

Pregnancy, risk perception and use of complementary and alternative medicine

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) during this time. However, there is little research exploring the factors that are influential in women's motivations to use CAM during pregnancy and childbirth.

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). A purposive sample of 14 women who had used CAM during pregnancy and childbirth participated in the study. Women's narratives were obtained through open ended interviews on two or three occasions. Narratives were analysed using a 4 stage process.

This paper presents some findings from this research which reveals women's motivations to engage with CAM are driven by contemporary discourses of risk and the medicalized and risk approach to maternity care.

Introduction

Pregnancy and birth are pivotal experiences in women's lives and hold powerful personal and social significance. For most women pregnancy is a normal physiological process and in developed countries childbirth has never been safer. However, high expectations and the inevitable uncertainty of pregnancy outcomes have contributed to increasing medicalisation of birth with some arguing that modern childbirth is in crisis (Walsh 2006). Alongside this significant socio-cultural context, there is increasing evidence to suggest that pregnancy prompts use of complementary and alternative medicine (CAM) (Allaire et al. 2000; Hope-Allen et al. 2004, Author 2008), [a trend facilitated by the increased commodification of CAM \(Author 2013\)](#). For the purposes of this paper CAM is defined as a range of health care practices which participants access outside of mainstream maternity services. The underpinning philosophy of these modalities are diverse, but mostly differ from biomedicine in their focus on the interconnectedness of mind, body and spirit, the recognition of the power of the body to self-heal and the power of the therapeutic relationship (Kelner et al 2003). Some research suggests that women utilise CAM in pregnancy and birth in order to avoid the perceived 'risky' technological and pharmaceutical interventions associated with the medicalised approach to pregnancy management but empirical evidence of this is presently lacking (Smith et al. 2006, Author 2008).

The late [nineteenth](#) century and the early [twentieth century](#) heralded increasing involvement of medical practitioners in birth, an increase in hospital birth and an increased use of technological interventions (Williams 1997). By the end of the 70's [a](#) medical model of pregnancy and childbirth was firmly entrenched. In the 1990s formalised risk management systems were introduced into the NHS and the assessment, management and prevention of risks became the pivotal focus of the maternity services (Lankshear et al. 2005). Underpinning the biomedical approach is the view that pregnancy and childbirth are inherently risky, and therefore in need of medical supervision and technological interventions (Symon 2006). The laudable

aim of risk management in maternity services is to improve the quality of care and patient safety (Heyman et al. 2010), yet this approach has contributed to the ever increasing rates of medical intervention in pregnancy and birth (Maier 2010, Fenwick et al. (2010). These practices are congruent with Beck's (1992) and Giddens' (1990) well-established thesis that risk and the management of risk has become increasingly important and pervasive in contemporary late-modernity.

In the UK less than two thirds of women achieve birth without medical intervention and rates of operative birth are at an all-time high (BirthChoice UK 2012). Worry, anxiety and fear of childbirth is common and seems to be on the increase (Aylrie et al 2005), confirming a range of risk theorists' views about the fear generated by risk (Beck 1992, Giddens 1990, Furedi 2002, Bauman 2006). Moreover, many women seem to have lost faith in their ability to birth naturally without medical intervention (Melender 2002, Hofberg and Ward 2003). As Davis-Floyd (2004) suggests the medical model shapes expectations, beliefs and practices and makes it difficult to think about pregnancy and birth in any other way.

In this paper the authors present findings from recent empirical qualitative research that explored women's motivations to use CAM and the contribution of CAM to their everyday experience of pregnancy and childbirth. The research findings highlighted considerable engagement from the women about risk, attitudes to risk in the context of pregnancy and childbirth, views towards medicine, and the management of risk in their own lives. This paper considers the central issue of the utilisation of CAM and the application of risk theory in particular the concepts of reflexivity and fateful moments within the context of pregnancy and childbirth. The conceptual and theoretical context, highlighted below, provides an important backdrop to key debates about the role of uncertainty in risk perception, and the agentic nature of risk avoidance practices as women seek to manage risk by using CAM during pregnancy and childbirth. The aim and methodological approach of the study will be explained followed by a narrative analysis of some key themes in the empirical data about risk and CAM use in pregnancy and childbirth. Our approach emphasises the social construction of risk, and will highlight how cultural influences on reflexivity provides insights into women's decision making in the face of risk and how this impacts on their decisions to use CAM.

