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'You Feel It in Your Body': Narratives of Embodied Well-Being and Control among Women Who Use Complementary and Alternative Medicine during Pregnancy

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Abstract: In Western societies, women's use of complementary and alternative medicine (CAM) during pregnancy and labor is increasingly ubiquitous, yet there have been few in-depth explorations of the lived experience of women who use CAM and little critical analysis of CAM's contribution to women's overall experience of pregnancy and childbirth. This paper explores women's narrative accounts of CAM use during pregnancy and childbirth to help uncover the meanings they attribute to CAM use. A qualitative narrative methodology was selected for this study, as it gives prominence to meanings that individuals assign to life events. A purposive sample of 14 women who were familiar with using a range of CAM modalities during pregnancy and childbirth took part in the study. This paper highlights different ways the women engaged with CAM, and how their embodied experiences became the mechanism by which CAM use, value, and safety were judged. CAM use in relation to embodiment became one way the women could reorder their world during pregnancy and childbirth. Moreover, CAM use among pregnant women may lead to the perception of more control and agency, but it also reinforces essentialist and naturalist conceptions of women's identities and bodies.

Keywords: complementary and alternative medicine; embodiment; well-being; pregnancy

1. Introduction

Pregnancy and childbirth are powerful, visceral experiences in a woman's life. In Western societies, pregnancy and childbirth have become an arena within which many key health and societal discourses are played out, particularly around medicalization [1], individual responsibility for health [2,3], and choice [4]. Many women across Western societies embrace complementary and alternative medicine (CAM) products and practices [5–11], partly as a response to these discourses, but also to give meaning and significance to those experiences and be provided with reassurance of the likelihood of a "normal" birth [12]. There is no consensus on the definition of CAM, but for the purposes of this paper, it is defined as "a wide range of health practices, treatments and technologies not traditionally associated with the health care system or training of conventional medical practitioners" [8] (p. 200).

Pregnancy frequently prompts an increase in CAM use and consultation [8,13–19]. The reasons for this and the meanings that pregnant women ascribe to it have been debated. Pregnant women cite the use of CAM modalities to help them cope with a range of symptoms (e.g., nausea and back pain) that can accompany pregnancy [20,21]. There have been reports of high levels of satisfaction with other CAM therapies, such as yoga, aromatherapy, herbalism, chiropractic, and massage [17,22–24].

CAM use can also demonstrate the "doing" of pregnancy [25], where engagement in self-care activities expresses ideas about women's social status and demonstrates their way of seeking approval.

Theories have been developed to account for why individuals turn to CAM [26], and increasingly for why they use CAM during pregnancy and childbirth. Although studies suggest that some women are reticent to use CAM during pregnancy due to concerns about risk [8,27], users of CAM prior to pregnancy often continue using particular therapies [23,24]. Use of CAM in pregnancy may be representative of a woman's dissatisfaction with biomedicine [28–30] or the risks associated with technological and pharmaceutical interventions in pregnancy and conventional maternity care [31,32]. Alternatively, women may be attracted to what CAM has to offer as a movement that values subjectivity and well-being [33], and as an individualized and personalized health care regime and philosophy [34,35]. Nissen [35] acknowledges these contradictory forces influencing women's choice about the use of CAM but suggests that CAM-seeking behavior demonstrates women's desire to nurture self-care, take responsibility, and achieve control over their own health and well-being [15,18].

As such, there are wider sociocultural contexts that are not related to either the appeal of CAM or the dissatisfaction of biomedicine. Pragmatic and pluralistic use of health care is increasingly common as CAM users actively make use of both conventional and alternative health traditions [36,37]. CAM usage therefore is indicative of vigilant health care consumers being actively concerned about responsibility for their own health [3,38], and reflects wider public health discourses about self-regulation and health monitoring. Such heightened concerns and feelings of responsibility for the health of the fetus lie heavily on women's shoulders.

Despite the contemporary risk-averse focus of biomedical maternity care, women differ in their perceptions and acceptance of conventional approaches during pregnancy [27]. Women may use CAM for their own bodies or self-care, but when thinking about the fetus, it is argued that more often they revert to biomedical practices; in this way, therapeutic pluralism could be characterized more by "therapeutic dualism" [27] (p. 174). As such, CAM use is one strategy for managing medicalized risk approaches to providing care in pregnancy [32]. Indeed, Keshet et al. [26] identified a significant theme in existing research suggesting that women's engagement with CAM arises as a coping mechanism against the power relationships and gender imbalances in health care. A complex and contradictory picture thus emerges: women engage in CAM partially to ameliorate the perceived risks of biomedical maternity care, but at the same time such engagement reinforces increased risk vigilance and a consumerist approach to further use of CAM health care strategies.

