

**“I trusted myself to pick what works for me”:**

**The meaning and management of  
complementary and alternative medicine during pregnancy**

by

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## **Abstract**

Pregnancy and childbirth are major life events for some women. These experiences hold great personal and social significance. In Western countries, the use of complementary and alternative medicine (CAM) among pregnant women is on the rise (Bakx, 1991; Eastwood, 2000; Tovey, Easthope, and Adams, 2003). There is little research into pregnant women's decision-making when choosing CAM (Adams et al., 2009) or how they negotiate discordant discourses on pregnancy, health, and wellbeing. This thesis explores the experiences of pregnant women who access CAM while simultaneously embracing biomedical knowledge and expertise. This study utilized semi-structured interviews to explore pregnant women's decisions to use CAM within the context of consumer-driven health care, rising neoliberalism, and the history of the medicalization of women's bodies. Foucault's theory of biopolitics is used as the theoretical framework for this project. The process of designing an individual prenatal health care regimen is complex and multi-faceted. The agency on the part of pregnant women to pick and choose the therapies that suit their own needs and preferences remains a potentially subversive act in the context of overarching medical dominance.

## **Preface**

This dissertation is an original intellectual product of the author, Bethany Schmidt. The semi-structured interviews included in this thesis are covered by UBC Ethics Certificate number H14-00186.

# Table of Contents

<b>Abstract.....</b>	<b>ii</b>
<b>Preface.....</b>	<b>iii</b>
<b>Table of Contents .....</b>	<b>iv</b>
<b>List of Tables .....</b>	<b>vi</b>
<b>Chapter 1: Introduction .....</b>	<b>1</b>
<b>Chapter 2: Background and Theoretical Orientation.....</b>	<b>4</b>
2.1 What is CAM? .....	4
2.1.1 Prevalence of CAM.....	4
2.1.2 CAM Use Among Pregnant Women .....	6
2.1.3 Integration with Conventional Medicine .....	9
2.1.4 Determinants of CAM Use in the General Population .....	10
2.2 Theoretical Orientation .....	11
2.2.1 Feminism .....	12
2.2.2 Consumerism and Neoliberalism.....	15
<b>Chapter 3: Methodology.....</b>	<b>18</b>
3.1 My Location in the Research .....	18
3.2 Semi-Structured Interviews .....	20
3.3 Ethical Considerations .....	26
<b>Chapter 4: Perfect Babies, Perfect Mothers, Perfect Pregnancies.....</b>	<b>28</b>
4.1 Perfect Babies .....	28
4.2 Perfect Mothers.....	29

4.2.1	Pregnant Body Image.....	33
4.2.2	Risk and Fear .....	35
4.2.3	Prenatal Testing .....	37
4.2.4	Choice and Autonomy .....	46
4.3	Perfect Pregnancies: CAM in the context of Neoliberalism and Consumerism.....	50
4.3.1	CAM and Personal Responsibility for Health .....	51
4.3.2	Choice and Responsibility .....	57
4.3.3	Informed Health Consumers .....	60
<b>Chapter 5: Conclusion.....</b>		<b>67</b>
<b>Works Cited.....</b>		<b>69</b>
<b>Appendices.....</b>		<b>89</b>
	Appendix A Recruitment Poster .....	89
	Appendix B Consent Form .....	91
	Appendix C Demographic Information Sheet .....	94
	Appendix D Interview Guide.....	95

## List of Tables

Table 1: CAM Coverage and Cost.....	7
Table 2: Participants' Biographical Information.....	31

## Chapter 1: Introduction

In this study, I explore how pregnant women negotiate their use of complementary and alternative medicine (CAM) in the current context of medicalized pregnancy and childbirth. Pregnant women are now combining conventional medical care with alternative therapies, reflecting an increasingly pluralistic and consumer-driven health care environment. There has been little research done on the ways in which women navigate the contradictory discourses set out by conventional medical care and alternative modalities. In a context with such diverse prenatal health care options, women must juggle multiple claims of expertise, models of health and disease, and divergent understandings of medical risk. This decision-making is the topic of my thesis. I argue that pregnant women make these decisions for CAM in a context of competing, at times, contradictory discourses of conventional Western medicine and alternative, holistic models of care. Women make decisions about their prenatal care in a deeply capitalist and neoliberal Canadian context that stresses the importance of individualism, choice, and freedom.

As in many post-industrial countries, demand for CAM in Canada has been increasing steadily in recent years. A significant consumer market for CAM products includes women of reproductive age (Adams, 2011). The current literature indicates that the prevalence of CAM use for women during pregnancy is significant, yet research exploring the factors driving this trend is lacking (Adams et al., 2003; Beal, 1998; Steele, 2013). It is not well understood why some women choose CAM during pregnancy or how they negotiate the use of these alongside conventional prenatal care (Adams et al., 2009; Warriner et al., 2014). An in-depth examination of women's lived experiences would help us to understand how women make sense of their prenatal health options and bring together both CAM and conventional care.

Mothers and pregnant women lie in the centre of various intersecting discourses on how to promote health and protect the environment of their fetuses and infants. Being a good mother in a neoliberal context has a lot to do with mitigating risk and taking personal responsibility for the health and wellbeing of the unborn. This yearning for a perfect baby is steeped in the eugenic legacy of our past. Angus McLaren (1990) details how eugenic logic pervaded Europe and North America in the early 20<sup>th</sup> century. He demonstrates how social leaders, doctors, psychiatrists,

social workers, and mental hygienists were able to alleviate the anxieties of white middle-class Canadians about social problems facing the settler colonial nation (McLaren, 1990, p. 130. If crime, poverty and other social ills were the product of faulty genes (not ineffective social systems), solutions were available. Biological based explanations for “race betterment” were employed across the country. Sterilization of those deemed “feeble minded” in Alberta and British Columbia were some of the most dramatic and enduring attempts to limit the reproduction of the “unfit” (Grøkul, et al., 2004; Malacrida, 2015).

Whereas “traditional eugenics” of the early 1900s focused on race and class, the advent of advanced genetic technology has been deployed using similar logic. Increased involvement in reproduction via medical technology (used to detect such genetic variations as Down syndrome, Tay Sach’s disease, and Trisomy 18) has the potential to radically impact the type of babies that are born. Birthing the “perfect” child is an impossible goal. Ultimately, in a neoliberal context, a disabled person is subject to the punishing stigmatization of being deemed “abnormal” and non-productive (the antithesis of the ideal citizen). There is a profound lack of resources available for the support and caring involved with raising a child with disabilities. This is implicitly understood by expectant mothers who have internalized expectations and hopes for a “perfect” child.

I am interested in how women take up CAM while simultaneously engaging with conventional medicine, given that the biomedical literature on CAM emphasizes potential dangers and adverse effects of alternative therapies (Miller et al., 1998; Werneke et al., 2004; Lewis, 2011). Engaging with both CAM and conventional care in the prenatal period indicates that these decisions are complicated and not as simple as was once imagined. CAM use is not an outright rejection of conventional medical expertise and practice. On the contrary, we are seeing how these two approaches are being taken up together.

This introduction is followed by three chapters and a conclusion. Chapter 2 outlines background to my topic as well as describing my theoretical orientation. The literature review focuses on CAM use in the Western context broadly as well as pregnant women’s use of CAM. It discusses the prevalence of CAM, defines popular types and also outlines common determinants for CAM use. I then outline how I employ feminist understandings of biopower,

defined by Foucault (1989) as “an explosion of numerous and diverse techniques for achieving the subjugation of bodies and the control of populations” (140). Expanding on Foucault, feminist scholars such as Deborah Lupton, Sandra Lee Bartky, and Susan Bordo inform my analysis on the surveillance and discipline of women’s bodies that became commonplace with the medicalization of pregnancy and childbirth. The work of these and other scholars serves to highlight the ways in which increasing medicalization discouraged active participation in prenatal health options and childbirth. In this way, my focus on CAM use among pregnant women illustrates active resistance to this medical management of pregnancy. Simultaneously, it is noted that women’s motivations for CAM are varied. The larger neoliberal and capitalist Canadian context that stresses the importance of individual choice and responsibility is central to the rise of CAM. The choice for CAM then is more complex than a simple rejection of paternalistic medical surveillance; it is an ongoing negotiation between competing paradigms.

Chapter Three outlines my methodology for this thesis. It outlines my use of semi-structured interviews along with email follow-up interviews. Here I also describe the techniques for data analysis that I employed. In this chapter I also locate myself in this research project and describe how my positionality has impacted my project. This discussion also includes a description of the ethical considerations I had during this research.

Chapter Four describes the three main themes that emerged from the interviews I conducted. It hinges on the active and ongoing negotiation that the women I talked to experienced in choosing CAM. All of the women I talked with were using CAM alongside conventional medical care. Women I talked with took up these CAM in unique ways, molding the offerings of a pluralistic health care market to their own needs and preferences.

Finally, Chapter Five summarizes the main findings and draws out the contradictions women face in the context of newly emerging CAM and online information alongside the continued dominance of scientific expertise. Once again, women’s decisions are set in the Canadian capitalist and neoliberal context. I suggest further research into the impacts of the internet and new CAM modalities on women’s choices for prenatal care.

## **Chapter 2: Background and Theoretical Orientation**

### **2.1 What is CAM?**

The National Center for Complementary and Alternative Medicine (NCCAM) is a component of the National Institutes of Health (NIH) in the United States. CAM is defined by NCCAM as “a group of diverse medical and health systems, practices and products that are not presently considered part of conventional medicine” (2013). Health Canada has extended this definition of CAM to the “diagnosis, treatment and/or prevention that complements mainstream medicine by contributing to a common whole, by satisfying a demand not met by conventional approaches, or by diversifying the conceptual framework of medicine” (Tataryn and Verhoef, 2001). Both of these definitions point to the diverse and varied nature of CAM. NCCAM categorizes CAM into five categories: 1) Natural Products such as herbal medicines, probiotics, vitamins and minerals often sold as dietary supplements. Health Canada uses the term “natural health products” and has regulated the supplements since 2004 (Health Canada, 2014); 2) Mind-body practices such as meditation, acupuncture, massage therapy, and yoga; 3) Manipulative and body-based practices such as massage therapy and spinal manipulation; 4) Energy-based practices such as Reiki, light therapy, and magnetic therapy; 5) Entire medical systems such as Ayurvedic medicine, Traditional Chinese Medicine, or Naturopathy (NCCAM, 2013). It should be noted that these categories are not mutually exclusive. For example, though acupuncture is considered a mind-body practice, it is also a component of Traditional Chinese Medicine, an energy practice, and a manipulative and body-based practice. Still, these categories are useful for understanding the diverse array of CAM products and practices. For the purposes of this study, I will use NCCAM’s definition of CAM to include all medical therapies outside of conventional (i.e. Western allopathic) medicine.

#### **2.1.1 Prevalence of CAM**

CAM use is rapidly growing in North America among healthy people looking to avoid illness, and the chronically ill looking for alternative therapies (Strohschein and Weitz, 2012). The rate of growth for some types of CAM practitioners has exceeded the rate of growth for

conventional health care providers (Clark, 2004). In 2009, Americans spent over \$33.9 billion out of pocket on CAM (NCCAM, 2013). This is a substantial sum and reflects the rising popularity of these types of healing modalities. Commonly cited estimates for yearly CAM spending in 1998 is \$5.6 billion (Ramsay, 1999), increasing to \$7.84 billion in 2006 (Esmail, 2007). Based on a Statistics Canada survey completed in 2007 there were 290 companies selling natural health products in Canada, which generate over \$1.7 billion in revenues (Cinnamon, 2009). This Statistics Canada figure is obviously low, as it only includes natural health product sales and not any of the numerous other types of CAM treatment options. There is a dearth of research focusing on the quantification of the out-of-pocket expense of CAM in Canada (Harris and Rees, 2000).

In British Columbia, the Medical Services Plan (MSP) insures “medically required services provided by physicians or supplementary health care practitioners, laboratory services and diagnostic procedures” (BC Ministry of Health, 2013). Also, “MSP does not provide coverage for the following: services that are not deemed to be medically required... chiropractic, massage therapy, naturopathy, physical therapy... preventative services and screening tests” (BC Ministry of Health, 2013). For low-income patients only, MSP provides \$23 per visit up to a maximum of ten visits per year for the following services: acupuncture, chiropractic, registered massage therapy, naturopathy, physical therapy and non-surgical podiatry.

Due to the diverse nature of CAM treatments available to Canadians, the estimates for out-of-pocket expenditure on CAM vary. For example, faculty members at the University of British Columbia have access to extended health care benefits through Sun Life Financial. Under this extended coverage, 80% of any visit to an acupuncturist, chiropractor, naturopath, registered massage therapist, homeopath, chiropodist, dietician, or audiologist is covered (up to a combined maximum of \$600 for each person per benefit year). This plan does not cover the services of spiritual healers, kinotherapists (using heat and infrared therapy), reflexologists or shiatsu practitioners (UBC HR, 2014). This coverage scheme is just one of many, and indicates the variable cost structure and coverage of different CAM therapies.

