Pregnancy, risk perception and use of complementary and alternative medicine

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Pregnancy and childbirth are events of major significance in women’s lives. In western countries women are increasingly using complementary and alternative medicine during this time. However, there is little research exploring the factors that are influential in women’s motivations to use complementary and alternative medicine during pregnancy and childbirth. This article draws on data from a narrative-based study designed to explore women’s experiences of complementary and alternative medicine use during pregnancy and childbirth. The study involved 14 women living in the South-west of England, who had used complementary and alternative medicine during pregnancy and childbirth. We elicited narratives by interviewing women two to three times. The women in our study used complementary and alternative medicine both as a response to the uncertainty of pregnancy and childbirth and as a defence against manufactured risk, and in doing so indicated their desire to transform an unpredictable and unmanageable future into one which is more predictable and manageable. It was a means of dealing with the stress and anxiety associated with uncertainty which has to be dealt with. Their consciousness of the risks of biomedicine developed though the practice of complementary and alternative medicine, and their high educational status and relative affluence facilitated their choices. There was a tension evident in their narratives between a need to ‘be in control’ versus a desire for a natural childbirth without medical intervention. Women in the study showed their autonomy by actively pursuing complementary and alternative medicine while at the same time selectively using expert medical knowledge.

Keywords: risk; risk perception; pregnancy; childbirth; complementary and alternative medicine

Introduction

Pregnancy and birth are pivotal experiences in women’s lives with powerful personal and social significance. For most women pregnancy is a normal physiological process and in developed countries childbirth has a low probability of a harmful outcome. 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 pregnant women are increasingly using complementary and alternative medicine (Allaire et al. 2000, Hope-Allan et al. 2004, Mitchell and Allen 2008), a trend facilitated by the increased commodification of complementary and alternative medicine (McCLean and Moore 2013). For the purposes of this article complementary

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and alternative medicine is defined as a range of health care practices which participants access outside of mainstream maternity services. The underpinning philosophies 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 complementary and alternative medicine 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, Mitchell and Allen 2008).

At the end of the nineteenth century and the early twentieth century there was 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 1970s 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 dangerous, and therefore require medical supervision and technological interventions to ensure safe outcomes (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 (Fenwick et al. 2010, Maier 2010). These practices are congruent with Beck’s (1992) and Giddens’ (1990) well-established thesis that risk and the management of risk have 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 (Ayrlie et al. 2005), confirming a range of risk theorists’ views about the fear generated by risk (Giddens, 1990, Beck 1992, 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 article we draw on a recent empirical qualitative research which explored women’s motivations to use complementary and alternative medicine, and the contribution of complementary and alternative medicine to their everyday experience of pregnancy and childbirth. This article, considers the central issue of the utilisation of complementary and alternative medicine 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, which we discuss first, provides an important backdrop to key debates about the role of uncertainty in risk perception, and the role of agency in risk avoidance practices as women seek to manage risk by using complementary and alternative medicine during pregnancy and childbirth. We then discuss the aim and methodological approach of the study and then present the main findings of our narrative analysis.
Risk, pregnancy and childbirth: theorising the utilisation of complementary and alternative medicine

Social theorists such as Giddens (1990), Beck (1992) and others (Douglas 1992, Lash et al. 1996, Watson and Moran 2005) have highlighted the complexities of contemporary western societies in relation to a conceptual framework of risk. A common theme across 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 by risks and dangers, leading to anxiety and uncertainty (Beck 1992, Giddens 1990). A central 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 complementary and alternative medicine. Of particular interpretative relevance in our article is Beck’s and Giddens’ perspective on reflexivity and our analysis will centre on whether this concept can illuminate women’s decision-making in choosing complementary and alternative medicine during pregnancy and childbirth.

Personal reflexivity is described by Beck (1996) as arising when individuals are faced with making decisions in the face of uncertainty. It 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, p. 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’, those unknown people or familiar institutions such as medicine, or the law (Giddens 1994, p. 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, pp. 39–40). A number of empirical studies confirm that notions of trust are central to risk perception and individual decision-making strategies (Green et al. 2003, Watson and Moran 2005, Brown 2009).