Pregnant Embodiment, Well-Being, and CAM

Pregnancy increases body awareness to such an extent that it represents an epiphany in a woman's life, sharpening feelings of embodiment [39]. Here, embodiment is defined as awareness of and responsiveness to bodily sensations and experiences [40], but it also denotes a social process that helps us understand the relationship between the individual body and society: society is the product of human bodies, but society is also "inscribed on human bodies" [25,36,41]. Broadly, theories of embodiment have fallen into two positions: the naturalist (essentialist) and social constructionist narratives [42,43]. Moreover, feminist theory has been key in reappraising the masculinist and essentialist bias in theories of embodiment as well as biomedical discourses on women's bodies [44].

Other terms, such as "pregnant embodiment" [25,27], "embodied gender/selves" [45], and what Sointu terms "embodied authorship" [46,47], help counter the ways in which women's embodied experiences of pregnancy have been marginalized by essentialist and medicalized approaches to care [1,43,48]. Women's awareness of their femininity during pregnancy is said to increase, as well as feelings of well-being and bodily pride. For some women, pregnancy is perceived as a challenge with physical discomfort, impacting on perceptions of well-being [49] and body image [50]. Sensations of another body within the woman's body, and perhaps unwanted feelings of being colonized by the fetus, can occur [51]. In addition to the side effects, such as nausea and backache, there is also the social pressure to maintain daily routines despite having to deal with these effects [52].

The ways women report their feelings about the impact of pregnancy on changes to the body are diverse, but a core biological (essentialist) narrative is that a woman has no control over the physical transformations that pregnancy brings about [53]; women striving for control against nature and pregnancy-related body changes is a key theme in the literature [50]. Women's experience of losing control can be considered antithetical to the dominant Western perspective of the body as something that can be controlled and manipulated [54]. CAM therapies can enable coping strategies around life transitions [55], enhance body awareness, and assist in the self-management of health and well-being [3,56].

Drawing on in-depth qualitative research exploring women's motivations and meanings associated with CAM use during pregnancy and childbirth, we highlight the different ways in which women engaged with CAM and how their embodied experiences of well-being became the mechanism by which CAM use, value, and safety were judged. CAM use in relation to embodiment became one way in which women could reorder and control their world during pregnancy and childbirth. This paper provides further illustration of how pregnant women, with the aid of CAM, cope with bodily changes and seek to exercise control over their own well-being, while at the same time their desire and actions to regain control replicate many of the essentialist fallacies they seek to repudiate.

2. Methods

This study was conducted in the southwest area of the UK. It is based on qualitative methods, using narrative methodology, which was chosen because narrative methods emphasize the meaning that individuals ascribe to life events [57–59]. Narrative research includes a range of research approaches, with individual stories at their core. Narrative research has gained popularity in research on health in the social sciences, indicative of a critique of medical science and notions of objectivity (which negates subjective experience for the individual) [60]. However, little contemporary narrative research focuses on women's experiences of pregnancy and childbirth [32]. Narrative inquiry promotes storytelling that allows individuals to make sense of their world, and this process is retrospective in nature [57]. Allowing individual women to tell their stories has the potential to shed light on meanings attached to this important life event and facilitate greater insight into why women use CAM during pregnancy and in childbirth.

The researcher (MM) shared with the participants her role as a mother, midwife, and complementary therapist. Revealing this information facilitated the development of a trusting relationship between the participants and the researcher and thus influenced the telling and interpretation of the narratives. Finley and Gough [61] highlight the importance of the researcher's awareness of and reflexivity on her individual connection to and influence on the research process and interpretation of the findings. To address this, an interview strategy recommended by Elliott (2005) as a way of attenuating the impact of researcher bias was employed [59]. During the second or third interview, the researcher encouraged participants to explore alternative perspectives on CAM use, for example asking them to respond to criticism, such as "CAM has no basis in science." This was a successful strategy and yielded fascinating insights into participant experiences and views about CAM and biomedicine.

