Homeopathy, Hypnotherapy/hypnobirthing, Massage, Reflexology, Shiatsu or Yoga

The study will involve sharing your experiences of complementary therapy use with the researcher Mary Mitchell who is a Senior Lecturer in Midwifery at the University of the West of England, a mother and a complementary therapy practitioner.



If you would like to take part in the study, have any queries or would like further information please contact **Mary Mitchell**, School of Health and Social Care, University of the West of England, Bristol. E-mail Mary.Mitchell@uwe.ac.uk or telephone 0117 32 88892.



University of the
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better together

Appendix 2. Classification of Complementary and Alternative Medicine

The House of Lords Classification of Complementary and Alternative Medicine

Categories of CAM disciplines

Group 1: Professionally Organised Alternative Therapies: acupuncture, chiropractic, herbal medicine, homeopathy and osteopathy

Group 2 Complementary Therapies

Alexander technique, aromatherapy, Bach and other flower remedies.

Bodywork therapies including massage, counselling and stress therapies, hypnotherapy, naturopathy, nutritional medicine and yoga

Group 3 Alternative Disciplines

- a) **Long established traditional systems of health care:** Chinese herbal medicine, naturopathy and traditional Chinese medicine

- b) **Other alternative disciplines:** crystal therapy, dowsing, iridology, kinesiology and radionics.

(Mills 2001) The House of Lords Report on Complementary medicine a summary *Complementary Therapies in Medicine* 9 (1), pp. 34-39

Classification of CAM: The National Complementary centre for Complementary Medicine.

Mind Body Therapies: behavioural, social, psychological and spiritual approaches e.g Tai chi, Yoga, Qi Kung, meditation and hypnosis

Alternative Medical Systems: complete systems of theory and practice developed outside of a western conventional biomedical approach to health and illness e.g. homeopathy, naturopathy, traditional Chinese medicine

Biological based therapies: natural and biologically-based products and practices and interventions e.g. herbs, supplements, diet therapy.

Manipulative and body-based systems: systems that are based on manipulation and/or other movements of the body e.g. reflexology, massage

Energy therapies: systems that use subtle energy field in and around the body to promote healing e.g. healing Touch, Therapeutic touch, acupuncture, reiki

National Centre of Complementary and Alternative Medicine:

<http://nccam.nih.gov/> accessed 10th July 2010

Appendix 3. Participants' Use of CAM

Participant	CAM used in pregnancy	Reason for use
1. Norma	Homeopathy Chiropractic and acupuncture Naturopathy and Herbal Remedies	Postnatal depression Back-pain Cleansing in preparation for pregnancy, for physical symptoms and wellbeing
2. Caroline	Yoga, Relaxation and Hypnotherapy, Reflexology Acupuncture Reiki-self administered Postnatal yoga	Preparation for birth Induction of labour Breech presentation and Mastitis Mastitis Wellbeing and as social event
3. Riley (Practitioner-Acupuncturist)	Kinesiology Shamanic journeying Chiropractor-cranial sacral Reflexology and acupuncture Herbalism Homeopathy Yoga Bach Flower remedies	Supporting pregnancy on a physical and emotional basis. Spiritual guidance and preparation for labour Backpain Induction of labour Support in labour Homeopathic kit in labour Pregnancy wellbeing and preparation for labour

Participant	CAM used in pregnancy	Reason for use
4. Star (Director of Natural Therapy clinic but not a practitioner)	Hypnobirthing Acupuncture Reflexology and massage Chiropractic Yoga	Preparation for labour Pregnancy nausea and in labour for energy. General wellbeing in pregnancy In labour for OP position and for the baby-support to breastfeed, painful head following birth Postnatal yoga with baby
5. Alison	Reflexology Massage Chiropractor	Breech, restless legs, itching in pregnancy, back-pain Restless legs Backpain and for her son-general support of musculo-skeletal system.
6. Rachel	Shiatsu Meditation and visualisation and hypnobirthing CDs Yoga	Physical and emotional wellbeing in pregnancy Relaxation and spiritual wellbeing Wellbeing and with baby for social support

7. Rose	Chiropractic and osteopathy Moxibustion Hypnobirthing CD's Yoga Reflexology Shiatsu	Back-pain Breech Relaxation and preparation for birth Preparation for birth Wellbeing
8. Ladybird (practitioner – massage)	Massage Acupuncture Herbal-evening primrose oil vaginally Chiropractic	Wellbeing and physical symptoms of pregnancy Breech Onset of labour Rib pain and for baby with ? colic
9. Stephanie	Acupuncture and reflexology Acupuncture in pregnancy Hypnotherapy	Fertility Nausea in pregnancy and general wellbeing, onset of labour Postnatal depression and preparation for labour, physical symptoms