In Beck and Giddens’ broadly realist position, risks are inescapable and thus individuals are compelled to confront, 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) also highlights the power of individual agency as they actively create the social world around them rather than being determined by it (Tucker 1998).
However, socio-cultural dynamics underpinning risk perception seem more important in the analysis of risk perception in pregnancy. There is always the potential for danger to 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, p. 131) description of ‘fateful moments’: as when ‘an individual stands at the crossroads of his existence’ (see also Scamell and Alaszewski 2012). 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, p. 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 article.

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 their assessment of the magnitude of this risk may differ 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 foetal monitoring in labour and access to pain relief at all times, and report these as essential for quality service (Green and Baston 2007). For some women, the risks of natural childbirth pose such fear they request elective caesarean section 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, Adam et al. 2000). Bauman suggests (2006) that individuals are induced to search for biographical solutions to systematic and institutional problems. Women’s use of complementary and alternative medicine during pregnancy and childbirth may be illustrative of this (Mitchell 2010, Lupton 1999). A number of studies have identified that pregnancy seems to provoke an increase in the use of complementary and alternative medicine (Allaire et al. 2000, Hope-Allan et al. 2004, Mitchell and Williams 2007). A number of factors have been shown to be influential in the use of complementary and alternative medicine 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). While the use of complementary and alternative medicine is increasing we currently have little understanding of why and how this relates to perceived risks of pregnancy and childbirth. In this article we aim to address this gap in evidence.
Methods: narrative research

**Design**

This article draws on an empirical study which used a narrative methodology to give voice to women’s experiences of pregnancy and childbirth and their use of complementary and alternative medicine. 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).

**Sampling**

We used a mixed sampling approach incorporating both purposive and snowballing strategies to identify a sample of women who had used complementary and alternative medicine during pregnancy and childbirth in the South-west of England. The sample was recruited by advertising through a local network of complementary and alternative medicine professionals. We did not use any incentives to aid recruitment as 14 women volunteered to take part in the study. These 14 women used a total of 20 different complementary and alternative medicine modalities between them during or following pregnancy. Their ages ranged from 30 to 49. One woman was from Germany, one Australian, one was Black American, one White American and the remainder were White British. All the women were in stable relationships. Educational status was high: all had further or higher education qualifications. Nine participants had used complementary and alternative medicine in their first and only pregnancy. The remainder had used complementary and alternative medicine in each pregnancy they had experienced, this ranged from 2 to 5. However, most women reflected on the use of complementary and alternative medicine during pregnancy and birth occurring within the past 1–2 years.

**Data collection and analysis**

In-depth interviews were conducted on two or three occasions with the 14 participants. The time frame that had elapsed since participants’ complementary and alternative medicine use during pregnancy and birth varied from 6 weeks to 23 years. All but one of the interviews took place in the participants’ homes. Most interviews lasted about 1.5 hours, the longest for 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 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 the interviewer to question and seek clarification. A transcript of the first interview was made available to participants prior to subsequent interviews. Permission to undertake the study was granted by the University of the West of England, Faculty Research Ethics Committee on 4th August 2009.

Mary Mitchell transcribed the entire interview verbatim aiming to provide a full and faithful transcription. The interviews were analysed using a four-stage reading process informed by key proponents of narrative research such as Somers (1994) and Reissman (2008). We modified it with the intention of identifying the motivations, experiences and meaning of complementary and alternative medicine use. Reading 1 focussed on the narrative in its entirety as we were interested in the individual and their journey to the present day. In the second reading we identified the themes within and across participants’ narratives. At the completion of this we identified sub-themes and core narratives and organised these using the computer software Nvivo. In reading 3 we focused on the analysis of discrete stylistic or linguistic characteristics of the narrative. In reading 4 we 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 on the emerging themes and interpretation of these in relation to risk theory. The final themes were shared with participants and feedback requested. To protect the identity, participants chose their own pseudonym.

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 medicalised 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 complementary and alternative medicine

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 now and what that means….yeh definitely nerve racking.