2.1. Recruitment, Sampling, and Data Collection

A mixed sampling approach integrating purposive and snowballing strategies was adopted to identify a sample of women who had used CAM during pregnancy and childbirth. At the outset of the research, MM contacted a local group of CAM practitioners to assist in recruiting participants. These practitioners displayed a flyer seeking participants for the study in their practice settings. Practitioners also recommended the study to individuals whom they knew had used CAM practices during pregnancy. Women then self-selected by contacting the researcher. A woman was included as a participant if she had used at least one CAM therapy in a past pregnancy or birth, could converse in English, and gave consent. Fifteen women met these inclusion criteria. Subsequently, one woman

dropped out, thus 14 women participated in the study. The time interval between the last pregnancy when CAM was used to involvement in the research was between 6 weeks and 7 years. Two women had 3 children each, 4 had 2 children each, and the remaining 8 had 1 child each. Educational status was high; all the women had further or higher education qualifications.

The reasons why individuals use particular CAM approaches are complex and dynamic; people sway from one therapy to another that best suits their needs at any given time [37]. As such, focusing on one CAM therapy would deny the complexity of CAM users' beliefs and practices. Participants had used a total of 20 different CAM modalities before, during, or following pregnancy. In addition, all participants had experience using at least one CAM therapy before pregnancy. Massage, yoga, acupuncture, reflexology, chiropractic, homeopathy, and herbalism were the modalities most used by participants. In this study, patterns of usage were very similar: participants frequently engaged first with a familiar therapy, and then incorporated other therapies in response to their needs or recommendations from significant others (e.g., friends and/or professionals) as their pregnancy progressed. A further significant issue relevant to the interpretation of participants' experiences with CAM use in pregnancy was that all modalities included face-to-face experience with CAM practitioners. Self-prescribed modalities such as vitamin supplementation and individual spiritual practices such as prayer did not feature substantially in the narratives. The characteristics of the participants matched the descriptors of those most likely to use CAM found within the literature. At the time of interview, participants' ages ranged from 30–49. One woman was German, one Australian, one was Black American, one White American, and the remainder were White British.

Narratives were obtained through in-depth interviews with the 14 women on two or three occasions, conducted by MM. The interviews were held in the participants' own homes during the time period November 2009 to September 2010. The length and number of interviews were determined by the individual wishes of the participants. The in-depth interview is a commonly used approach within narrative inquiry. Although conducting multiple interviews is not necessarily a narrative research technique, considering the needs of women with young children, several shorter interviews were conducted on different occasions over a period of 3–6 months. On average, interviews lasted about 1.5 h; the longest was 3 h. The second and third interviews allowed women to continue their narrative or the interviewer to question further and seek clarification. Cox [62] suggests that this approach can enhance trustworthiness, as it encourages participants to frame their own responses and focus on what is meaningful to them. It also proved essential in encouraging participants to provide rich and detailed narratives. It was evident that many of the participants reflected on their experiences between interviews, and this reflection provided further insights. For example, some participants began the second interview with a statement such as "I have been thinking about what I told you previously"; one woman said she made a conscious decision to reveal a particular sensitive experience and another identified that some of her thinking had been muddled and contradictory, leading her to provide further explanation. Before proceeding to the second interview, extracts from the first were incorporated into the interview schedule [63]. The value of the second and third interviews was clear in the depth of narrative revealed. This reminded participants of what was addressed previously, allowing for the development of emerging concepts and providing fluidity to data collection as compared to a one-off interview.

Obtaining informed consent can be difficult with narrative methods, as individual stories are socially constructed during interviews, so neither the researcher nor the interviewee can anticipate what may be revealed [64,65]. Thus, a process model for obtaining informed consent was adopted, where consent was renegotiated all through the research process. Participants chose their own pseudonyms. Permission to undertake the study was granted by the university faculty ethics committee.