Risk, Pregnancy and Childbirth: Theorising the Utilisation of CAM

Social theorists 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 a conceptual framework of risk. A common theme across ~~The principal argument in~~ these approaches is that risk has become increasingly important and pervasive in contemporary society. The 'risk society' is one in which the advantages of scientific and technological developments are overshadowed with risks and dangers, leading to anxiety and uncertainty (Beck 1992a, Giddens 1990). A central ~~theme-motif~~ is the everyday experience of living with risk, and yet despite the ubiquity of the conceptual framework, these theories have been neglected in the analysis of pregnancy, childbirth and the concomitant use of CAM. Of particular interpretative relevance in our paper is Beck's and Giddens' respective theses of reflexivity and our analysis will centre on whether this concept can illuminate women's decision making in choosing CAM during pregnancy and childbirth.

Reflexivity arises when individuals are faced with making decisions in the face of uncertainty (Beck 1996), and 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 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, arguing that when individuals cannot trust experts or institutions they are compelled to seek their own solutions for problems they face (Beck 2009). Here the individual is viewed as making rational conscious decisions, weighing up the pros and cons of expert knowledge, and often developing their own areas of expertise. Other contemporary changes such as ease of access to information and the increasing desire of individuals for autonomy in decision making help lubricate this process.

For Giddens (1990:35) risk is consciously calculated, individuals make cognitive decisions but, in contrast to Beck, these are taken with a basic trust in institutions and experts. All actions of daily living require acceptance of advice from 'absent others' i.e. unknown people or familiar institutions such as medicine, or the law (Giddens (1994:89). Trust arises as a result of childhood experiences resulting in feelings of confidence or 'ontological security' in the reliability of people and social institutions. 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 confirm that notions of trust are central to risk perception and individual decision making strategies (Watson and Moran 2005, Green et al 2003, Brown 2009).

In Beck and Giddens' broadly realist position risks are inescapable and thus individuals are compelled to confront, to avoid, or minimise risks. Although Beck (1999) is pessimistic about the risks of late modernity he is optimistic about the power of social actors and agency in seeking creative solutions for themselves and in transforming social structures. Likewise, Giddens (1994) thesis also highlights the power of the agentic individual as they actively create the social world around them rather than being determined by it (Tucker 1998).

However, socio-cultural dynamics in risk perception seem more important in the analysis of risk perception in pregnancy. 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 and are often at odds with the professional discourses. The uncertainty and unpredictability of pregnancy and childbirth heightens women's feelings of vulnerability and loss of control. These feelings are congruent with Giddens' (1991:131) description of 'fateful moments': as when 'an individual stands at the crossroads of his existence'. Fateful moments precipitate a breach in 'ontological security' and intensify risk perception. Consequently, individuals adopt a variety of approaches to deal with these feelings of risk including denial. Being overly cautious: the 'precautionary principle' described by (Giddens 2002:32) is one way in which individuals avoid difficult decision making in the face of unknown risks and examples of this will be evident later in the paper.

Perception of risk in pregnancy is complex and varied and is dependent on individual circumstances. Many women perceive low risk in pregnancy, but being aware of the uncertainty of pregnancy and birth are grateful for medical expertise and technology if and when it is required (Enkin 1994). Women who experience complicated pregnancies accept there is a risk to their own or their baby's health but the magnitude of that risk differs from that of the professional (Lee et al 2012). For some 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 (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). Others reject all professional attendance during pregnancy and birth in the growing phenomenon of 'freebirthing' (Nolan 2008)

Such extremes reflect the social and culturally bound nature of risk argued by social theorists such as Douglas (1992) and Lash (2000). Women's reactions to risk thus highlight how perceptions of risk are inextricably linked with personal understandings of what constitutes a danger or a threat. Individuals often adopt complex and inconsistent strategies in dealing with risks, simultaneously displaying attitudes of trust, acceptance, rejection and scepticism (Giddens 1991, Adams et al.2000). Bauman suggests (2006) that individuals are induced to search for biographical solutions to systematic and institutional problems. Women's use of CAM during pregnancy and childbirth may be illustrative of this (Author 2009, Lupton 1999). Women's use of CAM is increased in pregnancy (Allaire et al. 2000, Hope-Allen et al. 2004, Author 2007). A number of factors have been shown to be influential in CAM use during pregnancy and birth including dissatisfaction with biomedicine, concerns with the side effects of pharmaceuticals and a desire for more positive relationships with caregivers (Vincent and Furnham 2003).