(Clarissa)

These feelings of vulnerability match Giddens’ (1991, p. 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 highlighted the potential for pregnancy to threaten ontological security and to puncture the protective cocoon that usually
filtered out anxieties about risks and dangers. This breach of ontological security generated 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 hope 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 might face. This uncertainty had a profound effect on women. The resulting fear and anxiety impacted on their confidence to birth and prompted participants to seek a range of complementary and alternative medicine 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 noted:

all of it (complementary and alternative medicine) was motivated by my desire to have a home birth and to have myself emotionally and physically prepared as possible.

Ironically, although the women in the study subscribed to the belief in the naturalness of childbirth, it was also seen as something that had to be anticipated, planned and prepared for as Caroline stated.

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 were designed to help women develop self-help techniques of breathing, distraction, visualisation and positions to adopt in labour and provided the opportunity to practice these techniques. Thus, women in the study used these techniques to explore what labour might be like and how their actions could help them cope with the pain of labour. As Caroline explained it [yoga and hypnobirthing] 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 complementary and alternative medicine to help deal with these emotions. Riley said:

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 noted: 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 medicalized. 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 were only exposed to stories of difficult and traumatic births. Attendance at group complementary and alternative medicine sessions meant women were in the company of other women with similar beliefs and desires to achieve a normal birth. Complementary and alternative medicine 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 complementary and alternative medicine. Daisy talked about the normative culture of complementary and alternative medicine use in pregnancy:

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

Thus, from early pregnancy many of the women in our study were immersed in a culture where complementary and alternative medicine was viewed as acceptable. For these women, using complementary and alternative medicine represented an attempt to re-establish the ‘protective cocoon’ of ontological security and signified 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**

The women in our study experienced anxiety and heightened sense of vulnerability in relation to their own health and that of their baby. Alison with children aged 23, 16 and 7 years old, 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 [pregnancy and childbirth?] 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 per cent chance this might happen so don’t eat tuna, it’s all risk.
Alison’s narrative indicated the pervasiveness of risk practices in public health discourses which construct risk as a consequence of individual responsibility and lifestyle 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 foetus. For some of the women in our study complementary and alternative medicine was a reward or 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 well-being of the foetus. Alison described this in the following way:

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 women in our study 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 reflected 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)

Star’s narrative indicated that these women had to live in a world and make sense of these manufactured risks with the known and unknown side effects of drugs. As such the women had to make decisions knowing that some of the consequences were unforeseeable (Beck 1999). Daisy, Star and other women adopted the ‘precautionary principle’ (Giddens 2002, p. 32) avoiding drugs and their ‘unknown’ risks. Some of the women in the study were also cautious about using complementary and alternative medicine, for example, Daisy used chiropractic only because it had been recommended by a midwife as she would have worried about it not being safe. However most of the women in the study saw complementary and alternative medicine as safe and side effects perceived as minimal. This is in keeping with Slovic’s (2000) argument that individuals exhibit a greater tolerance of self-imposed risks compared to those imposed by others. Women’s previous positive experience of complementary and alternative medicine was the most important factor in their decision to use it during pregnancy. 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 was different to being subjected to risks by others (Lyng 2008), in this way these women are exhibiting a desire for high levels of control and agency.

In their narratives, women in the study reflected on the ways in which pregnancy and childbirth are framed in terms of risk. They gave 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 their pregnancies progressed, the women found the risk approach of maternity care increased their anxieties and fears. For example, Ladybird described how antenatal education classes reinforced the view that medical intervention in birth was the norm. A tour of the maternity unit served to increase her 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)

Riley described the ways in which her engagement with complementary and alternative medicine was an attempt to reduce anxiety about risk:

they (complementary and alternative medicine) 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)

The women in the study described the ways in which complementary and alternative medicine practices such as hypnobirthing and yoga enabled them to prepare themselves for labour and birth in a way that fitted with their values and beliefs. Some participants chose complementary and alternative medicine as a way of supporting their desire for a normal birth one: without unnecessary medical intervention. For others, engagement with complementary and alternative medicine became a way of building their confidence and reducing their anxiety about the risks of giving birth.