As a response to the rising consumer demand in America, the U.S. Institute of Medicine made the statement, “To provide a rational, effective, efficient and personally satisfactory health

care system, it is important and useful to understand who is using alternative therapies and why” (2005, vii). There is ample evidence demonstrating the widespread use of CAM in Western countries (Tindle et al., 2005; Barnes et al., 2004; Harris and Rees, 2000). CAM use is most prevalent among people who are middle-class and have higher education (Ruggie, 2004). In 2007, 38.3% of Americans used at least one type of CAM, according to the National Health Interview Study (Barnes et al., 2007). In 2005, more than half of all Canadians used at least one type of CAM (Boon et al., 2006) and these numbers are on the rise. In both Canada (Millar, 1997) and the United States (Eisenberg et al., 1998), use of CAM tends to be highest in the Western regions of the countries. A representative US survey found that over half of female respondents used CAM treatments (Wade et al., 2008). This figure is congruent with many other studies that demonstrate high rates of CAM use, especially amongst women (Bishop and Lewith, 2010).

### **2.1.2 CAM Use Among Pregnant Women**

The majority of women in Canada (94%) will seek prenatal care from a medical doctor, while some (6% of pregnant women) will seek prenatal care from a midwife (Public Health Agency of Canada, 2009). It has been demonstrated that consulting a range of health professionals often involves exposure to competing or conflicting claims to legitimacy, efficacy, and risk (Nettleton, 2006). The response of conventional medical professionals to the rise in popularity of CAM is diverse and ranges from acceptance to skepticism to hostility (Kelner et al., 2004; Nahas and Bella, 2011). Nevertheless, pregnant women have been identified in the literature as substantial CAM users. Pregnant CAM users are typically older, have higher education and income, and report more physical symptoms such as lower back pain and nausea (Adams, 2011).

Typical estimates of the prevalence of CAM use among pregnant women range from 20% to 60% (Ernst, 2000; Adams, et al., 2009), though specific studies have reported rates of CAM from as low as 13% (Gibson, et al., 2001) to a high of 78% (Gaffney et al., 2004). The range in reported prevalence is likely due to inconsistencies in study design and different working definitions of CAM. Despite these limitations, there is consistent evidence pointing to

pregnant women’s use of multiple types of CAM treatments (Gaffney and Smith, 2004; Nordeng and Havnen, 2004; Skouteris et al., 2008). The use of pharmaceutical agents in addition to CAM treatments during pregnancy was also found to be quite common (Holst et al., 2008).<sup>1</sup> Among pregnant women, the most common CAM treatments include massage therapy, vitamin and mineral supplements, herbal and botanical remedies, relaxation therapies, aromatherapy and yoga (Gaffney and Smith, 2004; Skouteris et al., 2008; Furlow et al., 2008; Adams, et al., 2009; Bishop and Lewith, 2010; Adams 2011).

Table 1 outlines the average cost, in Canadian dollars of common CAM prenatal therapies in Vancouver, BC. The table outlines whether each type of CAM is covered under MSP or typical extended health care coverage.

Table 1. CAM Coverage and Cost

<b>Prenatal CAM Type</b>	<b>BC Medical Services Plan (MSP) Coverage</b>	<b>Extended Health Coverage</b>	<b>Typical Pricing in Vancouver</b>
Acupuncture	No	Yes	\$90- \$150/ 1 hour private session
Chiropractor	No	Yes	\$70- \$120/ 1 hour treatment
Craniosacral Therapy	No	Yes	\$95+ 1 hour treatment
Doula Services	No	No	\$300-\$1500 depending on services included
Herbal Remedies	No	No	\$5-\$50+ for herbal teas, tinctures, vitamins, supplements and other natural products
Hypnotherapy	No	No	\$400-\$600/ full Hypnosis course

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<sup>1</sup> In British Columbia, prescriptions are filled in 63% of pregnancies (Daw et al., 2012). Among the most common drugs prescribed during pregnancy are pain relievers, salbutamol (for the treatment of asthma) and antidepressants (Andrade, 2004; Daw et al., 2012).

<b>Prenatal CAM Type</b>	<b>BC Medical Services Plan (MSP) Coverage</b>	<b>Extended Health Coverage</b>	<b>Typical Pricing in Vancouver</b>
Massage Therapy	No	Yes	\$85-\$120/ 1 hour massage
Meditation	No	No	
Moxibustion <sup>2</sup>	No	Yes	\$90-\$130/ 1 hour session (offered with many acupuncture treatments packages)
Osteopath	No	Yes	\$90- \$115/ 1 hour treatment
Pilates	No	No	\$18-\$23/ drop-in class rate
Yoga	No	No	\$13-\$22/ drop-in class rate

Some women may seek out CAM to deal with pregnancy symptoms because they offer greater control over their own bodies (Tiran, 2006; Warriner, 2007; Low Dog, 2009). This trend is in line with the increasing interest in a more “natural” birth process (free, where possible, from medical intervention) (Tovey and Adams, 2004; Tiran, 2001). Research has demonstrated that women value health care providers that are amenable to shared decision-making and working towards shared goals (Gaffney and Smith, 2004). This type of shared decision-making may be lacking in conventional medical practices where technical management of pregnancy and birth dominate (Stratton and McGivern-Snofsky, 2008). Furthermore, CAM referral practices in maternity care vary based on the type of health care provider. Midwives are more likely to refer clients to CAM practitioners when compared with obstetricians who are more cautious and skeptical than midwives of CAM use for women under their care (Adams et al., 2011; Steele, 2013).

While pregnant women regard CAM as more natural, safe, and/or having at least equal

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<sup>2</sup> Moxibustion involves the burning of herbs above the skin to apply heat to acupuncture points (NCCAM, 2013).

efficacy when compared with medical prescriptions (Hollyer et al., 2002; Lapi et al., 2008; Westfall, 2003; Gaffney and Smith, 2004), research has found that medical journals routinely reference associated risks for use of CAM therapies including toxicity, adverse drug interactions, adverse effects on fetal development, and other negative outcomes (Maats and Crowther, 2002; Lewis, 2011). There are persistent concerns in the mainstream medical community about the safety and efficacy of CAM for use among pregnant women.

Medical doctors exercise a monopoly on decisions for conventional medical treatments. This is not the case, however, for CAM treatments. Alternative treatments are more publicly accessible and therefore offer women greater autonomy and control in regard to their health care choices (Ohlen et al., 2006; Warriner, 2007). Past research suggests that most people who opt for complementary medicines do not inform their primary care provider of this decision (Tindle et al., 2005; MacLennan et al., 2006; Xue et al., 2007; Holst et al., 2009a; Nancarrow and Clarke, 2012). This same trend is also found among pregnant women. Some women are concerned they will encounter negative attitudes (Holst et al., 2009b) whereas others do not discuss their use of CAM simply because they are not asked (Furlow et al., 2008).

### **2.1.3 Integration with Conventional Medicine**

Conventional medicine in Canada includes practicing doctors who hold valid M.D. degrees along with various allied health professionals such as nurses and physical therapists. The boundaries and distinctions between “Western” or allopathic medicine and CAM treatments are not absolute or unchanging. Some CAM therapies are becoming increasingly integrated into conventional medical practice. In fact, the trend towards “integrative medicine” is already taking place. Integrative (sometimes “integrated”) medicine combines biomedical and complementary/alternative practitioners together within a holistic, and client-centered model of care that has been legitimated by ‘evidence-based medicine’ (Willis and White, 2004). This integration is based on scientific testing for the safety and efficacy of CAM therapies. The integration of CAM modalities is contingent on specific therapies being submitted to scientific scrutiny (Owen and Lewith, 2004).

The changes in commonplace descriptions of CAM treatments from “marginal” and

“unscientific” to “complementary” and “integrative” illustrate a larger redefinition and transformation of understanding of these practices. CAM is shifting from the fringes to the mainstream in both medical and popular discourse (Tovey et al., 2004). Acupuncture is an example of a type of CAM that has been integrated alongside conventional medical practice. Acupuncture was officially recognized by the National Institutes of Health (NIH) as a mainstream treatment in 1997, documenting the procedure’s safety and efficacy (Park, 2012). Though some CAM therapies have recently been embraced by conventional medical care providers, the evidence of the safety and efficacy of CAM therapies is currently still developing and mixed. While some therapies such as acupuncture have shown potential benefit for pregnant women, other CAM treatments have had mixed or insignificant results (Smith and Cochrane, 2009). Conventional health care providers and researchers have cautioned against the use of CAM and have emphasized the potential risks of some CAM therapies for pregnant women and their unborn children (Mills et al., 2006; Briggs et al., 2009). Some doctors are referring patients to CAM practitioners and even training in these alternative therapies that have demonstrated clinical effectiveness and safety (Brokaw et al., 2002; Lie and Boker, 2006). This integration is occurring more slowly than CAM offerings are coming to the marketplace, however (Strohschein and Weitz, 2012).

#### **2.1.4 Determinants of CAM Use in the General Population**

Individuals are compelled to seek out experiences that hold meaning for them. These meanings vary among individuals, but often are linked to one’s social roles, identities, and sense of self (Shointu, 2006). Connected to these meanings are people’s definition of health, illness, and well-being. These beliefs and may be radically redefined by certain CAM perspectives (Goldstein, 2003). Research has demonstrated that CAM use is associated with an ability to incorporate unconventional treatments into health beliefs (Foote-Ardah, 2004). Additionally, it has been found that an openness to new ideas (Furnham and Lovett, 2001) and strategies for assessing evidence (Barry, 2006) are also linked to increased CAM use. CAM use may be constrained if an individual believes that there is incongruity between their potential role as a massage therapy client (for example) and one’s “possible selves” (Markus, 1986).

Other micro-level indicators that have been linked to increased CAM use include personality traits, religious and spiritual beliefs, symptoms and health care needs, attitudes about health and well-being (e.g. Astin, 1998; Barnes et al., 2004; Eisenberg et al., 1998; Kelner and Wellman, 1997; Sirois and Gick, 2002; Wolsko et al., 2003). Research has indicated that some believe that CAM therapies provide safer alternatives to pharmaceuticals (Nordeng and Havnen, 2004; Lapi et al., 2008; Holst et al., 2009a). Though CAM therapies are not inert, they often have less serious side-effects or interaction effects with other medications when compared with pharmaceuticals (Coulter and Willis, 2007).

## **2.2 Theoretical Orientation**

Increased public engagement with CAM can be linked to the rise feminism, consumerism, and neoliberalism (Beck and Beck Gernsheim, 2001; Bix, 2004; Feldberg, 2004; Fox et al., 2005; Goldner, 2004; Nissen, 2011; Ruzak, 1978). The rise in popularity of CAM (especially as it relates to women's health) parallels feminist concerns about the medicalization of women's bodies, especially during pregnancy.

Medicalization occurs when a previously non-medical issue comes to be understood as a disease and treated within a medical framework (Conrad, 1992). Medicalization is the process by which conditions or behaviours come to be defined as medical issues in need of professional intervention. The increased use of ultrasounds during pregnancy, fetal heart monitors, high caesarean rates, and expanded use of amniocentesis demonstrate some of the ways that women's experiences with pregnancy and childbirth have been medicalized (Mitchell, 2010; Woliver, 2002). The driving force behind the medicalization of pregnancy is the assumption of risk connected to fetal, and sometimes maternal, health. Mitchell (2010) explains that within medical and social discourse pregnancy currently is conceptualized as a time of risk and

danger. Pregnancy and childbirth, previously considered natural or normal, have been transformed into an unnatural condition or illness whereby there is an assumption of risk to both maternal and fetal health (Woliver, 2002). The process of medicalization enabled doctors to assert their medical expertise while simultaneously discrediting midwifery (Ehrenreich and English 1973). Starting in the early 1900s, midwifery underwent serious decline and devaluation and remained without social, legal, or medical status in Canada for more than a century, even as most other industrialized nations maintained formal recognition for the profession (Mitchinson, 2002, p. 98). As the medical profession became more established, obstetricians as well as general practitioners had a financial and professional interest in controlling childbirth (Mitchinson, 2002, p.93). Campaigns to limit midwifery practice were especially targeted in areas where physicians were available to practice (Devitt, 1979). During this time, physician attended births became increasingly popular in Canada, especially among middle and upper class white women. Obstetric practices and knowledge were disseminated outward from Canadian cities (MacDonald, 2004).