2.2. Data Analysis

MM transcribed the interviews verbatim. A framework of analysis was constructed by drawing upon recommendations from the key methodologists associated with narrative analysis, such as

Reissman [57,66], Lieblich et al. [67], and Mishler [68]. Data analysis was conducted in a five-stage process with a focus on identifying the meaning and significance of CAM use in relation to pregnancy experiences. The five-stage process included analyzing the holistic form and content of the participants' narratives. This included the global perspective of the narrative, the meaning or interpretation of the story from the narrator's perspective, and how the perspective unfolds as the narrative progresses. The analysis of categorical form and content included the structure of the narrative, space and characters, plot, focus, and how emotions are reflected in the telling. A fifth layer of analysis was conducted to examine the sociocultural influences within the narrative. Finally, emergent themes in relation to embodiment and well-being were identified across all transcripts. The computer software Nvivo was used to assist in the analysis. The analysis led us to produce the findings in relation to stages of the narrative/narrative flow more than "themes" in the conventional sense. Both authors conducted the analysis and agreed on their emerging themes and interpretations in relation to ideas about control and embodied well-being.

3. Findings

Women's stories were primarily those of pregnancy and childbirth, and this is reflected in the findings below. Their reasons for choosing particular CAM therapies were complex and varied, similar to what is noted in the contemporary literature. Childhood experiences were viewed as being influential in the development of beliefs and practices, and the participants often maintained a worldview that supports a holistic orientation to health, along with an interest in spirituality and personal growth. Decision-making around CAM use arose as a result of cultural and lifestyle norms and values, which can help further contextualize the findings.

Moreover, for many of the participants, periods of physical ill health and/or emotional stress promoted CAM use. A belief that CAM offered a solution to health problems and dissatisfaction with biomedicine or with the approach of medical professionals were among the main reasons for CAM use prior to pregnancy.

In the findings below, we explore the themes of well-being and control, and embodied connections. The former focuses on the ways participants sought greater use of CAM to regain a sense of personal control over pregnancy and labor, to limit medical intervention, and to help enhance overall feelings of well-being. The latter theme highlights the women's thoughts about opening up to and connecting with both emotional and embodied experience during pregnancy and childbirth; their narratives draw attention to the relationship between embodied experiences during pregnancy and emotional well-being more generally.

3.1. Well-Being and Control

3.1.1. Pregnancy: Control Derailed

For many women, pregnancy brings significant changes both to the body and to self-perceptions about the body and well-being, with both positive and negative feelings expressed.

Stephanie, for example, reflected on how the growing fetus colonizes the space: "I believed that being pregnant was like having an alien growing in you and it just repulsed me." Negativity may be due to the physical signs and discomfort that are brought about by pregnancy, which are out of the control of pregnant women. Alexandra lamented the physical limitations and embodied feelings of dissatisfaction that pregnancy entailed:

> I was really looking forward to being pregnant, and when I had friends before that were pregnant I would just love their tummy and think, oh it must be so nice to be pregnant, and then when it was my turn I just hated it. I was huge, I was so big, and that obviously didn't help: you can't move, you can't walk, you have backache, and I couldn't turn over in bed, it was awful. (Alexandra, first interview)

Alison detailed a range of physical discomfort that came with pregnancy:

> It [massage] was so nice. I suffered terribly when I was pregnant, twitchy leg syndrome, twitches and twitches and there's sod all you can do about it and that really did help. I used to go for a full body massage but she would spend ages draining my calf muscles and thigh muscles and for the next couple of days it would be better. It was a murderous side effect of pregnancy. (Alison, first interview)

CAM (massage in Alison's case) was perceived as both reward and relief. Clarissa commented that in pregnancy "everything changes," referring to her changing sense of taste and smell, that she didn't know what she wanted to eat anymore, and "just being pregnant makes you think about your body space differently." Pregnancy has an impact in terms of shifting the embodied sense of well-being; it derails the normal sense of a body and life in control. Both losing control and needing to reassert it occur at different points:

> I was a bit out of control. . . . I sometimes just wanted to open my tummy and have a look and see if he is all right and close it again, and you can't, and it's not nice being out of control like that when everything else in your life you can somehow interfere with. (Alexandra, first interview)

A key narrative was that being in control was equated with being prepared and managing risk. Preparing for childbirth meant engaging more with the embodied feelings of well-being and rejecting medicalized discourse. As such, feeling out of control and the turmoil of control derailed led the women to become more responsive to bodily sensations and feelings. For some of the women, this meant focusing on health maintenance:

> [The] thing about pregnancy and childbirth is that you are not ill. You are very healthy and it's not about treating yourself as such. It is about maintaining your health and keeping things moving, which is why I used quite a lot of therapies when I was pregnant and in childbirth for that reason, because we are not sick as pregnant women. (Caroline, first interview)