**CAM use as a reaction 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. For example, if labour had not commenced by 40 weeks (the medically defined period for full term), many women felt under pressure to accept a medical induction of labour.

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 debate in the literature about the relative risks of prolonged pregnancy and of the induction process itself and there is lack of consensus about the best way of managing prolonged pregnancies (Westfall and Benoit 2004, Smith and Crowther 2008). Women in the study became aware of the discrepancy in professional advice, 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 suggests 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 had become a symbol of inappropriate medical intervention which threatened to undermine their philosophy of natural childbirth. Participants felt the threat of *induction* and subscribed to the belief that it is better for labour to start naturally. In the hope of getting their labour started rather than questioning the need to induce labour beyond term, women sought complementary and alternative medicine as a more natural means of instigating the onset of labour. Women in our study 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. This is confirmed by other studies such as that of Westfall and Benoit (2004). 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 2012) 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 the choice offered (Kirkham and Stapleton 2001, Scamell and Alaszewski 2012). When participants rejected the standard medical options they felt compelled to act, taking 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 chose not to go with the induction and he is stillborn. (Caroline)

Caroline’s comment reflected the moral danger of going against medical advice. Viisainen (2000) suggests that such moral risks significantly impact on women’s decision-making. For participants in this study complementary and alternative medicine provided emotional support and a way in which they could deal with the anxiety associated with this responsibility. 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)

Even though some women (Daisy, Alexandra, Stephanie, Ladybird and Riley) did not have prolonged pregnancy they did use a range of complementary and alternative medicine modalities such as reflexology, acupuncture and herbal products to encourage the onset of spontaneous labour and reduce the likelihood of induction. For this group of
women, choosing complementary and alternative medicine modalities to support the onset of labour illustrates a backlash against routine medical approaches, and an attempt to take control of the situation and be active managers of their own pregnancies rather than being as Westfall and Benoit (2004) conclude ‘disembodied subjects of medical intervention’. For these women the discourses of medicalisation and risk were powerful, opting out or resisting the advice of doctors and midwives provoked anxiety, fear and guilt (Heaman et al. 2004). Complementary and alternative medicine was a way to cope, and to reduce feelings of guilt by being proactive and 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, for example, when the baby lay in a breech position. Alison, Caroline and Ladybird sought complementary and alternative medicine when they found that their baby was in the breech position. 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, a routine medical procedure also failed and Rose 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 explained she would try anything if there was a chance it would help. Sharma (2003) also refers to this notion of desperation in seeking complementary and alternative medicine. However, this rather negative connotation to complementary and alternative medicine has a different perspective as their actions contributed to their internal sense of identity, of being proactive and being in control. Reflecting on her experiences of complementary and alternative medicine Rose said:

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)

The women in the study 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 decisions. Caroline realised the ways in which broader societal pressures impacted on professionals’ articulation of risks:

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

Discussion
The women in our study made 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. The women also incorporated into their decision-making strategies deeply held values and beliefs in relation, both a scepticism of expert knowledge and a belief and trust in their own bodies. Participants made decisions about complementary and alternative medicine that were relevant to their social and situational context. In many instances their actions could be described as both rational and irrational described by Zinn (2008) as an ‘in-between’ decision-making strategy in times of uncertainty. The practice of complementary and alternative medicine also 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 complementary and alternative medicine. The women in our study thus ‘repositioned’ risk within this framework.

Even though the women in our study did not necessarily accept expert assessment of risk, they had to make their decisions within the context in which risk was all-pervasive. For these women the possibility of induction and unwanted medical intervention were omnipresent. They viewed induction or caesarean section as the catastrophic events they wanted to avoid at all costs. These women were forced to think about risk and as Beck has argued it is ‘the staged anticipation of catastrophe obliges us to take preventative action’ (Beck 1999, p. 90). Beck (1999) suggests in this kind of scenario, reactions frequently are of denial, apathy or transformation. However, the women in our study did not deny the risks or become apathetic instead they sought to transform their experience and manage the risk through complementary and alternative medicine.