Participant	CAM used in pregnancy	Reason for use
10. Clarissa (practitioner-massage)	Homeopathy Massage Reflexology Acupuncture Shiatsu Yoga	Wellbeing in pregnancy To support the onset of labour In labour Postnatal for recovery General wellbeing and to help with physical symptoms To support the onset of labour To support the onset of labour General wellbeing General wellbeing and in preparation for labour
11. Erin (practitioner – massage)	Hypnobirthing Theta DNA Healing Chiropractic Yoga Acupuncture Homeopathy Herbal remedies- raspberry leaf tea	In preparation for labour Pregnancy- spiritual wellbeing Backpain General wellbeing and in preparation for labour Backpain Labour Preparation for labour
12. Daisy	Massage Reflexology Chiropractic Yoga	Wellbeing Wellbeing Backpain Preparation for labour

Participant	CAM used in pregnancy	Reason for use
13. Alexandra	Hypnobirthing Yoga	Emotional wellbeing, stress relief and preparation for labour Preparation for labour and postnatally with baby
14. Louise (practitioner- shiatsu)	Shiatsu Nutritional therapy Yoga	General wellbeing, preparation for birth Nausea General wellbeing

Appendix 3 continued: Characteristics of the participants.

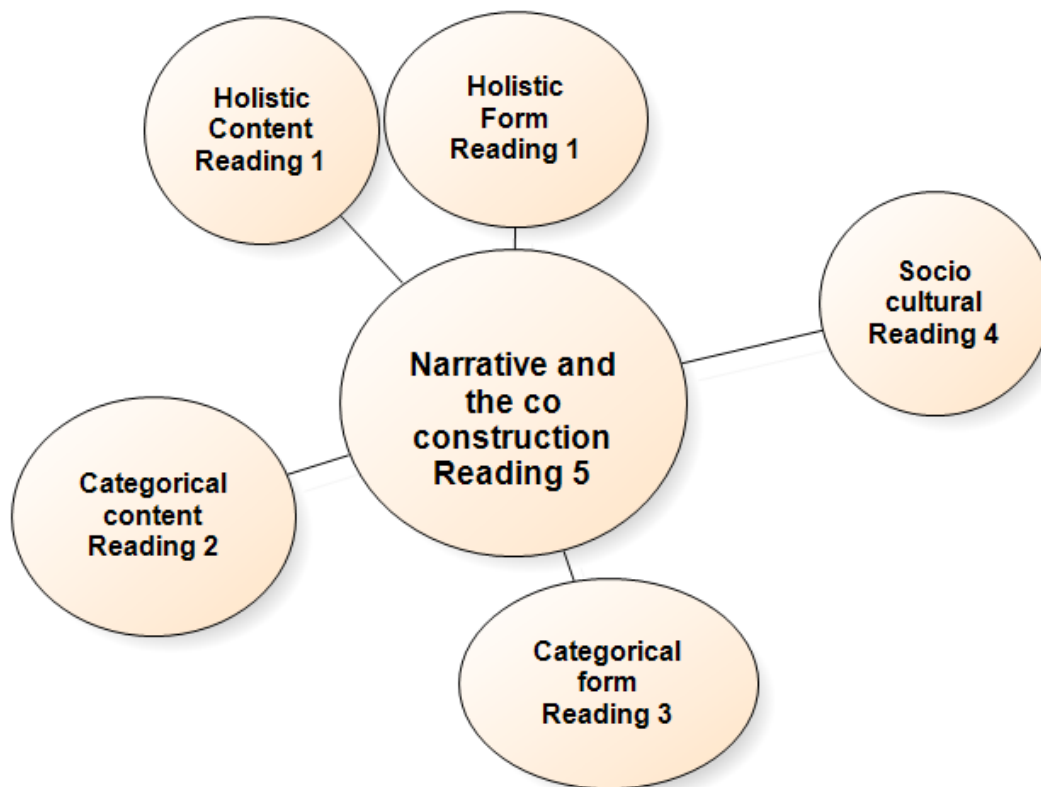
My participants included 14 women living in the Bristol and Wiltshire area. Their age ranged from 30-49. One woman was from Germany, one although British had lived most of her life in Australia, one was Black American, one White American and the remainder were British Caucasian. Two women had 3 children, 4 had 2 children and the remaining 8 had one child. The age range of the children was 8 weeks to 22 years. All the women were in stable relationships. Educational status was high, all the women had further or higher education qualifications, one was educated to PhD level.