Methods: Narrative Research

This empirical study used a narrative methodology to give voice to women's experiences of pregnancy and childbirth. Narrative research is an umbrella term that

includes a wide variety of research approaches, which have at their heart individual stories (Elliott 2005). It is a genre within qualitative research which focuses on the meaning that individuals ascribe to life events (Czarniawska 2004). The importance of narrative enquiry lies in the notion that story telling allows individuals to make sense of their world, and that this process is retrospective in nature. This allows for an exploration of the meaning of important life events.

Narrative research does not aim to achieve explanatory power in recounting original experience since any recounting of events is subject to memory and is open to different interpretations (Atkinson's 1997). However, by acknowledging the social construction of the stories and through the telling and listening to stories it is possible to grasp the meaning of those experiences. The role of the researcher is to provide a level of interpretation that aids understanding of the phenomena under investigation. 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 (Polkinghorne 2007). Permission to undertake the study was granted by the University Ethics Committee¹

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. The sample was recruited by advertising through a local network of CAM professionals. No incentives were used to aid recruitment as 14 women volunteered to take part in the study; between them they used a total of 20 different CAM modalities during or following pregnancy. Their age ranged from 30-49. One woman was from Germany, one Australian, one was Black American, one White American and the remainder were British Caucasian. All the women were in stable relationships. Educational status was high: all had further or higher education qualifications. Nine participants had used CAM in their first and only pregnancy. The remainder had used CAM in each pregnancy they had experienced, this ranged from 2 to 5. The time frame that had elapsed since participants' CAM use during pregnancy and birth varied from 6 weeks to 23 years. However, most women reflected on the use ~~of CAM~~ of CAM during pregnancy and birth occurring within the past 1-2 years.

In-depth interviews were carried out on 2 or 3 occasions with the 14 participants by MM. All but one of the interviews took place in participants' homes. Most interviews lasted about 1.5 hours, the longest 3 hours. Reissman (2008) suggests 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 the opening question for each participant. A desire to listen to their stories about pregnancy and birth was reflected by asking participants directly to '*tell me about your pregnancy*' or '*tell me about your labour and birth*'. Most, but not all of women, completed their story to the present time in the first interview. The second and third interviews served as an opportunity for women to either continue telling their story or for me to question and seek clarification. A transcript of the first interview was made available to participants prior to subsequent interviewssubsequent interviews.

Interview data were transcribed verbatim by MM, with the aim of providing a full and faithful transcription of the interview. Data analysis was conducted by a 4 stage reading informed by key proponents of narrative research such as Somers (1994) Reissman (2008). The method of analysis was modified to create an original approach with the intention of revealing the motivations, experiences and meaning of CAM use. Reading 1 focussed on the narrative in its entirety as the researcher is interested in the individual and their journey to the present day. In the second reading the themes within and across participants narratives were identified. At the completion of this reading themes, sub themes and core narratives were identified and organised through the computer package Nvivo. Reading 3 focused on the analysis of discrete stylistic or linguistic characteristics of the narrative. Thus reading 4, concentrated on socio-cultural influences in the narratives. The findings are presented in themes that were common across all participants. Both authors conducted the analysis and agreed the emerging themes and interpretation of these in relation to risk theory. The final themes were shared with participants and feedback requested. Participants chose their own pseudonym.² (1 University of the West of England, Faculty Research Ethics Committee Approval 4th August 2009)

Findings:

In this section we highlight some of the findings of the study, focusing particularly on women's decisions to use CAM as a response to the uncertainty of pregnancy, their anxieties about risk and medicalized approach of standard maternity care. Where appropriate we will highlight the use of a conceptual framework of risk with reference to key theoretical approaches.