For some of the women there was an aesthetic and hermeneutic dimension in their decision to use complementary and alternative medicine. 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 complementary and alternative medicine reflected this aesthetic and hermeneutic reflexivity. Other researchers have found too that the most valued elements of complementary and alternative medicine 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 well-being.

There are some limitations to the study which should also be considered in any interpretation. The sample was self-selected, relatively affluent and well educated, and all were enthusiastic complementary and alternative medicine users. Indeed, the women in our study spoke of their desire to take part in research to share their story of the positive contribution that complementary and alternative medicine 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 complementary and alternative medicine.

In this article, we have shown that for the women in our study pregnancy was a ‘fateful moment’. They indicated that they had a heightened sense of risk, uncertainty over pregnancy and birth outcomes, and fear of unwarranted medical interventions and that these feeling contributed to anxiety, worry, fear and sense of vulnerability. These feelings were a prime motivational factor in seeking complementary and alternative medicine. In participants’ talk of stress and anxiety there was 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, p. 40). With the failures of contemporary maternity care, participants found alternative ways to deal with their anxieties by seeking the relaxing effects of complementary and alternative medicine. Participants’ anxieties and fears result from the uncertainty of pregnancy outcomes, the inevitable risks of pregnancy and birth and the potential risks of 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 complementary and alternative medicine.

Conclusion
Women’s use of complementary and alternative medicine, whether as a response to the uncertainty of pregnancy and childbirth or as a defence against manufactured risk, reflected a desire to transform an unpredictable and unmanageable future into one which is more predictable and manageable. This supports Zinn’s (2009) argument that we should focus on the ways in which individuals seek to manage uncertainty rather than risk: when outcomes 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 though complementary and alternative medicine practice, aided by their high educational status and relative affluence facilitated their choices.

There was a tension evident in the women’s use of complementary and alternative medicine and their underlying discourse for the need to ‘be in control’ versus their desire for a natural childbirth without medical intervention. The women in this study demonstrated their autonomy by actively pursuing complementary and alternative medicine but also engaging selectively with expert scientific knowledge.

Participants’ decisions to pursue complementary and alternative medicine demonstrated the type of cognitive reflexivity described by Beck and Giddens, but more importantly reflexive decisions were based on emotion, intuition and aesthetics. In this article we have shown that the ontological insecurity of pregnancy and reflexivity which emerges during fateful moments motivates women to use complementary and alternative medicine. Women described the ways in which they used complementary and alternative medicine in this situation to retain control of their bodies and lives.

References
Adam, B., Beck, U., and Van Loon, J., 2000. The risk society and beyond: critical issues for social theory. London: Sage.
Allaire, A.D., Moos, M.K., and Wells, S.R., 2000. Complementary and alternative medicine in pregnancy: a survey of North Carolina midwives. Obstetrics and gynaecology, 95 (1), 19–23.
Atkinson, P., 1997. Narrative turn or Blind Alley? Qualitative health research, 7 (3), 325–344.
Ayrlie, G.M., Kethler, U., and Lohmann, S., 2005. Which components are important aspects of well-being in pregnancy. MIDIRS midwifery digest, 15 (2), 187–193.
Bauman, Z., 2006. Liquid fear. Cambridge: Polity Press.
Beck, U., 1992. Risk society, towards a new modernity. London: Sage.
Beck, U., 1996. Risk Society and the provident state. In: S. Lash, B. Szerszinksi and B. Wynne, eds. Risk, environment and modernity: toward a new ecology. London: Sage.
Beck, U., 1999. World risk society. Cambridge: Polity Press.
Beck, U., 2009. *World at risk*. Cambridge: Polity Press.

Becker, G., 1999. *Disrupted lives: how people create meaning in a chaotic world*. Berkeley, CA: University of Chicago Press.

Brown, P.R., 2009. The phenomenology of trust: a schutzian analysis of the social construction of knowledge by gynaecology patients. *Health, risk & society*, 11 (5), 391–407.

Czarniawska, B., 2004. *Narratives in social science research*. London: Sage.

Davis-Floyd, R.E., 2004. Let me tell you a story. *The practising midwife*, 7 (6), 18.