**Appendix 4. Model of Analysis
Holistic**

Holistic content	Holistic form
The global perspective of the narrative. The meaning or interpretation of the story from the narrator's perspective.	How the perspective unfolds as the narrative progresses. What the context is.
Content	Form
Categorical Content	Categorical form
The structure of the narrative e.g. introduction to time, space and characters, plot, focus.	How the narrative occurs. How the emotions are reflected in the telling of the event.

Categorical

Adapted from Lieblich et al. (1998). This model contributed to the development of my own framework of analysis shown on the next page.



My analytical framework

Appendix 5. Example of Holistic Analysis

Notes recorded in Nvivo on completion of interviews and following 1st analytical reading.

Holistic Analysis: Rachel

Genre: transformative, story of achievement with a number of challenges and uncertainties. A story of personal growth and change with CAM and motherhood enabling this. A story of how CAM has promoted the development of self-awareness and self-confidence in herself and her body. Story definitely told as a journey with particular references to physical and emotional challenges she has faced and how CAM has supported her during these times, one in which she strives to maintain her physical and emotional health for both herself and her baby. Pregnancy changed her made her more assertive and protective. This was facilitated by her therapist who she developed a very good relationship with.

Rachel as a person: healthcare professional, Rachel is an Occupational Therapist working in the field of mental health. Well educated, a thinker and a worrier, needs information and needs to be prepared and in control, needs connecting relationships (therapist and women friends and midwives). A belief in normal birth but still wants the backup of medical environment. Believes in the importance of mind/body connection for optimum wellbeing. Has some difficulty coping with uncertainty, worries a lot because consultant cannot tell her definitely how her fibroid will behave in pregnancy - evidence of narrative disruption here. Proactive: does her own risk management plan when travelling. Describes herself as a physical person. Concerned how she comes across doesn't want to present herself with polarised views of CAM and western medicine Sees CAM as complementary not alternative. However, also critical of western medicine and its focus on physical health.

Equates her use of CAM particularly shiatsu as a journey. Pregnancy a catalyst to CAM use, enjoys looking after herself. Journey begins with interest in CAM arising out of a taster session and leads very quickly to her undertaking some training (user to practitioner). In the first interview tells her story very quickly and factually. 2nd interview much chattier and expands on her beliefs about health, wellbeing, western medicine and CAM. 2nd interview nearly 2 hours, definitely feel more of a connection with Rachel compared to the first interview. CAM helped her prepare for birth and motherhood, she now takes her baby to baby massage and baby yoga.

Interest and use of CAM extends from personal life to work for physical and emotional issues. Tried lots of different therapies (dips in and out) with the exception of shiatsu. Attracted to shiatsu because of its scientific basis. Did not like it when a reiki practitioner spoke to her about spirit

guides. Comfortable with the concept of energy and the mind/body connection, talks a lot about energy and feelings in her body. Trusts her therapist implicitly and judges the benefits on her physical and emotional response to treatments.

Positive birth experience, no pain relief, used breathing, meditation and relaxation. Had a ventouse for prolonged 2nd stage but happy with this, felt it was appropriate. Very unhappy with postnatal care in hospital-exhausted and received very little help with breast feeding. Will continue with shiatsu and is thinking about taking a further course in it.

Erin

Genre: achievement, story line one of challenges, finding a way to overcome these challenges and personal fulfillment. Pregnancy a catalyst. Uses the word transformative.

Impression of Erin as a person: very well educated (very knowledgeable about physiology of pregnancy) non conforming and pleased to be so although doesn't judge others for their more mainstream approaches. Feels her life is enriched by her humanistic holistic world view. Both practitioner and consumer of CAM. Comes to realise that her world views are not congruent with many others e.g. trust in the wisdom of her body v trust in doctors. Feels very strong connection to women, world views and therapists. Relates herself to me 'interested in what you are interested in' why people choose complementary health. Ready to rise to the challenge of pregnancy and childbirth. Would have felt guilty and disappointed if had not been able to have normal birth or breastfeed. Active; needs to be prepared mentally more than anything else then can cope with challenges. Needs to be in control (felt very stressed when her body was telling her to push but the midwife was asking her not to). Needs to shield herself from negative images, horror stories about childbirth, talk of pain etc. Removes herself from situations where she anticipates negative emotions e.g. did not go to midwife led antenatal preparation classes as she rejects the belief that labour needs to be managed or pain relief is inevitable. Positive approach to life (talks about culture being around only sharing stories of when things go wrong about childbirth but also about life events e.g. moving house). Describes herself as being in the former camp as described by Einstein 'There's two ways to live your life, one is as if everything is a miracle and one is as if nothing is a miracle and I am definitely of the everything is a miracle side of life'