Pregnancy, 'Fateful moments' and CAM

For the participants in the study pregnancy signalled a period of transition, a change in relationships and feelings of vulnerability. They talked about the unexpected impact of pregnancy on their emotions and shared their feelings of anxiety and vulnerability. One of the participants, 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)

These feelings of vulnerability match Giddens' (1991:131) description of 'fateful moments' and for participants precipitated 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 generates anxiety and stress.

Feelings of vulnerability were amplified by the uncertainty of pregnancy. The potential for risk and for the development of unforeseen events was always considered a possibility. Women worried about their health and that of their baby, they worried about their ability to cope during labour and the risks of medical intervention. 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 for what they may face. This uncertainty has a profound effect on women. The resulting fear and anxiety impacted on their confidence to birth and prompted participants 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.

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

Practices such as yoga and hypnobirthing teach self-help techniques of breathing, distraction, visualisation and 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 explains *'it is like a rehearsal for childbirth'*. However, despite all the preparations women undertook, there was always an undercurrent of fear and uncertainty that events may be unforeseen. Women 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 a kinesiologist '
(Riley)

Media portrayal of childbirth partly 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*'. She attended antenatal yoga classes which provided her with the opportunity to be with women who hold a different perspective on birth as she explained:

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

Stephanie too harboured a deep fear of childbirth. A childhood experience of a sex education video left Stephanie '*traumatised*'. 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. CAM was influential in changing these participants' views about the naturalness of birth and their ability and confidence to birth in the way they had planned. Stephanie's use of acupuncture, hypnobirthing and hypnotherapy helped fundamentally change her beliefs about birth. She achieved the birth of two children in a community birth centre with no pain relief and described her experience as '*just perfect*'.

Becker (1999) argues people use cultural resources during times of vulnerability to help them make sense of their [lives. Participants](#) made reference to the accessibility of CAM. Here we see one of the participants referring to the normative culture of CAM use in pregnancy

'My yoga class makes you feel you are not the only one and that it (CAM) is an acceptable thing to do in pregnancy'. (Daisy)

Thus from early pregnancy many participants were immersed in a culture where CAM is viewed as acceptable. Reflexivity about risks and dangers comes to the fore as decisions women made became consciously orientated around their health and wellbeing and that of their developing baby. It could be argued that seeking CAM represents participants' attempts to re-establish the 'protective cocoon' and signifies a turning point in their lives as they learn to cope with their feelings of vulnerability and anxiety at this time.

Impact of risk discourses on the experience of pregnancy

Participant's anxiety and heightened sense of vulnerability in relation to their own health and that of their baby was intensified by contemporary discourses of risk and responsibility surrounding pregnancy and motherhood. Alison, with children aged 23, 16 and 7 was well placed to reflect on the impact of these risk reduction strategies and the changes she had experienced over the years:

'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)

Alison's narrative reveals the pervasiveness of risk practices in public health discourses which construct risk as a consequence of individual responsibility and life style choice (Gabe 1995, Lupton 1999). In following medical advice the health of the baby takes priority and women's needs become subsumed by that of their fetus. 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).

Many of the participants experienced the so called 'minor disorders of pregnancy' but were reluctant to take standard biomedical treatments for fear of risks. Although Daisy said she knew that '*paracetamol was safe*' she would not take it to ease 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)

Living in a world of manufactured risks, in this case both the known and potentially unknown side effects of drugs is 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 these women are exhibiting a desire for high levels of agency.

The impact of risk approach to maternity care was strongly evident in participant's narratives. They gave many examples of how the care they received impacted on their worries and exacerbated anxieties about their health, that of their baby or their confidence to birth without medical intervention. Ladybird described how excited she was about attending her first antenatal appointment but the focus on risk left her feeling very scared:

'The very first appointment I had with the midwife was all about our family history and all the things which could go wrong. I found that very upsetting. I had gone from feeling extremely elated about being pregnant to being really scared that all these things could go wrong'. (Ladybird)

As pregnancy progressed the risk approach of maternity care continued to exert its impact on participants, increasing anxieties and fears. Messages that medical intervention is the norm were reinforced during antenatal education classes and a tour of the maternity unit only served to heighten fears.

'when we went to do the tour of the hospital I came away feeling absolutely terrible, because I had never been to hospital before. It seemed very clinical and the tour finished outside the operating theatre and I was thinking well that's where I am going to end up'. (Ladybird)

Participant's motivation to engage with CAM was in an effort to ameliorate their perception of risk and as Riley explained:

'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).