### **2.2.1 Feminism**

Past research designated CAM users as individuals who either cannot find conventional management techniques for healthcare problems or are generally dissatisfied with conventional medical providers (Fulder, 1988; Murray and Shepherd, 1993). These sorts of research findings align with earlier research on pregnant women's use of alternative medicine during pregnancy. The demand for non-pharmacological therapies to deal with pregnancy symptoms corresponds with the rejection of the medicalization of pregnancy and childbirth. Pregnancy often provokes

feelings of fear, loss of control, and vulnerability, which have been linked to the medicalization of pregnancy (Mitchell, 2010). Many have argued that the medicalization of pregnancy has denied women the right to make their own decisions about their pregnancy and to control their own bodies (Davis-Floyd, 1990, 2000; Shuval, 2006). Critiques of the medical management of women's bodies during pregnancy and labour have developed across many disciplines including sociology (Graham and Oakley, 1981; Katz Rothman 1982; Oakley, 1980), anthropology (Davis-Floyd 1990, Romalis 1981; Sargent and Stark 1989), public health (Brown et al., 1994), and medicine (Chalmers, Enkin and Keirse 1989; Tew, 1995). Historically, the medicalization of pregnancy and childbirth is grounded in patriarchal understandings of women's bodies and reproductive systems. By this definition, the pregnant body is intrinsically pathological and in need of medical intervention, care, and treatment. Scholars critiquing this view have argued that the appropriation and medicalization of pregnancy and childbirth is not due to the inherent nature of the female body, but instead reflects women's social position in relation to doctors and the health care system (Malacrida and Boulton, 2012). Given that CAM values experiential knowledge, and the idea that people should actively participate in their own healing (Hughes, 2004), it is understandable that prior research linked CAM with the conscious rejection of conventional medicine.

Though earlier research has emphasized the rejection of allopathic medicine as the main determinant of CAM use, recent research suggests that the decision to use CAM is a complex process determined by more than one's experiences with conventional medicine (Siahpush, 1998). Dissatisfaction with Western allopathic medicine is just one factor (among others) that leads to CAM use (Leiser, 2003). Leiser (2003) suggests that CAM use may, for some, represent

active de-medicalization on the part of the patient/consumer. Importantly, the decision to use CAM is not made out of desperation, but made strategically based on one's beliefs regarding health and the effectiveness of CAM (Nichol, et al., 2011). This claim seems to align with evidence that most individuals use CAM in conjunction with conventional medical practices rather than in place of them (Gaffney and Smith, 2004; Tindle et al., 2005; Bishop and Lewith, 2010). Often, pregnant women value the holistic approach to health that CAM offers (Gaffney and Smith, 2004). This finding is consistent with research indicating that the rising popularity of CAM is due more to changes in attitudes towards health and well-being, rather than a simple rejection of conventional medicine (Coulter and Willis, 2007).

Both CAM and conventional medical prenatal care are concerned with maximizing health and well-being for the fetus and, to a lesser extent, the expectant mother. This focus on maximizing health led me to use Foucault's concept of biopower as an organizing theoretical principle for this project. For Foucault, biopower and biopolitics is the site where life and politics meet. The regulation of life is at the center of contemporary politics. Biopower necessitates the maximization of life through varied technologies that are deployed over a population. "The old power of death that symbolized sovereign power was now carefully supplanted by the administration of bodies and calculated management of life" (Foucault, 1989: 139-140). Pregnancy is an important site for this 'calculated management of life' because it is so central to the production of life. Mothers today are not just responsible for the health of their fetus, they are also responsible for the health of the population, and ultimately the health of the nation. Under this logic, pregnant women must be kept under constant surveillance. Foucault explains that "the hystericization of women, which involved a thorough medicalization of their bodies and their

sex, was carried out in the name of the responsibility they owed to the health of their children, the solidity of the family institution, and the safeguarding of society” (146-147). Foucault (1989) refers to this as women’s “biologico-moral responsibility” (104). In the current context, this responsibility has important implication for the decision-making process of pregnant women.

### **2.2.2 Consumerism and Neoliberalism**

The current political and economic climate presents CAM therapies in a context of consumer choice and rising individualism. Individuals are able to seek out information and pay for services and products that they personally deem useful. The increasing prevalence of CAM also coincides with neoliberal understandings of personal responsibility as it relates to health and wellbeing. Given that the vast majority of CAM products and services are not covered by health insurance, the out-of-pocket expense for these can be significant to the individual.

Lupton (1997) has demonstrated the link between the citizen consumer and the reflexive project of the self, where individuals actively take on the practices of self-scrutiny and health care self-management. Under the logic of neoliberalism, what is “healthy” becomes a normative judgment to which all are subjected. Modern health care consumers have internalized the central tenets of neoliberalism including individual responsibility to pursue improved (or optimized) health. In the context of eroding confidence in the conventional medical system and established expert knowledge, some individuals are seeking out CAM (Coulter, 2007; Fries, 2008). In this capitalist context, health itself is a commodity. Health is an individual goal that must be maintained through routine consumption of health care products and medical interventions and risk management strategies (Nichter, 2003).

Health sociologists have noted the relationship between consumption and health care for some time (e.g. Friedson, 1970; McKee, 1988; Salmon, 1984). In the past, the welfare state had authority over the promotion and production of health (Fries, 2008). Under neoliberalism, it is the individual citizen that is responsible for her own health (or illness). This new arrangement is what Lupton (1995) describes as an “imperative of health” where individuals are targeted by public health programs to become increasingly reflexive and concerned with their own well-being. In this context where individuals are empowered by medical consumerism to pursue their own health goals, the rise of CAM may be explained by the reflexive project of the self (Beck et al., 1994). Moore (2008) describes this “new paradigm of health” as a transition from the focus on curing illnesses and diseases to the prevention of illness and the preservation of good health. Further, this new paradigm of health posits that preventative measures should be of primary importance in national health policy (Moore 2008). This shift has cemented the ideal healthy citizen as a vigilant and self-monitoring individual that is aware of possible risk factors and works consciously to mitigate these hazards. The mechanisms of biopower are utilized in order to bring about these changes in the population.

There is pressure placed on pregnant women to successfully self-regulate and mitigate potential risk factors in their own environments in order to deliver a healthy infant. Medical advice and recommendations given to pregnant women have been criticized for prioritizing the health of the fetus over the well-being of the mother (Bordo, 1993; Lupton, 2012). The “duty to be well” (Moore, 2008) is especially true for pregnant women, who are responsible for not only their own health, but also the health of their unborn child. This responsibility is reinforced through extensive self-care advice aimed at the avoidance or minimization of risk (Bartky,

2003). Women are held personally and morally responsible if they fail to achieve this healthy ideal or reject common suggestions or understandings. For example, women may be held responsible if they reject this advice or fail to seek prenatal care, and they may be found criminally negligent if their baby is not born healthy (Lupton, 2012). The rise of the “expert patient” (Fox et al., 2005) coincides with the increased use of the internet and e-commerce sites. Research has demonstrated that CAM users access the internet as an important source of information, support and even as a marketplace to buy self-administered therapies (e.g. Broom, 2005; Broom and Tovey, 2008; Conrad and Stults, 2010; Dickerson et al., 2006; Evans et al., 2007

The neoliberal ideal of informed and empowered health consumers appeals to those who are able to afford to pay out-of-pocket for these services or those that enjoy extended health care benefits. In British Columbia, CAM therapies including acupuncture, naturopathy, massage therapy, and others, are not currently covered under MSP (BC Ministry of Health, 2013). The relationship between the legitimization and rise of CAM alongside neoliberal ideologies has been seen in Australia (Baer, 2007). Some research has suggested that governments’ and conventional medicine’s support for CAM treatments may be seen as a cost-cutting measure, as CAM treatments are less expensive than pursuing allopathic care (Baer, 2007).

## **Chapter 3: Methodology**

For the purposes of this thesis, I interviewed pregnant women and new mothers about their decision making processes during their pregnancies and interpreted the results using Foucault's theory on biopolitics (2003). This project received approval from the University of British Columbia Behavioural Research Ethics Board in July 2014. In the following discussion, I explain how I am positioned in reference to the research topic. I then go on to describe the process I took to conduct the semi-structured interviews and follow-up interviews with pregnant women and women who used CAM during pregnancy. I then discuss how I completed a short online survey with local CAM practitioners. I explain why I chose the methods I did, how I sampled participants and the kinds of questions I asked of them. I conclude by describing how I analyzed the data.

### **3.1 My Location in the Research**

Reflexivity is an important issue, especially when conducting qualitative research (Creswell, 1998). Who I am as a researcher, and the values I hold have influenced the questions I have asked and the choices I have made at various stages in the project. There is a need to reflect on my own position and values and how they have informed the research. It was necessary for me to understand my own assumptions and experiences I brought to this project. This will also provide the reader with the necessary information to understand how my conclusions were derived. I am a 26-year old white, middle class, single heterosexual, cis-gendered woman raised in Western Canada. Being white and middle class, I am part of the dominant culture; having said that, I am not a mother. I have had the privilege of working to earn a graduate in sociology at the

University of British Columbia. I have also been shaped by the birth stories of my sisters and mother. I endeavor to be aware of how this positions me, and my tendency to view others through white middle class standards. I attempt throughout all of the stages of this project to continually challenge and question the assumptions that I hold due to my own subject position.

Throughout my adolescence and into my young adulthood, my two older sisters became pregnant and gave birth a total of seven times. I was young and keenly interested in their prenatal care and how their bodies changed and shifted over time and with subsequent pregnancies. I sometimes accompanied them to doctor's visits and was keen to learn all I could about this exciting, and as we understood it, risky time. It should be noted that based on prenatal screening, my sisters' pregnancies were classed as "low risk". I witnessed the "normal" course of medical interventions that accompanied their labours, which cast my sisters into positions of passivity. Just one of my seven nephews and nieces was delivered vaginally with minimal medical intervention. My sisters' multiple cesarean deliveries, and the subsequent recoveries, were difficult and had a significant impact on me.

As an undergraduate student, I had the opportunity to work as a research assistant on a project exploring the resources available to pregnant women in Southern Alberta (Malacrida and Boulton, 2012). This project was broad in scope and included interviews with pregnant women, practicing doulas, and lay midwives working in southern Alberta (at that time, there were no registered midwives serving smaller southern Alberta communities). It also included research on the history of birth and the profession of midwifery in Canada. My interest in the topic grew as I came to learn more about the issues around conventional medical "choices" available to pregnant women. Additionally, the area is of personal interest as I may give birth in the future and will

support women close to me through their pregnancies.

I am aware that I have strong values about my research topic. As a feminist, I am a proponent of women becoming informed and active partners in their prenatal care, especially in the current context of increasing medical interventions (Bryant et al., 2007; MacDonald, 2004). It is my own assertion that prenatal care that focuses on technology to ward off potentially risky situations may discourage women from acting as authorities over their own bodies during their prenatal care. Though there are exceptions, the conventional medical model tends to treat pregnant women as though they are lacking agency over their own bodies (Davis-Floyd, 2000).

Researchers can differ from, or be similar to, research participants in a variety of ways, including age, ethnicity, culture, physical ability, sexuality, gender, religious belief, and many others (Tinker and Armstrong, 2008). In my research, I have found that I am both an insider and an outsider, and I oscillated between these positions within and between interview settings. My own experience as a woman who has never given birth or been pregnant positioned me well in order to elicit detailed responses from women while they explained their prenatal experiences with CAM. My knowledge and experience with certain CAM modalities (namely yoga and massage) helped to position me as somewhat of an insider in terms of the knowledge and practices involved in alternative therapies.

### **3.2 Semi-Structured Interviews**

This thesis addresses the lack of previous research on CAM use among pregnant women in the Canadian context through qualitative inquiry. For this thesis, a qualitative study design was appropriate due to the nature of the topic. According to Creswell (1998), a qualitative design is appropriate when variables of interest are not easily identifiable or theories used to explain

individual actions and behaviours have not been developed. I used purposive sampling to select participants who were, at the time of interviewing, pregnant and using CAM or women who had given birth in the last six months and used CAM during their pregnancy. Purposive sampling is well suited to a qualitative research design because it enables the researcher to choose participants who are able to provide richness of information that is needed for detailed research (Patton, 2005). For this study, recruitment posters that included the details about the study were posted in various public locations throughout the city of Vancouver. Locations included doctors' offices, midwifery offices, alternative health care providers' offices, community centers, yoga studios, and acupuncture clinics, among others. Care was taken to distribute the posters in diverse areas and neighborhoods throughout the Vancouver area in an attempt to encourage diversity in the sample population. The recruitment poster (Appendix A) provided potential participants with my contact information. Both my email address and my telephone number were provided on the poster so that participants could contact me in a way most comfortable for them. Once participants contacted me, I provided additional information about the study and answered any questions they had. At the time of first contact, I confirmed all inclusion criteria for participation in the study. If participants were interested in proceeding at this point, we then worked together to set up an interview time and meeting place that was convenient. I encouraged women to choose a location that was quiet and where they would feel comfortable. In some cases, this meant we met at a quiet local coffee shop, other times, I was invited into participants' homes.