3.1.2. Labor, Childbirth, and Embodied Well-Being

The women often privileged embodied awareness and experiences over intellectual concerns about their health and pregnancy. They held a strong view that labor and birth is an instinctual, intuitive, and embodied process, and this was particularly the case when thinking about preparing for labor, where the use of CAM was mentioned frequently. As such, medical intervention was perceived as problematic:

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

Yet some participants also had a fear of childbirth, and their views about the normality of pregnancy and childbirth arose from their experiences using CAM. A childhood experience of a sex education video left Stephanie "traumatized," with a deep fear of childbirth. With the help of acupuncture, hypnobirthing, and hypnotherapy, Stephanie reviewed her beliefs about birth and came to a realization:

> I could be in control or I could be done to, and I realized that if I went into hospital with everything I heard, is that my labor would be managed and the intervention is there and you have no control in the matter. (Stephanie, first interview)

A recurring theme for the participants was their need for a normal birth, a fulfilling birth experience with limited biomedical intervention. They actively sought to decrease the role of biomedical intervention in pregnancy, whereas we could argue that women in general during pregnancy take a more pragmatic approach.

Feelings of control are linked to an embodied experience:

> You really have to let go of your thinking brain and connect to your primitive brain, which isn't the rational thinking brain. That's where your instinct and intuition and your animal drive and your gut is rooted, and if you don't connect with that throughout your pregnancy then you are going to be lost when you are in labor. I think that's what a lot of these therapies are good at. (Riley, third interview)

CAM use, therefore, represents bringing the person into the body, a key determinant of being in control. CAM is seen as offering practical solutions for gaining control and being prepared:

> I just found it [yoga] a fantastic preparation for labor. It was very positive about how the labor could be, and what things to expect through it and lots of very, well ... practical advice like how to, how you might use your body, all the different phases. (Clarissa, second interview)

The women's narratives about labor and childbirth highlighted the importance of control, but also the paradox of what control might imply, even in situations where, as Riley said, the woman knows that some element of control has to be ceded to others or to the body's demands. Stephanie, for example, used an acupuncturist 12 h before labor started, and said, "he just said he was going to get me feeling on top form and ready."

From the participants' perspective, the risks of labor and childbirth are focused on losing control and being unable to share in certain common birth experiences. Daisy said that she used CAM because "I wanted to make sure I was as physically prepared for it as possible," and this also meant that medical intervention was seen as giving in and ceding control to others: "I felt I wanted to have that control myself, and if I was induced that I would probably lose all control of what would happen to me." Alexandra was more explicit in highlighting the self-blame that goes along with the desire for control over the process: "The thing that I desperately didn't want was an epidural, because then you are lying and then that is it, you have lost control." CAM, for many of the women, offered an approach that allowed them to retain more control.

3.2. Embodied Connections

3.2.1. Emotional Well-Being Connections

A key part of the discourse about being prepared for labor and childbirth is that women engage with their emotions and feelings as well as with the baby, and the emotional aspects are not distinct from the body but are integral to it. Women themselves frame this in terms of "connectedness," as well as "openness" and being "open" to embodied experience. There was also a connection established in participants' narratives between embodied experiences during pregnancy and emotional well-being.

Being prepared for and open and connected to a range of important experiences is perceived as essential to accessing a positive birth experience. Engaging in CAM allowed the women to express some of these discourses about connectedness. One area the women talked about was connecting to their emotions and the feelings of embodied wellness that should accompany that, as well as the connection to the therapist/practitioner. Here CAM (shiatsu) is described as a system that provides access to the emotional level:

> With shiatsu, somehow you can still have that physical experience because we do some work that works with muscles but it is going another level than beyond just the muscles and ... how to explain ... it does tap into different emotional feelings. Each of the meridians has a physical and an emotional correspondence. (Louise, first interview)

Emotional access and connectedness was important, and as a consequence of hormonal changes, their view is that emotions may be very mixed. The idea of emotions within the embodied state points to an effect of the emotional state on the physical body (an idea rejected by biomedicine). Participants intuitively sensed this connection between their physical well-being and their emotions. Seeking help from CAM for their physical symptoms enhanced their emotional well-being. Rachel described how the emotional state may influence the baby and therefore the birth process:

> She [the therapist] might pick up emotions in the body so she will say stuff like 'oh there is a lot of fear' or like 'in the spine there is a bit of fear there' or 'there's excitement but there is also fear' and then that brought my attention to OK what am I fearful about. What have I not, sometimes reaching into the emotions as well, and thinking about working through that after the treatment. (Rachel, second interview)

The CAM practitioner was seen as instrumental in offering a different kind of emotional connection, one that individualizes the pregnant woman, and the approach is more appropriate to the embodied experience:

> Whatever type of modality of [CAM] therapy that you find, they offer so much more than GPs, and it's not just that they listen and it's not just that they talk to you or connect to you, it's like whatever it is, there's a physical touch and there's an actual diagnosis that's connected to you, how you are at that moment, and that's what Western medicine does not do. That is what I need. I need to connect with somebody. (Riley, second interview)

3.2.2. Bodily Connections

Many of the women talked about the pressure of having a particular birth experience, and that some degree of biomedical intervention was perceived as ceding control to others. They felt responsible to ensure that didn't happen. Clarissa, for example, spoke about the threat of induction during labor and how this challenged her sense of what her body should do naturally, how it questioned her body, her femininity, and whether she would blame 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 threat, 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, first interview)

In the second interview, Clarissa confirmed these anxieties, as well as feelings of blame, again referring to key overarching discourses about a "good" birth:

> There was another element, which was about somehow not being a woman, being forced into labor when it should have been the most natural thing, and that was really difficult. I had to really, it's not kind of an ego thing, but almost sort of somehow I would have failed and ... um . . . I wasn't susceptible enough in my body or my body wasn't open, I don't know but somehow my body wasn't. (Clarissa, second interview)

Failing as a woman and being blamed, when the wider discourse is on the "naturalness" of birth, shows how Clarissa viewed the importance of managing the risk. CAM is used as a method of ensuring some sensitive connection to the body, or at least giving women strategies for feeling more engaged with the embodied experience during birth:

> The more you engage with it [the body during pregnancy] and allow it a place to be, the more you let it go and the more you are likely to be able to engage in being in labor and letting your body do, and at the end of the day it is getting it out of your own way, because I think your body knows exactly what it has to do and it's just about finding a place in you that allows it. (Riley, second interview)

For Riley, the body is "knowing" (expert) and the woman needs to be fully open and engaged with this. Caroline, for example, spoke about focusing on the physical activity of yoga breathing as a way of encouraging this openness and bodily connection:

> When you are in labor all you can do is concentrate on the breath [Ujjayi yoga breath] because there is no room for thinking about anything else, because you are so consumed by the physical experience of it. You can just about manage to ask for a drink or something to eat or what the time is. The breath is the thing that is um . . . what I mean is, all you can do is breathe. Your body is doing it anyway. (Caroline, second interview)

For Caroline, birth is an all-consuming embodied experience, a total immersion. She also mentioned how CAM techniques may have practical application. Yoga, breathing, and other CAM practices were perceived as specifically useful in preparing the body. For example, Rachel meditated and used shiatsu to help her be "aware" of her body, but also acknowledged the impact these had on emotional well-being:

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

Significantly, the fetus/baby was not seen as separate from the embodied experience. The women's view was largely that CAM helped in childbirth, partly by providing them with some energy and life force, but also the CAM experience connects them to the baby and provides the "tuning in":

> I suppose it feels like a good fit to be going after therapies when you are producing something like a baby. . . . I think especially the reflexologist could really give me, really tune into him. (Caroline, second interview)

For Caroline, using a yoga therapist was instrumental in encouraging that connection. Erin talked about the role of her chiropractor in that process:

> It made her feel very connected with my pregnancy and it was nice, you know. There was the kind of compassion about ... I don't know, there was just something very nice about the way she would kind of feel the position of the baby and just that kind of confidence in her touch around the baby and the abdomen, was really nice and very reassuring. (Erin, second interview)

The women talked about the instinctual, intuitive experience of birth, about the importance of connecting to the baby through that embodied experience. Others, like Louise, felt that they could encourage this connection through self-massage:

> No one [such as the Shiatsu therapist] was really that comfortable working that much on my abdomen, especially with massage. I used to massage it quite a lot because I felt that was a really important part of connecting with the baby and just being aware of how the baby is responding. (Louise, first interview)