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. Some participants chose CAM then as a way of supporting their desire for a normal birth one without unnecessary medical intervention. For others who engaged with CAM for other reasons i.e. because it was seen as a cultural norm or they recognised a need to prepare themselves for birth CAM practices facilitated a change in belief and a reduction in risk perception and a confidence to birth.

CAM use as a backlash against routine medical intervention

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 contributed to increased worry and anxiety. This procedure was seen as producing unacceptable risk as Clarissa explains:

'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 then 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).

There is much debate in the literature about the risks of prolonged pregnancy and the induction process itself. The evidence divides professional opinion and different management options are often advised (Westfall and Benoit 2004, Smith and Crowther 2008). Many of the participants became aware of the discrepancy of professional advice in their consultations with doctors and midwives, with some professionals recommending early induction of labour and others suggesting a more conservative approach or waiting for the onset of spontaneous labour. 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)

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.

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. As in the study by Westfall and Benoit (2004) participants did not consider prolonged pregnancy to be a medical problem in itself but they felt pressurised by maternity carers to conform to standard policies and procedures. Despite the clear policy agenda of informed choice set out in successive government reports such as Changing Childbirth (1993), Maternity Matters (2007) and the Choice Framework (DH 2013) research findings consistently show the rhetoric is not matched in reality. Institutional pressures, the contemporary discourses and professional language of pregnancy and birth act to limit choice offered (Kirkham and Stapleton 2001, Scammell and Alaszewski 2012). When participants rejected the standard medical options they felt compelled to act with the weight of responsibility for their decisions and actions, as Caroline explains:

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

Caroline's and others response reflects the moral risks of going against medical advice. Viisainen (2000) suggests that these moral risks significantly impact on women's decision making. For participants in this study ~~CAM provided~~CAM provided emotional support and a way in which the anxiety associated with this responsibility could be coped with. Below Clarissa describes 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)

Even though pregnancy was not prolonged for Daisy, Alexandra, Stephanie, Ladybird and Riley, 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, that women prefer 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 medicalisation 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. 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 reflects 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?'
(Rose)

Participants' rejection of induction and caesarean section because of the risks is demonstrative of reflexivity described by Beck and Giddens. Women recognised the limitations of the 'scientific evidence' favoured by professionals. They appreciated the construction of scientific knowledge did not take into account personal or cultural circumstances and therefore they lacked trust in professional ~~dec~~decisions~~sions~~. 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).

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 (2008) 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 (2008) 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. Risk is thus 'repositioned' within this framework (Adam et al. 2002:10).

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. There is evidence of 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.

Conclusion

There are some limitations to the study which should also be considered in any interpretation. As discussed, the sample was self-selected, relatively affluent and well educated, and all were avid CAM users. 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. Narratives can be disconnected and incomplete and thus have their limitations in revealing the very essence of experience (Richard 1997). Nevertheless, the findings, illustrate how childbearing women negotiate perceived risks when deciding on how to manage their pregnancy and birth and their decisions to use CAM.

The findings of this study confirm pregnancy was indeed a 'fateful moment' for participants. Their heightened sense of risk, uncertainty over pregnancy and birth outcomes, and fear of unwarranted medical interventions contributed to feelings of anxiety, worry, fear and sense of vulnerability. These feelings were a prime motivational factor in seeking CAM. In participants' talk of stress and anxiety there is evidence of 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. 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. The focus on the assessment and management of physical risks of pregnancy on the mother and baby contrast sharply with the risks self-defined by women as lying within their emotional reactions and social domain. Finding a way to address these feelings became an imperative for participants' action in seeking CAM.

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 reflect a desire to transform an unpredictable and unmanageable future into one which is more predictable and manageable. This supports Zinn's (2009) argument that the common denominator is uncertainty rather than 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.

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. A tension is evident in women's use of CAM and their underlying discourse for the need to 'be in control' versus their desire for a natural childbirth without medical intervention. Participants demonstrated their autonomy by actively pursuing CAM but also engaging selectively with expert scientific knowledge.

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 central arguments presented in this paper that the ontological insecurity of pregnancy and reflexivity which emerges during fateful moments motivates women to use CAM.

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