I chose semi-structured interviews as the method of data collection for this thesis. Qualitative methods were used in order to allow concepts and themes to derive from the

interview data (Charmaz, 1990; Glaser and Strauss, 1967). Asking women to describe their experiences with conventional medicine and CAM was done to increase the accuracy, complexity, and validity of the findings. Qualitative research focuses on “naturally emerging languages and the meanings individuals assign to experience. Life-worlds include emotions, motivations, symbols and their meanings, empathy and other subjective aspects associated with naturally evolving lives of individuals and groups” (Berg, 1998: 11). In this situation, individuals’ narratives provided during the interview process may be understood as a product of the interrelationship between the participant and the researcher. As a researcher, I must draw from my own experiences in order to ‘co-construct’ the respondent’s feelings and experiences as accurately as possible (DeVault, 1990). As Mishler (1986) suggests, during the interview process, the participant and I “strive to arrive at meanings that both can understand” (65). When explaining personal experiences, participants relate both particular events and their meanings. During the interview, individuals are able to place the meanings and narratives in social and cultural context (Mattingly and Garro, 2000). Qualitative approaches to research are particularly useful in the study of women’s lives, which may be considered non-normative in theory-driven research (Reinharz, 1992). Allowing women to describe their experiences in their own words validates women’s authority over their own treatment experiences (DeVault, 1990) and allows them to generate themes that were not previously planned by me as a researcher.

Upon meeting for the scheduled interview, I reiterated the details of the study and had participants read and sign the consent form (Appendix B) before the interview began. Next, participants were be asked to fill out the very short demographic information sheet (Appendix C) so that I could gain some background information without having to ask this sensitive

information aloud. Sometimes, participants opted to fill in the demographic form after the interview was completed. The written format of the demographic form helped to maintain good rapport with participants by avoiding overly sensitive questions at the beginning of the interview. The in-depth interviews were audio recorded for later transcription. The interviews were typically between 60 and 90 minutes long. In total, 8 interviews were conducted for this study. Interview participants were given a \$20 honourarium for their time and effort (see Chapter 4 for description of participants)

Given that data collection and analysis often occurs simultaneously in qualitative research (Merriam, 1998), I worked to transcribe all interviews and field notes as soon after the interviews as possible. Some interviews were transcribed immediately after the fact, while others took longer to complete. I assigned pseudonyms to all participants to protect their identities. These pseudonyms are used later in this thesis when I quote directly from the interview data. Recording the interviews was useful because it captured the participants' full answers without me having to interrupt in order to write down answers (Maykut and Morehouse, 1994). The audio-recordings also make use of full quotes from narrators possible. However, the women's way of speaking may have been affected by the presence of the recorder (Rapley, 2001). All participants were asked if they agreed to the audio recording of the interview. The interviews were then loaded into Atlas.ti, a qualitative data coding software for analysis. After readings the interview transcripts several times through, I developed descriptive codes. Next, I worked to develop analytic codes after reviewing these descriptive codes and rereading the data (Patton, 2005).

After going over the data, I realized that there were certain themes that seemed to emerged from the data (namely, women's decisions motivated by a desire to avoid undesirable birth outcomes) that I did not get the chance to fully explore in the initial interviews. For this reason, I chose to conduct follow up interviews via email. I contacted all eight participants and asked if they would be interested in participating. Seven of the eight women were willing and able to participate in the follow-up email interviews.

I chose to conduct the follow-up interviews via email for several reasons. Email offers the opportunity to access participants' thoughts, ideas, and opinions in their own words. The use of this medium also may work to empower participants, as they are in control of the flow of the interview (Bowker and Tuffin, 2004). Participants may feel more relaxed while answering questions in a familiar setting (i.e. their home or work) and this may result in them being more relaxed and able to express their opinions and experiences (Kennedy, 2000; Lehu, 2004). Participants are able to answer questions at their own convenience and in ways that they feel are suitable (Kennedy, 2000). Email also allows narrators to take the time they need to reflect and edit messages before sending them. This may result in a closer link between the intended meaning and the final message (Levinson, 1990). Online-based data collection also effectively eliminates some of the problems associated with telephone or face-to-face interviews, and may safeguard against possible loss of face among participants when describing potentially sensitive information (Kim et al. 2003). This facilitates the potential for greater disclosure of information, which benefits both participant and researcher (Bowker and Tuffin, 2004). Online-based communications may make participation in research possible for individuals living with speech or mobility disabilities (Murray and Harrison, 2004), Online interviewing may also help to

ameliorate problems arising from status differences between the interviewer and participant (e.g. gender, race, age, dress, non-verbal communication). Certainly the internet does not flatten all difference, but it does allow for some things to be held in the background (or to go completely unnoticed). In my case, conducting follow up interviews via email (instead of face-to-face or telephone interviews) contributed to the high (7 out of 8) response rate. Based on participant feedback, this was largely due to the convenience of replying online for these women. For example, one participant let me know that email was more convenient than meeting in person because “having 3 [children] I have very little control over the day! Lol” (Michelle).

Additionally, email interviews cost considerably less to administer than telephone or face-to-face interviews. The use of written emails also eliminates the need for transcription. Data generated in this way need little editing before it can be processed for analysis. Kraut et al. (2004) explain that “research on the Internet is not inherently more difficult to conduct or inherently riskier to subjects than more traditional research styles. But because the Internet is a relatively new medium for conducting research, it raises ambiguities that have been long settled in more conventional laboratory and field settings” (p. 114). Naturally, there are drawbacks to this medium as well. Not everyone has access to the technology and resources needed to communicate online. It is also possible that some participants are not as effective writers as they are speakers (Karchmer, 2001). Due to the non-synchronous nature of online communication, questions must be self-explanatory since follow-ups or clarifications may go unanswered.

Online communication for research purposes has both benefits and drawbacks. Certainly, face-to-face interviewing is expected to provide richer data than telephone interviews, and telephone interviews will garner richer data than online-based interviewing (Schneider et

al., 2002). This decreased level of richness in the data is due to the limitations of the medium itself. The physical distance means that researchers will not be able to read body language, facial expressions, tone of voice, or other communications. These non-verbal (or non-written) cues are important in conveying meaning in face-to-face settings (Selwyn and Robson, 1998).

The qualitative coding software Atlas.ti was used to organize and analyze the interview data, follow-up interview data. Previously, I discussed my use of descriptive and analytic codes. This process of returning to the data and trying to understand women's accounts in context was an ongoing process. All interview data, follow up interview data and online survey data were analyzed and subject to the descriptive and thematic coding I created. These were applied across the data to understand emerging patterns, themes, concepts, similarities and dissimilarities.

### **3.3 Ethical Considerations**

This study proposal was submitted to the University of British Columbia Behavioural Research Ethics Board (BREB) and was approved in July of 2014. Following BREB approval, participants were recruited and interviewed between August 2014 and December 2014. Women's experiences with pregnancy and birth are important to women's physical, emotional and even spiritual lives. Due to the personal nature of the subject matter, some women may find thinking about and recounting their pregnancy experiences stressful. Efforts were made to mitigate undue stress on participants by emphasizing the voluntary nature of the project, describing the study to participants, and providing informed consent. Each participant was provided a second copy of the consent form to retain for her own records. The identities of the women participating in this study were protected by the use of pseudonyms. All of the interviews were recorded using a

digital voice recorder and then encrypted and stored on the researcher's laptop. The transcripts of the interviews are stored on a password protected external hard drive. The personal computer being used is password protected and any working documents including transcription data are encrypted. These files will be deleted from the personal laptop after this project has finished. The files will be retained on the password protected external hard drive for the customary period of time.

## Chapter 4: Perfect Babies, Perfect Mothers, Perfect Pregnancies

### 4.1 Perfect Babies

It is a common understanding in contemporary society that all mothers desire a ‘healthy baby’. What exactly does this expressed desire mean? Health care providers refer to a ‘healthy baby’ as a kind of reverse diagnosis; the infant born without any discernable signs of illness is labeled as ‘healthy’ (McGee, 2000). In pregnancy and birth, there is a tendency to conflate ‘health’ and ‘normality’; however, both of these subjective categories bring complex experiences that cannot be reduced to a single diagnostic criterion (Herzlich, 1973). For example, many would consider a child born without any sign of physical or mental disability ‘normal’. Some, however, would classify children with a range of disabilities as normal. One example is that some deaf parents regard their children’s deafness (or potential deafness) as a benefit rather than a health risk or abnormality (Davis, 1997). It becomes apparent that these categories of ‘healthy’ and ‘normal’ are more fluid than some may imagine.

Still, in the current social context, there is marked pressure to bear children that are free of mental or physical disability (Dixon, 2008). Within capitalist logic, children who are born with disabilities are not only ‘defective’ in a medical sense, but also seen as unproductive socially as well. These children are understood to fall short in terms of expected normalcy or uniformity and are labeled as damaged, defective, or disabled (Landsman, 1998; Phillips, 1990; Martin, 1987). Mothers who make the decision to give birth to children with disabilities therefore are understood to weaken the overall structure of the neoliberal capitalist society since neither they nor their children are deemed to be fully productive citizens (Scheper-Hughes and Lock, 1987). There is a profound lack of resources available for the support and caring involved with raising a child with disabilities.

## 4.2 Perfect Mothers

I interviewed eight women for this study. They ranged in age from 26 to 38. All but one was married or common law. All eight were heterosexual and cis-gendered. The sample was quite homogenous racially, one participant was Chinese-Canadian the other seven were Caucasian. Though there was a range in average household income, all considered themselves to be “middle class”. Table 2 summarizes some of my participants’ biographical information at the time of the first interview. At the time of the follow-up email interviews, all of the women had given birth. The women I interviewed provided insight into their prenatal decision making. Six of the eight women I interviewed had a midwife as their primary care provider. Seven of the eight had postsecondary education (three of which held advanced degrees). My respondents’ general age characteristics do align with overall trends we see in Canada today (later age at first birth).

In Canada today, women are having fewer children overall and they are bearing them later in life. In Canada, the average age of mothers at the time of first childbirth is 30.2 years (Statistics Canada, 2013). The total fertility rate in Canada is 1.61 children per woman (Statistics Canada, 2013). Demographic studies and census data are chiefly concerned with fertility and keeping track of new citizens as well as projecting these individuals into the future as successful and contributing adults. Finding data on the births in a nation such as Canada is easy; finding reliable data on women who opt not to have children is more convoluted. Statistics Canada (2011) offers some proxy measures for this, such as the fact that in 2011 one-person households surpassed the number of couples with children for the first time. In the United States in 2006, 20% of women aged 40-44 had never had a child. This trend toward increased childlessness (or childfree status) has been on the rise for decades (Blackstone

and Stewart, 2012).

In the *New York Times*, several articles have been published recently that have reported on this trend towards chosen childlessness (Bolick, 2105; Huneven, 2015, Wayne, 2015). The numbers have increased enough that the first NotMom Summit will be held in Cleveland in October 2015 (NotMom Summit, 2015). The decisions to be childless (or “child-free”) correlates to national trends and also mirror the hosts of public figures who have spoken publically about their decisions to remain child-free, including celebrities such as Oprah Winfrey, George Clooney, Ricky Gervais, and Chelsey Handler.

Though the trend towards remaining child-free is on the rise, that majority of women in Canada will give birth in their lifetime (Statistics Canada, 2013). “Things may be marginally different now, but, even if there is something she wants more than children, that is no reason to remain childless” (Daum, 2015). Having children today is considered a choice instead of a foregone conclusion. It is often presumed that women who decide to have children do so at the expense of furthering their education or focusing on career advancement.

Table 2.