Childbirth as normal. natural doesn't like hospitals. Homebirth. Comes to pregnancy without fear of childbirth as a result of her own personal family upbringing and mothers experiences of birth. Route to CAM use from childhood exposure, parents both into CAM, mother was trained in massage, father taught yoga. CAM as normal. Feeling unfulfilled which led to training as a massage therapist. Sees her use and engagement with CAM as a life long journey. Looks for fulfilment. Story line interrupted with pregnancy as unplanned/conflict with partner - narrative disruption

Pregnancy as a catalyst to her ideas and use of CAM. Needed support outside of her own inner resources during pregnancy. Wanted a healthy pregnancy as possible, wanted to create a safe place. Main support from hypnobirthing. CAM made sense to her (links issues with physiology and with her mothers experience to make sense of the ancestral influence on her health, life and experiences). Use of CAM for physical and emotional issues and spiritual uses the word transformative. CAM to support normal labour- role of relaxation. Mind/body connection-relaxation crucial. Boundary issues of how much CAM she accepts and engages with. Strong belief in connection with the baby and the baby having to make it own journey. Doesn't visit GP much. Dissatisfaction with routine midwifery care and lack of support with the journey of pregnancy Has clear belief's about the value/role of western medicine e.g. good for diagnosis and for reassurance.

Pregnancy as a transition 'a turning point'. Very positive experience of birth at home, no pain relief. Used a range of CAM remedies in labour. Responsibility of motherhood, wants her children to see CAM as normal and something they can use without recourse to health professional advice.

Alexandra

Genre; achievement, pregnancy as challenge, uncertainty of pregnancy. Pregnancy as catalyst for CAM use. CAM as coping strategy, personal fulfilment, transformative-life strategies. Says she couldn't have done it without hypnotherapy or at least the outcome would have been very different. Very positive birth experience. Evidence of narrative disruption in that Alex was desperate to have children but it did not happen as planned. She hated being pregnant and became very 'low' in the 5th month of pregnancy. Hypnotherapy helped her to cope with this disruption.

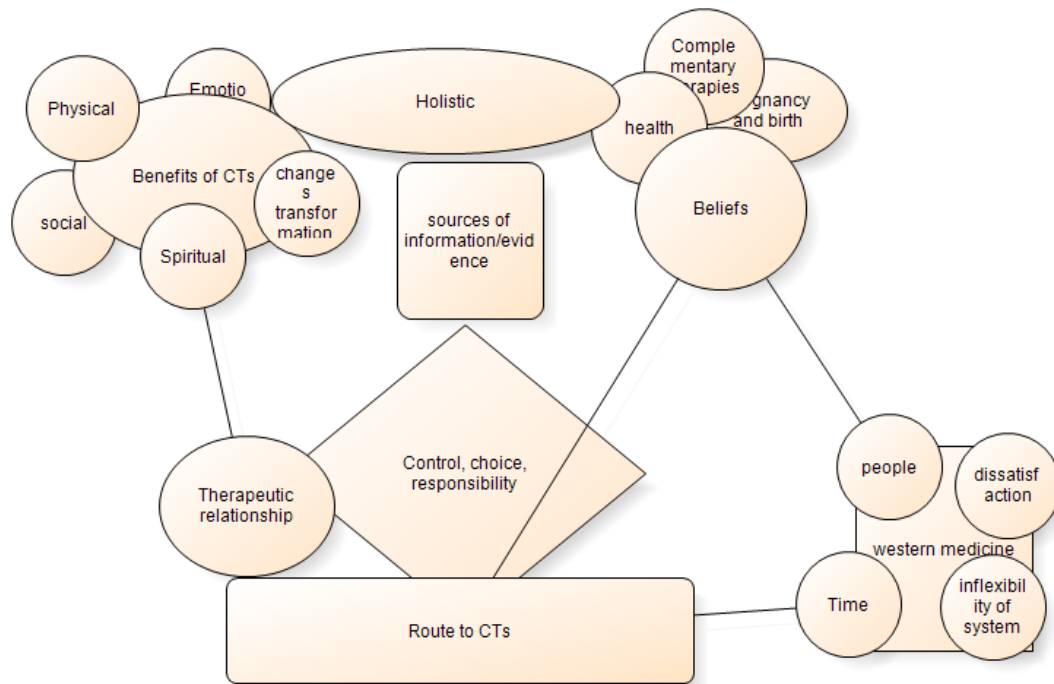
Alexandra as a person: well educated. fulfilment through family and motherhood.