Department of Health, 1993. *Changing childbirth*. London: HMSO.

Department of Health, 2007. *Maternity matters: choice, access and continuity of care in a safe service*. London: The Stationery Office.

Department of Health, 2012. *2013/14 Choice framework* [online]. London: Department of Health. Available from: https://www.wp.dh.gov.uk/publications/files/2012/12/2013-14-Choice-Framework.pdf [Accessed 28 April 2013].

Douglas, M., 1992. *Risk and blame: essays in cultural theory*. London: Routledge.

Elliott, J., 2005. Using narrative in social research, qualitative and quantitative approaches. London: Sage.

Enkin, M., 1994. Risk in pregnancy, the reality, the perception and the concept. *Birth*, 21 (3), 131–134.

Fenwick, J., *et al.*, 2010. Why do women request caesarean section in a normal healthy first pregnancy. *Midwifery*, 26 (4), 394–400.

Furedi, F., 2002. *The culture of fear*. London: Cassells.

Gabe, J. ed., 1995. *Medicine health and risk*. Oxford: Blackwell.

Giddens, A., 1990. *The consequences of modernity*. Cambridge: Polity Press.

Giddens, A., 1991. *Modernity and self-identity*. Cambridge: Polity Press.

Giddens, A., 1994. Living in a post-traditional society. In: U. Beck, A. Giddens and S. Lash, eds. *Reflexive modernisation: politics, tradition and aesthetics in the modern social order*. Cambridge: Polity Press.

Giddens, A., 2002. *Runaway world: how globalisation is reshaping our lives*. London: Profile Books.

Green, J. and Baston, H., 2007. Have women become more willing to accept obstetric intervention and does this influence birth outcome? *Birth*, 34 (1), 6–13.

Green, J.M., Draper, A.K., and Dowler, E.A., 2003. Short cuts to safety: risks and rules of thumb in accounts of food choice. *Health, risk & society*, 5 (1), 33–52.

Heaman, M., Gupton, A., and Gregory, D., 2004. Factors influencing pregnant women’s perceptions of risk. *Maternal and child nursing*, 29 (2), 111–116.

Heyman, B., *et al.*, 2010. *Risk, safety and clinical practice: health care through the lens of risk*. Oxford University Press.

Hofberg, K. and Ward, M.R., 2003. Fear of pregnancy and childbirth. *Postgraduate medical journal*, 79 (935), 505–510.

Hope-Allan, N., *et al.*, 2004. The use of acupuncture in maternity care: a pilot study evaluating the acupuncture service in an Australian hospital antenatal clinic. *Complementary therapies in nursing and midwifery*, 10 (4), 229–232.

Kelner, M. *et al.*, eds., 2003. *Complementary and alternative medicine, challenge and change*. London: Routledge.

Kirkham, M. and Stapleton, H., 2001. Informed choice in maternity care: an evaluation of evidence-based leaflets (CRD Report) [online]. York: Centre for Reviews & Dissemination, University of York NHS. Available from: http://www.york.ac.uk/inst/crd/CRD_Reports/crdreport20.pdf [Accessed 9 April 2013].

Lankshear, G., Ettore, E., and Mason, D., 2005. Decision-making, uncertainty and risk: exploring the complexity of work process in NHS delivery suites health. *Risk and society*, 7 (4), 361–377.

Lash, S., 2000. *Risk Culture*. In: B. Adam, U. Beck and J. Van Loon, eds. *The risk society and beyond critical issues for social theory*. London: Sage.

Lash, S., Szerszynski, B., and Wynne, B., 1996. *Risk, environment and modernity towards a new ecology*. London: Sage.

Lee, S., Ayers, S., and Holden, D., 2012. Risk Perception of women during high risk pregnancy: a systematic review. *Health risk and society*, 14 (6), 511–531.

Lupton, D., 1999. *Risk*. London: Routledge.
Lyng, S., 2008. Edgework, risk and uncertainty. In: J.O. Zinn, ed. Social theories of risk and uncertainty. London: Blackwell

Maier, B., 2010. Women’s worries about childbirth: making safe choices. British journal of midwifery, 18 (5), 293–299.