Participants' Biographical Information (at time of first interview)

Name	Age	Racial Identity	Relationship Status	# of children (Not counting current pregnancy)	Income	Education	Religious Affiliation	CAM Used	Prenatal Testing	Primary Care Provider
Jamie	38	Caucasian	Married	2 (pregnant at time of interview)	Less than \$50000	Master's Degree	Protestant	Traditional Chinese Medicine, Acupuncture, Naturopath, massage, yoga, herbs,	2 ultrasounds	Midwife
Allison	30	Caucasian	Married	0 (pregnant at time of interview)	\$150000	Bachelor's Degree	None	Acupuncture, moxibustion, herbs, massage, chiropractor, naturopath, yoga	8+ ultrasounds	Midwife
Katelyn	35	Caucasian	Single	0 (pregnant at time of interview)	\$90000	Bachelor's Degree	None	Massage, yoga, Hypnosis, herbs	2 ultrasounds, SIPS	Midwife

Name	Age	Racial Identity	Relationship Status	# of children (Not counting current pregnancy)	Income	Education	Religious Affiliation	CAM Used	Prenatal Testing	Primary Care Provider
Jenny	37	Caucasian	Married	0 (pregnant at time of interview)	\$120000	Bachelor's Degree	None	Doula, herbs, yoga, naturopath, acupuncture, chiropractor	Several ultrasounds, genetic screening	Midwife
Sara	28	Caucasian	Married	1 (pregnant at time of interview)	n/a	College Degree	Protestant	Massage, yoga, herbs	2 ultrasounds	Midwife
Leeann	26	Caucasian	Married	0 (pregnant at time of interview)	Less than \$40,000	Some college	Protestant	Chiropractic, massage, yoga	12+ ultrasounds, SIPS	Ob/Gyn
Mia	28	Chinese Canadian	Married	0 (pregnant at time of interview)	\$100,000	Master's Degree	Protestant	Massage, acupuncture, yoga	2 ultrasounds, IPS	Ob/Gyn
Bridgette	28	Caucasian	Common-law	0 (pregnant at interview)	\$100,000	PhD (in progress)	None	Yoga, Hypnosis	2 ultrasounds (8 weeks; 25)	Midwife

#### 4.2.1 Pregnant Body Image

We are all familiar with the tropes of women “having it all”(Erwin, 1996). Women are celebrated for bringing the same rising level of commitment and education to having and raising children as they have brought to their careers. Ringrose and Walkerdine (2008) argue that “the feminist political dilemmas of housewife versus career woman... have been replaced by narratives of renaissance women who juggle thriving careers... with motherhood” (p. 232). This idea of women ‘having it all’ can also be seen in the focus on beautiful pregnant bodies. Issues of weight management were recurrent in the interviews I conducted. Mia is married, and at 28, she is pregnant with her first child. Mia described her own weight gain during pregnancy as follows:

It’s not good to gain weight too quickly so exercise makes it so I am gaining weight sparingly and I also feel good after exercising. I’m sure it helps strengthen the muscle tone of different body parts. I think it is also good for self-esteem.

Here, pregnancy becomes another project of self-realization, a ‘body project’ to be managed and shaped. It becomes another arena for feminine performance and anxiety. Mia went on to describe her worries about weight gain during pregnancy:

Another concern I had was that my body would change too much and that I wouldn't like how I looked or felt after childbirth. I became a bit obsessed about my weight gain and whether I was fat or not - even though I clearly wasn't! I became very self-conscious - and normally I have a very healthy body image so that was something strange and unexpected that surfaced.

Mia’s experience of the stress that maintaining a feminine (i.e. small) body while pregnant is

intimately linked to contemporary North American medical discourse. The Society of Obstetricians and Gynecologists of Canada (SOGC) and Canadian Society for Exercise Physiology (CSEP) guidelines suggest that “women and their care providers should consider the risks of not participating in exercise activities during pregnancy,” which include “loss of muscular and cardiovascular fitness, excessive maternal weight gain, higher risk of gestational diabetes or pregnancy-induced hypertension . . . and poor psychological adjustment to changes of pregnancy” (Davies et al., 2003, p. 2). These anxieties Mia describes are not atypical as concern over weight gain results in constant vigilance on the part of expectant mothers. Five of the eight women I interviewed voiced explicit concern about body image and weight gain during our face-to-face interviews. In the follow-up email interviews, all eight women expressed that weight gain or body image was a concern they had about pregnancy. Jenny is married, 37 years old and works in the health care field. In Jenny’s case, she felt that she had failed in maintaining her weight and fitness during pregnancy.

My fitness level is not where I want it to be and my diet’s not perfect. *I certainly feel that I’m more overweight than I would like to be.* I am trying to gradually improve things... I am definitely nowhere near where I want to be, especially as far as diet goes. *Unfortunately right now, I am a bit lazy* and you get busy and it’s not that easy to eat the way you know you should or feel the way you should. (emphasis added)

This excerpt aptly illustrates how the internalization of strict body standards among pregnant women leads to a process of self-admonishment. The dissatisfaction with her body that Jenny describes is the direct result of the internalization of a strict set of standards about what a pregnant (and post-pregnant) body should look like.

#### 4.2.2 Risk and Fear

The concept of prenatal care, where a woman's risk status is defined by medical experts, is a recent development. Before the 20<sup>th</sup> century, pregnancy and childbirth were the sole purview of women (Mitchinson, 2002, p. 69). At that time, pregnancy required no medical supervision or intervention. The type and amount of prenatal care we are familiar with today became necessary in a context where pregnancy and childbirth became pathologized and understood a site of potential danger (Mennill, 2012, p. 28). Additionally, as pregnancy came under medical supervision, the focus began to shift from the health of the pregnant woman to that of the fetus. Now, the pregnant woman's view of her own experience is no longer the primary source of information about the well-being of the unborn child. Rather, medical technologies are understood to be the sole access into the realm of fetal health and development. Techniques for intervention and visualization (lab testing, ultrasounds, etc.) are central to our understanding of fetal health (Oakley, 1986; Schadler, 2014).

In her investigation into the history of birthing in Canada, Wendy Mitchinson (2002) clearly delineates the ways in which Western medicine is gendered. Through her discussion of female agency in childbirth in the late nineteenth and early twentieth century, she describes the disempowerment of female patients. Women were at a double disadvantage because they were seen as particularly weak by the medical establishment: "as well as being patients, they were women and thus were constrained by their place in society" (Mitchinson, 2002, p. 7). Mitchinson (2002) notes that Aboriginal mothers and immigrant mothers in Canada experienced further discrimination, often living in areas that lacked adequate health care access. Additionally, health care professionals were, at best, suspicious of Aboriginal birthing traditions (p. 103). Kelm (1999) argues that "sustained contact with Europeans fundamentally altered the physical health of the First Nations, and that change has become emblematic

of the effects of Euro Canadian domination on both Native and non-Native people” (p. xv). This legacy of marginalization included the marginalization of Indigenous knowledge and practices pertaining to pregnancy and childbirth (Mennill, 2012, p. 9).

The concern for health and wellness in Western culture is constantly increasing. According to Mennill (2012), this phenomenon linked with the medical profession’s need to maximize their professional status and jurisdiction have encouraged an ever-widening conception of the conditions that require medical management and treatment (p. 26). In *The Birth of the Clinic*, Foucault describes the growth of modern medicine through the seventeenth and eighteenth centuries where it became possible to regulate populations in order to maximize life itself. When linking prenatal care and biopolitics, it is key to maintain the notion that “it was in the taking charge of life, more than the threat of death, that gave power access to the body” (Foucault, 1973, p. 143).

Positioning uncomplicated pregnancy as a potentially pathological state (as opposed to a regular life event) placed it within a disease model (Barker, 1998). Within the logic of this model, only doctors have the necessary skills and experience to deal with pregnancy. Women’s own knowledge and experiences were set aside. As Barker (1998) argues, public health efforts aimed at expectant mothers came to emphasize the riskiness of pregnancy and encouraged increased self-regulation and proper care to ensure the birth of a healthy infant.

Women are acutely aware of their own clinical risk status. For example, when Jenny described her own health during pregnancy to me, she began by talking about her experience, but quickly deferred to medical indicators and risk assessment.

Yeah, I had pretty good energy. My iron levels got low, but it was a really non-complicated pregnancy. *I was worried that I’m a bit older*, I’m thirty-seven. Going in

everyone was like, *everything I read was like, 'above thirty-five it's a high-risk zone.'* (emphasis added)

Jenny has internalized, to some degree, these medical definitions outlining the riskiness of her pregnancy experience. This knowledge stems from the fact that reality, or the 'truth' of the pregnancy experience is defined by medical experts, not through the woman's reported experience.

### **4.2.3 Prenatal Testing**

In order to manage the risk of bearing a less-than-perfect child, women are encouraged to partake in various disciplinary regimes before and during pregnancy. Outside of prenatal testing, women are encouraged to engage in a range of individual health-promoting behaviours, such as a focus on nutrition, avoiding alcohol, and smoking. The responsibility to have a successful pregnancy that results in a healthy baby lies chiefly with pregnant women. This responsibility is reiterated and expounded upon in countless handbooks aimed at pregnant women. These books tend to focus on the myriad of potentially hazardous risks of pregnancy that could negatively affect the unborn. It is partly through these books that women are taught a long list of expected behaviours along with lengthy lists of things to avoid. These recommendations touch on every aspect of pregnant women's lives. One particularly popular example is the bestselling classic (now in its fourth edition), *What to Expect When You're Expecting*. In this handbook, Murkoff and Mazel (2010) insist that pregnant women should avoid sugar and sugar substitutes (pp. 92-93), avoid the consumption of alcohol (p. 70-72) and tobacco (p. 72-76), they should not use electronic heating blankets (p. 79), avoid having diagnostic x-rays (p. 203), be wary of using household cleaners (p. 80-81), avoid spa baths (pp. 147-148), make sure their microwave ovens are not leaking (p. 78), and not take prescription or over-the counter therapeutic

drugs (pp. 509-513). Pregnant women are further encouraged to manage their diets in order to maximize vitamins, minerals, and certain macro-nutrients (pp. 88-111). Women are instructed to attend regular pregnancy check-ups administered by a primary care provider and undergo a series of blood and urine tests as well as a series of internal exams (pp. 64-65). The scrutiny and management of the pregnant body continues with admonitions to regularly monitor blood pressure and other vital signs (Murkoff and Mazel, 2010, pp. 206-207). The handbook also details when and how to request various medical tests including genetic tests such as ultrasounds and integrated prenatal screenings (IPS). Also included is a discussion of proper weight gain during pregnancy. Experts in Canada recommend that all pregnant women have at least one ultrasound while they are pregnant (SOGC, 2014). These trends are altering the logic and process of decision-making for women.

The state management of public health has had a profound impact on the development of prenatal testing technology and techniques. By the end of the 1940s, prenatal mortality was officially added to the list of total deaths in Canada. “Official vital statistics do more than count deaths; they represent targets for national and subnational health systems to reduce” (Weir, 2006, p. 28). With this new type of mortality becoming the purview of national health systems, it also began to warrant closer attention and management. Therefore, new strategies of prenatal risk assessment became crucial to the management of health during pregnancy. The optimization of health and wellbeing during this period was integrated in clinical practice by the late 1960s (Weir, 2006).

Scientific advances were also of critical importance to the development of prenatal diagnostics. Watson and Crick were the first to map the structure of deoxyribonucleic acid (DNA) in 1953. Karyotyping (testing chromosomes to detect genetic abnormalities) began less than 15 years later. The ability to extract fetal DNA via amniocentesis then photograph and analyze the

chromosomes present had a large impact on the management of prenatal health (Singer et al, 1998, p. 633). From that point forward, the race to find genetic markers for potential fetal abnormalities began.

One of the most common forms of prenatal screening is the diagnostic ultrasound. The abdominal ultrasound was introduced in the mid 1950s when physicians began using it to scan for abdominal tumors (Neilson and Grant, 1989). With technological developments in the following two decades, it became possible to capture real-time photographs of the developing fetus in utero (Milne and Rich, 1981). It wasn't long until ultrasound technology became the most common form of fetal prenatal testing. Today, it is a routine part of prenatal care in Canada (Society of Obstetricians and Gynecologists of Canada, 1999; Health Canada, 2002; Williams, et al., 2005).

In Canada, genetic prenatal screenings are used to estimate the risk of Down syndrome, Trisomy 18<sup>3</sup>, and open neural tube defects. The types of screening offered to pregnant women will differ based on gestational age, maternal age, and other factors. In British Columbia, a Serum Integrated Pregnancy Screening (SIPS) is offered to all pregnant women (whether from a medical doctor or a midwife). In British Columbia, SIPS along with specialized (nuchal translucency) ultrasound is offered to women deemed to be at a higher risk of having a fetus with Down syndrome or Trisomy 18. In assessing prenatal risk for these chromosomal abnormalities, doctors use the result of the SIPS including blood tests and detailed ultrasounds alongside other information such as maternal age, maternal ethnicity, maternal weight, maternal diabetes status, maternal smoking, and more. Due to

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<sup>3</sup> Trisomy 18 is “a genetic disorder in which a person has a third copy of the material from chromosome 18 instead of the usual two copies... Symptoms include: clenched hands, crossed legs, feet with rounded bottom, mental delay, small head, small jaw, low birth weight” (NIH, 2015)

variability, the possibility exists for false positives<sup>4</sup> (Perinatal Services BC, 2014).