The need to connect with the baby was mostly described in positive terms, and mother and baby were seen as one, not as embryo and mother on competing terms. The downside, which Clarissa mentioned, is the ambivalent feeling of being physically tied to an embryo that competes for body resources:

> We [with the homeopath] did one session completely with the birth and how I felt about the birth so it was brilliant preparation. Getting strong helping me connect, because I think at that point I was a bit scared to connect with the baby somehow, 'cause I felt that this little boy was a ferocious kind of . . . a strange thing being pregnant, a most wonderful time but it kind of felt like that this thing, I don't know, it sort of becomes like a physical fight between you and the baby. (Clarissa, first interview)

4. Discussion

Pregnancy and childbirth rarely have the potential to be chaotic, out of control, or potentially life-threatening for women today in Western societies, and yet anxieties and concerns surface for women about how best to manage the body, experiences, and sensations, and about whether to cede control to medicine (e.g., in the "disembodied" aspects of pain relief [43]) or take back control [15,17,18,33,69,70]. Essentialist and biological ideas [42,43] about women's bodies suggest that they (particularly pregnant bodies) are undisciplined and out of control, and so women's responses here express ways to reassert it [15,18]. Clearly, women are very individual in how they reestablish control, but for women who use CAM, such therapies encourage embodied connections and engagement.

The findings and analysis in this paper suggest that the experience of pregnancy and childbirth for some of the women was overshadowed by feelings of uncertainty in the face of risks [32], and needing to feel in the best possible physical, mental, and emotional shape by focusing on preparedness. Various CAM therapies enabled women to attune to their intuitive feelings and become more connected to their body (embodied well-being), their feelings, and their baby, all of which helped in terms of their confidence and their preparedness for labor. However, there is clearly a tension here, as we need to think about why these women feel it is important to focus so much on preparedness when they also say that you just let go and listen to the body. Moreover, as Frawley et al. suggest, why would many pregnant women choose to use CAM products to gain control when evidence for the efficacy and safety of CAM practices and products during pregnancy is somewhat limited [18]?

Using CAM therapies implies personal choice and agency, as well as empowerment and personal control [15,18,69,70]. "CAM both establishes a sense of control and produces individual agency" [33] (p. 728). On the one hand, their actions seem agentic, as they represent gaining control (and choice) over their bodies and their emotions, and this rests on ideas that they only have to tune in and connect to their embodied feelings. They also exercised their agency and autonomy in the choice of both CAM therapies and practitioners. Notions of agency are also evident in the self-authorization of participants as they seek solutions for their problems.

However, we can see that there is a wider agency/structure tension being played out as women, with the aid of CAM, cope with bodily changes and seek to exercise control over their own well-being, but at the same time, their desire and actions to manage this appear to demonstrate the essentialist fallacies that they are also rejecting. For instance, some of the ideas about control of the body that we see here play to essentialist notions of the body that women have only to tune in to their body and that it is a "natural" thing to do (the "naturalist" narrative), an idea criticized both within and beyond midwifery [42]. Such a perspective emphasizes that all women are seen as the same and is largely premised on the idea that we need to return to this natural instinctive approach to childbirth that socialization and biomedicine have destroyed. The decision to use CAM is therefore double-edged—on the one hand, it may lead to the perception of more control and agency, but on the other hand, it may reinforce essentialist and naturalist conceptions of women's identities and bodies [42,43].

CAM use represents acceptance of a wider discourse that childbirth is a "natural" event and that women should be able to do it with limited "medical" intervention. However, some ambivalence about "naturalness" is still expressed. For example, we saw that there were anxieties about the baby colonizing the space of the body and feelings that it must feel "natural." Pregnancy challenges the boundaries of the body as a "hybrid" [71], as "the boundaries between self and other are already troubled as the woman's body nurtures another human being within" [42] (p. 461). Women may see the body as a "stranger" to them [50]. Women may either express comfort in sharing their body with the fetus, or feel that it is invasive [50].