McCLean, S. and Moore, R., 2013. Money, commodification and complementary healthcare: theorising personalised medicine with depersonalised systems of exchange. Social theory and health, 11, 194–214.

Melender, H., 2002. Experiences of fears associated with pregnancy and childbirth: a study of 329 women. Birth, 27 (3), 101–111.

Mitchell, M., 2010. Pregnancy, risk, and complementary therapies. Complementary therapies in clinical practice, 16 (2), 109–113.

Mitchell, M. and Allen, K., 2008. An exploratory study of women’s and key stakeholders experiences of using moxibustion for cephalic version in breech presentation. Complementary therapies in clinical practice, 14 (4), 264–272.

Mitchell, M. and Williams, J., 2007. The role of midwife-complementary therapists: data from in depth telephone interviews. Evidenced based midwifery, 5 (3), 93–99.

Nolan, M., 2008. Free birthing: why on earth would women choose it? The practising midwife, 11 (6), 16–18.

Polkinghorne, D.E., 2007. Validity issues in narrative research. Qualitative inquiry, 13 (3), 471–486.

Richard, L., 1997. Fields of play. New Brunswick, NJ: Rutgers University Press.

Riessman, C.K., 2008. Narrative methods for the Human Sciences. Los Angeles, CA: Sage.

Scamell, M. and Alaszewski, A., 2012. Fateful moments and the categorisation of risk: midwifery practice and the ever narrowing window of normality during childbirth. Health, risk & society, 14 (2), 207–221.

Sharma, U., 2003. Medical Pluralism and the future of CAM. In: M. Kelner, et al., eds. Complementary and alternative medicine, challenge and change. London: Routledge.

Slovic, P., 2000. Perception of risk. Sterling, VA: Earthscan.

Smith, C.A., et al., 2006. Complementary and alternative therapies for pain management in labour. Cochrane Database of Systematic Reviews, 18 (4), CD003521.

Smith, C.A. and Crowther, C.A., 2008. Acupuncture for induction of labour. Cochrane Database of Systematic Reviews. doi:10.1002/14651858.CD002962.pub2

Smith, J., Sullivan, J., and Baxter, D., 2009. The culture of massage therapy: valued elements and the role of comfort, contact, touch, connection and caring. Complementary therapies in medicine, 17 (4), 181–189.

Somers, M.R., 1994. The narrative construction of identity: a relational and network approach. Theory and society, 23 (5), 605–649.

Symon, A., 2006. Risk and choice in maternity care: an international perspective. Edinburgh: Churchill Livingstone.

Tucker, K.H., 1998. Anthony Giddens and modern social theory. London: Sage.

Viisainen, K., 2000. The moral dangers of home birth: parents’ perceptions of risks in home birth in Finland. Sociology of health and illness, 22 (6), 792–814.

Vincent, C. and Furnham, A., 2003. Users of CAM. In: M. Kelner, et al., eds. Complementary and alternative medicine, challenge and change. London: Routledge.

Walsh, D., 2006. Risk and normality in maternity care: revisioning risk for normal childbirth. In: A. Symon, ed. Risk and choice in maternity care. Edinburgh: Churchill Livingstone.

Watson, S. and Moran, A., eds., 2005. Trust, risk and uncertainty. Hampshire: Macmillan.

Westfall, R.E. and Benoit, C., 2004. The rhetoric of ‘natural’ in natural childbirth childbearing women’s perspectives on prolonged pregnancy and induction of labour. Social sciences and medicine, 59 (7), 138–140.

Williams, S.A., 1997. Women and childbirth in the 20th century stroud. Stroud: Sutton Publishing.

Zinn, J.O., 2008. A comparison of sociological theorising on risk and uncertainty. In: J.O. Zinn, ed. Social theories of risk and uncertainty: an introduction. Oxford: Blackwell.

Zinn, J.O., 2009. The sociology of risk and uncertainty a response to Judith Green’s is it time for the sociology of health to abandon risk. Health, risk & society, 11 (6), 509–526.