Testing programs are often described as having the goal of providing parents-to-be with information about the health status of their fetus so that they can make an informed decision about the progression of their pregnancy. Currently, there are no therapeutic interventions to treat most anomalies that are detectable through prenatal testing (Brajenovi- Milic et al., 2008). When presented with a non-reassuring test result (indicating that the fetus is affected with a congenital disability), women's only options are to terminate the pregnancy or to prepare themselves for a life with a child with disability (Brajenovic- Milic et al, 2008: 79-80; Rothenberg an Thompson, 1994).

Prenatal testing may occur through either screening or diagnostic procedures. Screening tests indicate whether a fetus is at increased risk for congenital abnormalities, while diagnostic tests indicate whether a fetus is affected with a particular congenital abnormality (Health Canada, 2002). In the health care field, the simple existence of a technology often implies its use value. Hofmann (2002) describes this phenomenon as an imperative of potential action whereby that which is possible to do has to be done. Taking action (under almost any medical circumstance) is considered a virtue in medical culture (Fox, 2000). Physicians may feel compelled, potentially due to the Hippocratic Oath, to do everything possible to ensure their patients achieve the greatest health possible. Among doctors, there is a preference to solve health problems with the use of technology (Nordin, 2001). Both physicians and patients alike are more likely to ask about the most technologically advanced way to proceed with an intervention, rather than asking whether a particular intervention should be done at all

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<sup>4</sup> Approximately 2-3% of women who undergo prenatal genetic screenings will receive a positive test result. This means that the probability that the woman is carrying a fetus with a chromosomal abnormality is high. The majority of these women, however, will NOT be carrying a fetus affected with a chromosomal abnormality. This is a false positive. (Mount Sinai Hospital, 2013).

(Callahan and Parens, 1995). The assumed high value of medical technological interventions often goes unquestioned, with consequences at both the individual and societal level. Biomedical knowledge and technological advancement consistently outpaces the understanding of social, political, and ethical consequences of diagnostic technology to society (Gregg, 1993; Tudiver, 1993; Lippman, 1991).

Dominant discourse concerning this topic would suppose that women must be scientifically informed and must be "knowledgeable about the risks they may face, about how these risks can be recognized or diagnosed and about how they can neutralize them" (Beaulieu and Lippman, 1995, p. 65). From the standpoint of Western medicine, it is important to note that only the scientific expertise of gynecologists, obstetricians, or geneticists can be considered valid since the premier risk to the welfare of the fetus stems from what experts have classified as medical problems. Beaulieu and Lippman (1995) found that there was a choice of outcomes provided for women: either the birth of a normal and healthy infant or the preventable birth of a somehow 'defective' infant, whose condition could have been discovered earlier using prenatal testing had this option been chosen (p. 71-72). The assumption here is that women would (and should) clearly choose to abort a pregnancy that, as a result of prenatal screening, was seen to be 'defective'. Ruhl (1999) elaborates how medically indicated abortions may be understood as a form of eugenics when she says "the interiorization of eugenics suggests that eugenic norms have been internalized so that no outward discussion of the terms of prenatal diagnosis is required. It is simply assumed that a positive result will end in abortion, since this is seen as more responsible than giving birth to a child with known birth defects" (p. 112).

Several studies have shown a general trend towards the broad social acceptance of genetic testing in the prenatal period (Garcia et al., 2008; Jacques et al., 2004; Root and Browner, 2001;

Santalahti et al., 1998). In a Western context, “those who choose not to use testing or choose to continue affected pregnancies are increasingly regarded as irresponsible” (Modra, 2006, p. 206).

In a neoliberal capitalist society, healthy bodies are most desirable because they are argued to be the most productive and independent ones. This explains why health is seen as a valuable possession (Clark et al., 2003). Health is understood, in capitalist terms, as an individual goal that must be achieved and maintained through self-disciplining routines that simultaneously promote health and actively seek to avoid illness (Nichter, 2003). Following from the logic that health is an individual responsibility, it is deemed a mother’s responsibility to bear a healthy child (Parker, 2007: 280). This responsibility is a moral one (Clark, 2003). Therefore, bearing a child that is seen as both ‘normal’ and healthy is a social and moral responsibility for women in capitalist society.

The use of prenatal testing is the one of the ways women attempt to ensure they will have a “perfect” child. Lupton (1999) and Lippman (1991) suggest that parents may be attracted to multiple medical screenings and genetic testing because it is a way to enable proactive participation in the construction of the perfect baby. It is evident from the interviews I conducted that women were chiefly concerned with birthing an unhealthy baby or miscarrying. Leeann<sup>5,6</sup> describes her fears around pregnancy mainly concern “whether my child will be a typically-developing, healthy child.” For Leeann, a 26-year-old married woman who had delivered a stillborn baby in 2013, the fear was especially relevant. These types of fears were common among the women I interviewed.

Some fears experienced by pregnant women are literally unspeakable during the prenatal period. For this reason, the email follow up interviews became important in order to revisit the topic of

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<sup>5</sup> Participants have been assigned pseudonyms to protect their identities.

<sup>6</sup> Unless otherwise indicated, the direct quotations are taken from the initial face-to-face interviews. Excerpts from the follow up email interviews will be identified as such.

fears and anxiety. At the time of my email follow up interviews, all of the women had given birth. This proved to be important for some women, for whom the prenatal context itself limited the topics they felt comfortable discussing. For example, it was only in her follow-up interview that Katelyn felt comfortable expressing the fears she experienced while pregnant. As a single expectant mother (the only non-partnered woman I interviewed for this study) Katelyn works in television broadcasting. Katelyn detailed her greatest fear pertaining to pregnancy as follows:

My biggest fear was that I would not come home from the hospital with a baby in my arms, that he would be stillborn, or that he would somehow not be healthy. It's not something I would dare voice out loud during my pregnancy for fear of superstitiously making it come true. I even left tags on some baby items I purchased just in case. Thankfully, everything turned out great but you hear stories about the worst and just hope that will not happen to you and your own baby.

The fears surrounding pregnancy coincide with increased prenatal testing and monitoring. The ubiquity of prenatal testing implies that it is possible for every woman to give birth to a “perfect” child. Infants who are deemed “less-than-perfect” need to be justified and explained. Often, these children are understood to be the result of their parent’s less than perfect decisions. Pregnant women are faced with a moral dilemma when confronted with the choice to undergo prenatal testing. In a social environment where technology is ever-evolving, women must decide what constitutes a life worth living (Rapp, 1998).

Babies born with disabilities are labeled, along with their mothers, as ‘non-normal’. Mothers are blamed for difficulties during pregnancy and any perceived ‘defects’ in their babies once

they are born. Women themselves are often held responsible for their birth outcomes whether or not they could have done anything to change the outcome (Ruhl, 1999). This label is associated with deviance and badness.

These strategies for prenatal testing cause significant stress on mothers as they undergo multiple and ongoing screenings. Jenny, for example, explained how she began a regular schedule of testing early in her pregnancy. Her primary care provider (an obstetrician) suggested this testing regimen due to her age (37) and two previous miscarriages. The false positives that sometimes result from medical screenings can cause a lot of stress.

With my doctor, it's like, well when I first got pregnant, she wanted me to go and have my hormone levels tested every other day, just to make sure I wasn't miscarrying. I was like, 'oh, well I'll do what she tells me' I wish I hadn't, it was very stressful... So she calls me up one day and says, 'your levels have dropped, you are probably going to have a miscarriage' and I was just like- that was really, really stressful! I was very stressed out and ultimately a little angry that that happened.

The anxiety surrounding these types of tests can be debilitating. This is one of the reasons that Bridgette decided to forgo certain types of genetic screenings. Bridgette is 28 years old and lives with her common-law husband. Her partner and his family were adamant that she have genetic screening, since a rare genetic condition, Aicardi syndrome<sup>7</sup>, runs in their family line. There is no

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<sup>7</sup>Aicardi syndrome is “a rare genetic disorder that primarily affects newborn girls... The precise gene or genetic mechanism causing Aicardi syndrome is not yet known. Originally, Aicardi syndrome was characterized by three main features: 1) partial or complete absence of the structure (*corpus callosum*)

definitive prenatal screening for Aicardi syndrome in particular. Bridgette decided to forgo amniocentesis, however, she did have two ultrasounds during her pregnancy. She describes her reasons for opting not to have genetic screenings are based on the fact that these tests would likely result in personal stress and anxiety on her part.

One of the main [reasons I chose to not have genetic testing] was that it was more opportunity for worry than for peace of mind. The margin of error is so high and the way they give them to you is weird, especially for Downs [Down Syndrome]. The threshold for being negative is so high that a lot of them come back positive and then you get further testing and realize that it is really not likely. So that just feels like an *opportunity to worry*. And I don't feel like I could terminate the pregnancy even if there was something, so why am I finding out? So I guess there is an argument that you can be better prepared, but right now, *I didn't feel there was a lot of benefit to it*. There was a lot of potential for stress and worry which is the opposite of what I need and can cause problems in pregnancy. *Also, my risk level is so low, being young and stuff. It didn't feel like it was worth it.* (emphasis added)

The preceding excerpt highlights several different ways in which this topic is fraught with anxiety and ambiguity. Genetic testing forces mothers to think through a hypothetical situation (that is often negatively appraised) where her unborn child is discovered to have some variety of genetic

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that links the two halves of the brain 2) infantile spasms (a type of seizure disorder), and 3) *chorioretinal lacunae*, lesions on the retina that look like yellowish spots. However, Aicardi syndrome is now known to have a much broader spectrum of abnormalities than was initially described" (NIH, 2015).

abnormality. Jessica sees her option to terminate the pregnancy as non-viable, and therefore does not see the point of finding out if there is a higher potential that her child could be born with genetic abnormalities. Jessica then discusses her clinical risk category (low) as a further justification for not getting genetic screenings. She appeals to dominant medical discourse (citing her lower medical risk classification) in order to justify her decision (or terminate the pregnancy).

#### **4.2.4 Choice and Autonomy**

It is generally accepted today that becoming a mother is a choice, not an obligation. It is understood that mothers have children at the expense of higher career aspirations or that women delay having children until they have achieved a level of security in their careers. For this reason, “every child that is born must be ‘worth it’ in relation to other options available” (Landsman, 1998: 73). Genetic screening and wellness regimes are insurance to achieve the perfect offspring. It has been established that parents are attracted to genetic screening and diagnostics because it provides them with the opportunity to actively participate in the creation of a healthy pregnancy and (by extension) fetus (Lupton, 1999; Lippman, 1990). This discourse makes it seem as though every mother can have a ‘perfect’ child; any infants born ‘less than perfect’ are considered to be the result of a woman’s irresponsible choices during pregnancy. In this way, a healthy baby is linked to the moral identity of the mother.

Women’s narratives of choice for CAM are key to their identity construction as ‘good mothers.’ With these gender essentialist notions of mothering, these women stress the importance of their individual choices to maximize the health and well-being of their children (Conrad and Potter, 2004; Loe and Cuttino, 2008) while downplaying the significant time, energy, and resources that

facilitate these choices and make this brand of intensive prenatal expectant mothering possible.

Women's insistence on the personal agency exercised in the pursuit of CAM highlights the various ways neoliberal logic infuses women's own sense of control and dominion over their personal lives and obscures how privilege enables these choices. At the same time, insistence on personal choice in pursuing CAM is also enacted resistance against patriarchal authority over pregnant bodies.

Bridgette describes her birthing philosophy in the following ways:

A lot of what I've gotten out of it, or wanted to get out of it, is just *feeling like prepared and feeling like I am actively taking part in my pregnancy*, not just waiting for someone else to tell me what I should be doing or having someone else be the expert, that is my sense of the more traditional conventional medical model. It's like the doctor is the expert and they kind of tell you what you need to do. I really kind of wanted- and this was very much the message of the Hypnobabies<sup>8</sup> course- *I really wanted it to be my experience and my birth. My pregnancy and to get as much information for myself so I could be the driver of my decisions.* (emphasis added)

Jenny also emphasized the importance of choice during pregnancy. For her, CAM provided a way to exercise greater choice during the prenatal period.

I feel like [CAM] gave me more tools for dealing with things that came up in pregnancy. More choices and more options and more, I don't want to say control, but *really validated for me that it is my body and just has made me feel, there's totally a*

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<sup>8</sup> Hypnobabies is a 6-week childbirth education course that focuses on self-hypnosis for pain management during labour. The self-hypnosis training begins during pregnancy where expectant mothers attend classes and learn hypnosis scripts meant to facilitate deep relaxation. The course typically costs \$400-\$600 and includes several Hypnobabies CDs and workbooks.