That women's feelings about pregnant embodiment are ambivalent may be due to the perception that women's identity and sense of self change following pregnancy [44,72]. Feminist writers on embodiment, such as Bailey [45], argue that particular discourses on pregnant bodies and identity suggest that there are feminist (and anti-medicalized) conceptualizations of self in women's accounts. As Bailey explains, "there are strong elements in some white, middle-class women's

discourse concerning themselves as gendered subjects, which could also contribute toward a corporeal feminism—a feminism that takes seriously women's embodied experiences" [45] (p. 127). We see how a similar preoccupation emerges in these (largely middle-class) women's accounts.

Furthermore, we see this with the women's anxiety in terms of feelings about self-blame, increased vigilance, and responsibility for what happens during birth. In recent years, government policy has encouraged women to take control over childbirth, including the right to make choices. Vigilance and concern over the potential risks of biomedical maternity care may lead to rejecting technological interventions, but this reveals not only fear of risks, but also fear of oppression and disempowerment. The sense of control, taking responsibility, and making active (agentic) decisions contributed equally to their sense of well-being. Even when pregnancy or labor did not proceed as the women had hoped, they seemed content with their decision-making around CAM use.

CAM philosophy has much in common with public health and preventive medicine: CAM use allows consumers to take responsibility for their own health and well-being. CAM use promotes enhanced body awareness, additionally contributing to self-management of health and well-being [3,56]. Here, notions of agency can help illuminate our understanding of women's actions. Biomedical approaches to maternity care undermine women's confidence in their ability to birth without intervention [73]. In this study, the women were aware of the risks of medical procedures and took steps to strengthen their body, strengthen their connection to their body, and build their preparedness for birth. The uncertainty that participants faced in deciding whether medical intervention was really warranted and the fear of risks, such as induction, mobilized them to action.

Many of the women conceptualized their decision-making as a desire to be "in control." In encouraging individuals to take responsibility for their well-being, CAM can be viewed as empowering [74], but it also reflects contemporary neoliberal discourse about individual responsibility for health and self-surveillance of health behaviors [34] that encourages women to blame themselves for not being prepared enough. The risk society encourages individuals to both choose and be in control, but they are constrained against this by procedures within current maternity services in the UK [32]. Engagement with CAM enables such feelings of being in control, and we can see how relationships established with CAM practitioners present an alternative partnership model to midwifery care [19].

Herein lies a paradox: while CAM users such as pregnant women strive to demedicalize their lives by avoiding or limiting biomedical interventions, CAM approaches that stress the importance of well-being and emotions to achieving health can create just the same authoritarian stance. Indeed, women feel tremendous pressure to stay healthy during pregnancy, since the weight of responsibility for the well-being of their babies lies firmly on their shoulders.

Limitations of the Study

One of the authors, MM, is both a midwife and a complementary health practitioner. She acknowledges that some of her personal assumptions and beliefs likely impacted the research process and revealed the dynamics between herself and the participants. In terms of sampling, the 14 participants in this study were self-selected and all CAM users prior to pregnancy. Some of the participants came forward for the research project to share their experiences, largely positive, with the research and CAM community, and to advocate for the use of CAM during pregnancy and childbirth. It has been noted that CAM users can become strong advocates for therapies, thereby embracing the underpinning ideas and philosophies and then often projecting their worldview into social activism.

5. Conclusions

This qualitative study is located within a broader literature on women, embodiment, and CAM [27,33,46] and presents original qualitative data to shed light on CAM as gendered embodied health and social practice. Although some studies have explored CAM use prevalence and women's experiences of CAM during pregnancy, these studies mostly adopted a positivist paradigm that reveals less about women's complex and individual motivations. As such, this paper offers an important

contribution, in that the focus is on women's experiences and the varied meanings they ascribe to their use of CAM therapies.

In this paper, we explored pregnant women's motivations to use CAM and the meanings of CAM use in their experience of pregnancy and childbirth. The women interviewed maintained a more ideological involvement and commitment to CAM (acknowledged by their use prior to pregnancy), though it is important to note that not all women's involvement in CAM implies sharing of beliefs and values of therapists and therapies. We explored the different ways in which women utilized CAM and how their embodied experiences became the mechanism by which CAM's use, value, and safety was judged. CAM use by pregnant women represents some way of gaining control over a life derailed, in which women could reorder their world during pregnancy and childbirth. Moreover, this paper is placed in the context of a wider sociocultural discourse about embodied well-being and control. Here, women engage in CAM alternatives as a way to ameliorate the perceived risks of biomedical maternity care, and to support them in achieving well-being and a normal birth.

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