Likes to be in control, a worrier and thinker. Non conformist and happy to have different view to mainstream (e.g. CAM, parenting strategies weaning). Reads prolifically and asks questions - challenges mainstream views. Active and proactive in maintaining health and wellbeing but needed outside help during pregnancy. pregnancy as a journey - connection with baby. Self affirming- 'the midwife was amazed- I made her day'. Knows what she wants and likes to be prepared. Desperate for a baby but hated being pregnant. Holistic view of health. Some paradoxical impulses e.g. understands the limits of screening, declined biochemical screening but only reassured by ultrasound that pregnancy was healthy, wanted more ultrasounds in pregnancy, compared UK practice to that her sister received in Germany where she could have all the scans she wanted. Confident in her body to birth but not in producing a healthy baby. Dreamed about a home birth but husband would not

support for fear of the risks.

Route to CAM- childhood. Early experience in Germany where homeopathy and acupuncture seems to be the norm. Very surprised at sceptical views of friends and family in the UK. Pregnancy as catalyst for CAM use. Pregnancy as a challenge- emotionally and physically- anxious, uncertainty, fear. Dissatisfaction with midwifery care- no time, medicalisation, threat of induction. Positive and normal view of birth. Did not want intervention. Recognises importance of stress reduction and relaxation to health and wellbeing. Yoga part of her life now, goes to baby yoga. Evidence-proof of the pudding- has not doubts about the limits of western medicine and the benefits of holistic approaches particular the more psychological approaches. Happy to stand up and argue for her beliefs- husband is a medic and very anti CAM. Tells lots of stories of the positive effects of CAM she has witnessed in friends and family.

Appendix 5. Themes and sub themes generated following content analysis



Appendix 7. An explanation of the model used to re-present participants' use of CAM

Narrative diachronicity is represented by the inclusion of a statement at the top of the model regarding the importance of previous positive experience of CAM and how this contributed to women's motivations in seeking CAM during pregnancy. The statement underneath the model indicates how participants' positive experience of CAM use during pregnancy consolidates and 'crystallises' their beliefs about CAM and promotes further CAM use for themselves and their baby.

The outer dark yellow circle indicates the contribution CAM makes to women's ability to avoid pharmaceutical therapies in pregnancy and to defend themselves against unnecessary medicalized interventions during birth.

The white circle naming CAM modalities demonstrates that it was not the particular CAM modality that in itself was significant. More important was the choice and congruence between the individuals' world view, with the CAM philosophy and the approach of the therapist.

The next pale yellow circle indicates the 'protective cocoon' described by Rachel to illustrate how CAM promotes relaxation and helps to shield participants and their babies from stress and anxiety.

The inner 3 circles represent Caroline's use of the term '*Forewarned, Forearmed and Relaxed*' in summarising the contribution of CAM to the experience of pregnancy and childbirth.

The term '*Forewarned*' refers to participants' use of CAM as a way of alerting themselves to and coping with the side effects of pregnancy both from an emotional and physical perspective. The notion of '*forewarning*' also refers to participants' use of CAM as a way of negotiating between contradictory lay and professional discourses of risk surrounding pregnancy.

'*Forearmed*' refers to how participants' use of CAM became a strategy by which participants could symbolically '*arm*' themselves to fend off unwanted and unnecessary medical intervention and arguably, more importantly, defend themselves against the fear of such interventions.

'*Relaxed*' Caroline's word signifies the importance of relieving stress and achieving a state of relaxation as the ultimate accomplishment contributing to a healthy pregnancy, birth and an emotionally fulfilling experience. Reducing anxiety and achieving a state of relaxation, by use of CAM became a further way in which participants could control and manage both the inherent risks of pregnancy and the fear of the potential risks of medical interventions.

The figure in the centre illustrates that all participants' narratives were primarily of pregnancy, childbirth and motherhood. CAM contributed to their overall positive experience of this disrupted time in their lives. It also draws attention to the emphasis participants paid to their bodily experiences during pregnancy and the enhanced feelings of embodiment that took place throughout the process of pregnancy and childbirth.

The 3 overlapping circles emphasises that participants strive to strengthen themselves for the work of pregnancy, childbirth and motherhood and this demanded a holistic approach where physical, emotional and spiritual health was vital to overall wellbeing. **The interlocking circles suggest that CAM with its focus on the physical, emotional and spiritual needs can transform women's experiences of pregnancy and birth.**