*word for it—authority over my own experiences and my own health.* As I said, I do think that pregnancy can be this thing that happens to women, and having a traumatic birth, this thing just kind of happens to women, they don't have a choice over their own experience and their own body. *It was really important to me that I had that choice.* (emphasis added)

Allison is a 30-year-old registered nurse. She had experienced several miscarriages prior to her current pregnancy. Doing all she could to make this one “stick” she sought out CAM before and during her pregnancy. In her seventh month of pregnancy, she turned to acupuncture and other types of CAM after learning her baby was breech<sup>9</sup>. If the baby did not turn in the final weeks of pregnancy, he would likely have been delivered via cesarean section. Since Allison desired to give birth vaginally, she turned to CAM in hopes of turning (or “spinning”) the baby in the womb.

Like most people, I wanted to feel like I was doing something about it [baby presenting as breech]. When I started, I talked to a midwife and *I looked at the Spinning Babies site and was like, ‘I’ll try all these things’ because I feel like I’m doing something.* I didn't expect them to work, but I was hopeful that they would. So whichever combination of them it was that flipped it, or the baby was just going to flip on its own anyways, who knows. So, I guess my approach to CAM is that I'm willing to try it first and if it's successful, that's enough for me and if it's not, then I will pursue conventional therapies or medications. (emphasis added)

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<sup>9</sup> Most fetuses are positioned head down in the uterus. This facilitates the transition into the birth canal (vagina) at time of childbirth. Sometimes, the fetus is positioned so the feet or buttocks are down and enter the vagina first. This is called a breech presentation (Society of Obstetricians and Gynecologists of Canada, 2015)

When faced with a situation such as a breech baby, women may turn to CAM therapies in order to feel as though they are “doing something about it.” They exercise choice and do their best to try to navigate a situation that may or may not be impacted by the therapies that are presented. The plethora of new modalities available to pregnant women is historically unprecedented. The internet makes information on new therapies like Hypnobabies readily available and accessible to many women. The internet also presents new opportunities for communication whether through social media, blogs, websites or user-generated content. These online spaces enable collaboration and information sharing in a way that we have not witnessed before. Every woman I interviewed discussed her use of the internet in accessing information about her pregnancy in general and particular CAM therapies in which she was interested. Whether women are accessing information online or another way, engaging with CAM therapies is enough to alleviate mothers’ anxieties about being a good mother, at least temporarily.

Other women I interviewed reiterated these anxieties surrounding pregnancy and motherhood. Jenny’s concerns ran the gamut from avoiding interventions during birth to avoiding autism.

I wanted to avoid interventions such as epidurals, episiotomies, c-sections. I wanted to be as calm as possible, as stress hormones are harmful to the fetus. I wanted to avoid having a baby with birth defects / disabilities, if possible – having a child with autism is one of my biggest concerns – not much specific you can do about autism specifically, but taking prenatal vitamins, eating well and not drinking all help prevent birth defects.

By defining CAM therapies as central to the health promotion efforts of pregnant women, mothers communicate their commitment to the health of their unborn children while typically unaware

of how these choices are resource-dependent and not equally available to all expectant mothers. As mothers link their own positive birth outcomes to their choice for CAM during pregnancy and reiterate the superior care and prenatal decision-making they were able to achieve, they reinforce neoliberal ideas. These neoliberal ideas hold individuals responsible for their own choices and outcomes. Instead, they tended to reiterate the centrality of their own needs and the ultimate importance of the health of their own children.

#### **4.3 Perfect Pregnancies: CAM in the context of Neoliberalism and Consumerism**

Neoliberalism encourages us to view health and well-being in terms of the various strategies for self-management and participation in particular consumptive practices. Burns and Davies (2015) argue that “health as well-being has come to operate as a modality of neoliberal government” (p. 72). Individuals are encouraged to take up these forms of self-discipline in order to align with normative ideals and create selves that are productive, independent, responsible and healthy. I will illustrate how neoliberal strategies associated with health as well-being – individualism, self-responsibility, choice and a risk-management- were taken up by pregnant women in order to uphold norms of healthy motherhood.

Discussion of choice and individual preferences pervades women’s attempts to define themselves as good mothers, and in turn, good women. This discourse of choice has arisen from the current neoliberal context in the West. There are two separate aspects to this discourse. One focuses on the economic-based arguments that emphasize self-interest, decentralization, and competitiveness (Steger and Roy, 2010, p. 12). The second holds that individuals should feel obligated to self-consciously manage their own being and behaviours, to work hard, behave morally, and avoid risk

through informed decision-making (Murphy 2000; Wilkins 2014). As women strive to be good mothers, and are held disproportionately responsible for decisions concerning their health and the health of their unborn children, they claim and perpetuate their own privilege.

Neoliberalism is a political philosophy that emphasizes free market competition, privatization, and decentralized government, with an overall aim to decrease the role of the state in people's lives (Navarro, 2007). Alongside this trend for less government intervention comes an expectation for greater responsibility and for individuals to manage their own lives. Neoliberalism highly values individual potential, choice, and opportunity. This focus obscures the systemic inequalities that differentially position some individuals to make "right" choices while others are unable to meet these normative standards. In an era that Angela McRobbie calls "postfeminism," women are at once expected to reject the idea of enduring structural inequality and see their own personal successes or failures as a cumulative result of either their "right" or "wrong" choices (McRobbie, 2007, p. 732).

#### **4.3.1 CAM and Personal Responsibility for Health**

Dominant discourse on well-being during pregnancy emphasizes that health is proactively achieved through self-discipline, choice, and personal responsibility. Though CAM may have countercultural or spiritual histories (Warriner, 2007), the current urban Canadian context is one defined by capitalist and neoliberal logic. In the current Canadian public health context where the health care system is facing increasing financial demands based on the effects of an ageing population, advanced technology, and a diminishing tax base, there has been a fundamental shift towards and individualistic orientation to health and well-being (Broom, 2005; Broom and Tovey, 2008). Rather than situating women's experiences of dis-ease, illness, or other prenatal stressors as being implicated

in various political, economic, and structural forces, CAM places the onus of being well directly onto the consumer. It is this consumer focus on the pregnant woman that contributes to making health care a commodity to be bought and sold in the neoliberal marketplace.

The implementation of neoliberalism in Canada began in the mid 1980s and gathered momentum in the following decade (Rose, 1998). Macroeconomic policy, social welfare, and citizenship were reassessed and adjusted during this time. When compared to other developed nations, Canada has experienced the greatest cuts to spending on social programs since the 1960s. These spending cuts have been seen across all policy areas, and these reductions have resulted in greater inequality and negative impacts to public health (Creese and Strong-Boag, 2009; Morris et al., 2007). The effects of these spending cutbacks in social housing, women's shelters, mental health and addictions programs, to name a few, disproportionately impact women who experience multiple intersections of disadvantage (Coburn, 2010; Creese and Strong-Boag, 2009; Varcoe, Hankivsky and Morrow, 2007). In terms of prenatal health care, Medical Services Plan (MSP) in British Columbia covers the cost of the primary care provider (whether a doctor or a midwife). Alternative therapies are not covered unless an individual has access to extended health care benefits through their employer, private insurance, or through the insurance of a spouse.

Overall, there is an underlying assumption that all women are able to make choices and exercise agency and autonomy in their prenatal health care choices. Even when that idea is briefly called into question, as in the following excerpt where Bridgette acknowledges that not all women are equally able to use CAM, she immediately resorts to neoliberal logic.

It would be great if these things were more accessible. It does set up a situation where those that don't have the funds can't do it. I wish they could. It also takes time to have

those things, but no, I am happy to have invested that time. I could have spent it just sitting and fretting about the baby, so I would rather do it... It's obvious that I want to think about it and really be conscious about my choices.

Through their individual choice-making, some women are able to embrace identities as proactive, accomplished, and ultimately, "good" mothers, even as their access to these choices is facilitated by their class, whiteness, and educational privilege. Simultaneously, since women are encouraged to take up individual responsibility for their health outcomes and the health of their babies, any outcome that is deemed less than desirable is understood to be the direct result of a mother's less than perfect choices. The 'choices' women discuss only exist within a state context that structures policy requirements. Those individuals with access to resources are able to exercise greater and more varied choices.

Every woman interviewed in my study identified the high cost of CAM as a major drawback to accessing these alternative therapies. Jamie is a 38 year old trained as a therapist and life coach. She is currently not working and feeling the stress of getting by on her husband's income alone. Jamie explicitly describes how the cost of CAM is linked to government spending on health care.

That's a downfall, how much it costs. Especially because the government is not supporting it. You go to a doctor and it's free, right? And chiropractor and massage, sometimes that can be covered with BC med or whatever, so it's more affordable, but you know, there's Poke<sup>10</sup>, by donation.

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<sup>10</sup> Poke is a community acupuncture clinic in the Mount Pleasant neighborhood of Vancouver providing affordable group acupuncture services on a sliding scale of \$20-\$40 per treatment. This is significantly less than standard fees for acupuncture treatments, which typically cost \$90-\$150.

Jamie notes that there may be some reprieve for those with extended benefits, or those able to access affordable ‘by donation’ CAM clinics, but these are rare. This led her to engage in some creative bartering with those in her social network to access holistic care. When asked where she goes for naturopathic health and diet counseling, she explained, “I always just ask my friend [a naturopath]. I’ll trade her some coaching in exchange.” As a therapist and life coach, Jamie is able to trade services with her peers. Even if the cost of CAM can be high, there are sometimes creative ways to improvise. The high cost of alternative therapies was a common theme in the interviews I conducted. Allison’s definition of CAM emphasizes its location outside of the publically funded system. She describes it as follows:

It is very rare to have alternative care funded in any way through the public system. Or if you do have extended benefits then it’s considered a benefit, but not always covered.

And, anecdotally, I would say that complementary and alternative medicine is something that you have to convince some family doctors and specialists that it’s a good idea.

Though I do not have the sense that CAM is by definition incompatible with government-financed health coverage, the current climate is such that most CAM is paid for out-of-pocket (See Table 1). The out-of-pocket expense for CAM services can quickly add up for pregnant women looking to maximize their health and wellbeing. For example, Jenny describes how much she has spent on CAM during her pregnancy.

Doula<sup>11</sup> services are pricey; I certainly debated before we got the doula. I mean, it was nine hundred dollars. Very much worth it, it was fabulous, but you don’t know that going

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<sup>11</sup> Doulas provide emotional and physical and informational support before, during and just after childbirth. Prices for doula services vary based on the types of services and number of visits provided.

in. Acupuncture was quite cheap, through Poke. I don't think I spent that much on herbs and you are supposed to take prenatal vitamins anyways. I think that if you are going to a chiropractor it can rack up, if you are going to studio yoga classes, those can certainly add up. I used to go to YYoga regularly, I had a pass there and they are not cheap, but you can also practice in your own home. It doesn't have to be expensive.

Though Jenny concludes with the idea that CAM need not be prohibitively expensive, in practice, this is often the case. For some women, accessing the types of CAM they desired was just not financially possible. For Sara, accessing a naturopath was out of financial reach. Sara is a 28-year-old stay at home mom. I interviewed her while she was pregnant with her second child. Commenting on the financial cost of CAM, she noted:

Yeah, I saw a naturopath [before I became pregnant], I just haven't throughout my pregnancy because I felt like the midwife kind of covered that, not that she is a naturopath, but she was able to offer me similar care as a naturopath. Naturopaths costs money and a midwife didn't. Cost has a lot to do with it.

Pregnant women, like Sara, who are unable to financially access the services of a naturopath, are instead looking to midwives, a health care service covered under MSP to provide them with some of the services that other CAM professionals may be able to provide. Midwives assist in 18% of the total births in British Columbia every year (Crawford, 2014). There are about 200 practicing midwives in

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Typically, a doula package will include at least one prenatal visit, dedicated attention and support during childbirth, and at least one postnatal visit. Optional services include, but are not limited to: lactation support, birth photography, placenta encapsulation or preparation, childbirth education classes, belly casts, accompaniment to prenatal doctor or midwife visits, written birth story.

the province. Midwives have be regulated and licensed in BC since 1998. Since that time, midwifery care has been covered under the provincial MSP.

However practicing midwives are not only overworked (the demand for midwifery services far exceed the supply in British Columbia and other provinces) but expectations for their care are on the rise. There are too few midwives working mixed with rising demands for CAM expertise and therapy from women who are actively seeking out this information but who may or may not have adequate financial means.

Many of the women I interviewed noted a shortage of midwives in the Vancouver area. The dearth of midwives in Canada has been noted (Busing, 2007; Sheldon, 2006). Women I have interviewed pointed to their personal experience on waiting lists and also their inability to procure midwifery services altogether. Katelyn began looking for a midwife as soon as she learned she was pregnant. As she explained to me,

There's like a big shortage of midwives in Vancouver, actually. Yeah, and it's hard to get in. They'd say, 'due in September, nope, we're booked up!' I had to get this woman to help me from the first midwife place. I had to say, 'I haven't been able to find somebody could you help me find someone?' and she made some phone calls for me and all that. But yeah, there is quite a shortage here.

Eventually Katelyn was able to find an available midwife across the city, and had to commute significant distance to meet with her during pregnancy. Leeann reiterated this sentiment.

Yeah. There's just not enough for the demand. And I called around to the different clinics in this area. And maybe if I was willing to drive to Abbotsford, but I was not willing to

do that. But no, I just wanted something closer. So, then that was kind of- the door closed on that. I was still on a waiting list though because I was hoping to still get in.

Leeann was not able to gain access to a midwife during her pregnancy. Greater access to time and other resources may have made it possible to procure the services of a midwife outside of the city.

#### **4.3.2 Choice and Responsibility**

In a the North American context of intensive (and extensive) mothering (Christopher, 2012) women are encouraged to take up the personal responsibility to strategize ways to promote the health and development of their own children (Hays, 1998). In her interview with me, Allison contended that CAM provides an opportunity for pregnant women to exercise individual control and choice over the health of their unborn children. She contrasts this opportunity with mainstream health care: “I think that conventional medicine stops that personal responsibility of having to take things upon yourself, ‘cause they just think popping a pill, and that’s what we’ve been told, and that will be enough.”

Leeann describes how she was able to blend conventional prenatal care with alternative therapies:

Before I was pregnant, I was mixing conventional and natural medicine already. *I just saw the value in what both of them had to offer. It was helpful to have both, I felt because I think that they view, they come at medicine differently. I just want to know what their opinion is and then evaluate it myself even though I don’t have the education that either side does, I still felt that because it was my body I could determine a bit more of how I was feeling based on mixing the two together. (emphasis added)*

In this act of blending, Leann reasserts her own individualism, describing how she is able to take in various sources of information and evaluate them individually. At times, mothers report embracing expert advice and at other times they rejected conventional expert advice. Katelyn describes the process this way:

But I've been doing a lot of research, and if a topic comes up, say the vitamin K injections for the baby, *I start Googling and researching and reading and finding a few books. I'd get information and if I didn't feel comfortable with it, I would question it and research it more, am I comfortable with it now or am I not? So I feel like this is about not always accepting the norm and just trusting yourself and knowing yourself and what you want and what you think would be good.* It's very easy to get caught up in 'this is how it's done, this is how it's always been done, this is what we do'. (emphasis added)

In the above excerpt, Katelyn describes the process by which she selectively chose the therapies that she deemed most useful. In this way, pregnant women like Katelyn wrest a certain degree of power from biomedical experts by seeking out alternative practitioners to maximize their own health and the health of their children. This process requires women to take individual responsibility to manage their own health and risk status. The amount of time and energy the women I talked with invested in identifying, researching, and "trying out" CAM was extensive. As relatively privileged mothers research and investigate the benefits and drawbacks of various prenatal health strategies, they do so from the luxury and privacy that resources are able to provide (Lasch, 1995; Reich, 2005). I do not mean to suggest that women living in poverty do not exercise agency in their own lives (Hill, 1994; Brubaker, 2007). Rather, I suggest that

prenatal health strategies are unevenly supported and financed by the state, resulting in some parents' ability to exercise greater parental freedom.

The women I interviewed for this project often referenced the ways in which they were able to exercise active decision-making in their prenatal period. They discussed how they chose to change primary care providers, manage nutrition and wellness regimes, conduct independent research, and advocate for themselves with medical care providers. As with other aspects of mothering, women who are able negotiate with providers, access outside resources, and move through the social world without fear of state surveillance, are best able to exercise choice. Allison, a registered nurse, describes how she navigates the conventional health care system:

I know how to get what I want within the health care system. Which, I think, unfortunately, for the large majority of the public, they're just at the mercy of who advises them, their GP, their specialist, their nurse in emerg[ency] or whoever. They just kind of have to take that as truth and to have some information as to how the health care system works can be a huge advantage when you are trying to navigate it... *Being informed within the health care system and being your own advocate is much easier when you work in it for sure.* (emphasis added)

Bryant et al. (2007) discuss how women take up neoliberal logic and embrace the idea that "women are self-governing autonomous subjects" (p. 1197) entitled to seek out services and information. They found that "feeding this belief are coexisting discourses that serve to organize 'free choice' in terms of safe/unsafe, order/disorder, life/death; and with the ontological meanings, by structuring women's mothering identities as good/bad" (Bryant 2007, p. 1199). In this context, then women are bound to a neoliberal obligation to manage risk and pursue the maximization of health for

both themselves and their babies. Women are exercising their individual agency when choosing CAM products. Their decisions are made within competing claims of expertise of health and wellness knowledge. For women with time and money, the choice for CAM can be understood as an act of resistance against the medical surveillance and management of pregnant bodies in the contemporary health landscape.

### **4.3.3 Informed Health Consumers**

Under neoliberalism, maternity, much like femininity, has been commodified. International maternal markets trade not only in clothes and beauty products, pregnancy photo shoots, and fertility treatments, but also in complementary and alternative medical therapies. In a neoliberal context that emphasizes consumer choice, CAM is well positioned to gain market share. Pregnant women who access alternative therapies generally use CAM in conjunction with conventional medical treatment. This pattern is especially true for the demographic most likely to access CAM during pregnancy, that is, highly educated, discerning individuals with money to spend and a strong belief in consumer choice. As Conrad (2005) notes, “in our changing medical system, consumers of health care have become major players. As health care becomes more commodified and subject to market forces, medical care has become more like other products and services” Conrad (p. 8)

Women evaluate alternative prenatal care from a perspective that treats CAM as a technology for individual consumption that needs to be assessed. The pregnant woman becomes more active in her own self-discipline, engaging in individual risk-management strategies. She looks to the increasingly competitive marketplace for expert health advice from many. The relationship between experts and patients/clients exists, but it has shifted form. Rose (1993) asserts that the “injunctions of the experts

merge with our own projects for self-mastery and the enhancement of our lives” (p. 298). The eight women I interviewed decided whether or not to access particular types of CAM based on their independent research. This ethos of personal responsibility reflects neoliberal ideals of individualism and self-management.

The increasing availability of health information online has transformed the patient into a reflexive consumer expected to make active decisions concerning treatment options (Lupton and Tulloch, 2002; Henwood et al., 2003). This trend towards increasing consumer choice in the realm of complementary and alternative care was prevalent in the interviews I conducted with pregnant women. For example, Allison decided to undergo regular acupuncture treatments alongside other alternative therapies in an attempt to shift the orientation of her unborn child. Allison discussed her active research and decision-making process after learning her baby was breech:

I did some research into what options were available to try and flip the baby, I read studies on the use of chiropractic and acupuncture in pregnancy, compared control groups of women. There was one study with one hundred and fifty women with breech, and seventy five were given acupuncture once a day and seventy five weren't, or they were, but they weren't the points for flipping babies and the seventy five that had received acupuncture on the points to flip a baby, something like seventy percent of them flipped. It was a pretty significant difference.

Allison ultimately decided to undergo acupuncture treatments along with numerous other CAM therapies (including moxibustion, massage, yoga, herbal remedies). Her baby was delivered vaginally (the baby flipped prior to labour) but Allison was not sure about which, if any, of the therapies was responsible. There was a general sentiment among the women I interviewed that taking personal

responsibility for the types of care accessed during pregnancy was key to greater personal satisfaction with the pregnancy experience itself. Leeann describes it this way: “I think if you didn’t do your own research and you just went along with whatever is recommended [by a primary care provider], I feel... it might not be as positive.” According to the women I interviewed, doing independent research is understood to have yielded positive results during pregnancy. This type of self-directed independent research is not only beneficial, but generally understood as expected of pregnant women.

The expectation that one must actively manage and take responsibility for choices about care needed during pregnancy is a perfect illustration of neoliberal decision-making in action. Leeann articulates the expectation for independent research this way,

I think a lot more women are doing a lot more of their own research. For previous generations you just took a doctor’s word on something and that was sort of it. And maybe that was the only thing that was accessible was to ask a doctor. But now with the internet, and all the different blogs or resources that you can find, I feel people are doing more of their own looking around. Just maybe wanting a bit more. What conventional medicine offers for pregnancy is very narrow, they just maybe want more care or just a different opinion.

By engaging in these practices of independent research, women are seeking to be informed consumers of health care services. Women are not only conducting research before accessing certain CAM services, but for some like Bridgette who participated in a hypnosis-based birthing class, the research continues. Bridgette explains that once she signed up for the class,

We got a lot of materials, a whole book of information, research articles and suggested readings for other things, and they’ve done a lot of research for things, people who talk

about birth positively, so they've done a lot of that kind of work for you. It was the hypnosis stuff, there's a lot of guided hypnosis CDs, so we also got all the CDs.

This push towards more information seeking is done in an attempt to mitigate risk.

Sara, age 28, reflected on her own mother's lack of prenatal health choices. She compared her own experiences as a pregnant woman with those of her mother.

I don't think she was as informed about it. When she had me it was very much like, you go to your doctors appointments and you do what the doctor says. There's nothing wrong with that, but I don't think that she felt as empowered as I do now to seek out other forms of care and that kind of thing and to make pregnancy enjoyable and comfortable.

Sara highlighted how increasing information on prenatal health options led to positive personal outcomes. Later on in the interview, it became apparent that access to more choices and information is also a source of anxiety. Sara describes first her research foray, and then how it made her feel. "Yeah, a few things I did... you know, Google every once in a while when I feel nauseous, or when I am spotting, usually not very helpful, just makes me paranoid." The contradictory consequences of increasing consumer health choices is relevant here.

All of the women I interviewed had conducted their own research on the best ways in which to maximize the potential health of their unborn babies and themselves. There are also tensions around finding reliable sources of information on CAM upon which women can make their decisions whether to engage with a particular therapy or not. However, these calculations are not always clear. For example, Jenny describes how she is prone to seek out information on CAM that she is interested in and yet she has trouble finding reliable sources.

I'd be inclined to look at research and see what research is out there... I think a lot of the data out there [on CAM] is anecdotal. I don't think I seek out particular experts on things, more a number of different things from different people that has been effective. I don't really know where I would go [for expert advice on CAM]. I also feel like people who like a chiropractor for example, they are very biased towards chiropractic. I don't know where you go to get unbiased information.

Women brought together oftentimes disparate practices according to their level of accessibility, to suit their own needs and preferences. Skepticism towards both biomedicine and CAM was evident in pregnant women's accounts. Many women discussed the limitations of science to deal adequately with their pregnant experiences. Jamie eloquently brought out this attitude of skepticism towards both CAM and conventional medicine. As a critical, educated consumer she recognized the shortcomings of conventional medicine:

I trust it [conventional medicine], it's not like I don't trust it. It's not like I resist going to the doctor or going to the hospital or thinking that anyone doesn't have the full or a good idea about what's going on, I just don't consider it the full picture, if that makes sense. I don't see it as the full picture. I always get second opinions from, you know, more holistic health practitioners, like naturopaths or acupuncturists or people that work with energy, that I think have a more holistic view on the body system and spiritual-energies and spiritual systems and stuff like that doctors conventional medicine does not understand. So, conventional medicine, it has its limitations, I guess. And, but thank goodness it's there.

Discussions of the limitation of conventional medicine were common among the women I interviewed. Jenny echoed a similar sentiment about the limitation of Western medicine when she said, “in conventional medicine...there is often an emphasis on illness and fixing things that are broken rather than fostering health, whereas alternative therapies seem to be more focused on fostering health.” The skepticism the women express is not just aimed at conventional medicine, however. The women also talked openly about their uncertainty of certain CAM therapies and questioned the scientific basis for some CAM health claims. Jamie expressed skepticism towards certain CAM therapies that may be less regulated: “I guess it’s (CAM) just a little less regulated, I guess that’s the word to use. The rigorousness of their education and their practicums and stuff like that... I think that’s a little bit dodgy.”

Contemporary CAM users have often been characterized as ‘bricoleurs’ or ‘designers’, that is, active citizens that construct and mould the offerings of a pluralistic health care market to their own wants and needs (Broom, et al., 2012; Meurk et al., 2012). It has been found that pregnant women value holistic approaches to medical care and use CAM to complement, rather than replace allopathic treatment (Gaffney and Smith, 2004; Tindle et al., 2005). In a similar way, Coulter and Willis (2004) found that the rise in the popularity of CAM had more to do with changing attitudes about health and wellbeing rather than a pointed rejection of Western allopathic medicine. Researchers have also linked CAM use to emerging postmodern values that emphasize self-actualization and individuality, among others (Siahpush, 1998). With the neoliberal emphasis on self-regulation and responsibility, individuals are attracted to CAM in order to create and maintain optimal health. As people become more active health care consumers, they are able to seek out information and gain greater control over their own

wellbeing. Individuals are increasingly able to purchase health services and products directly, without the need for an intermediary such as a medical doctor.

The heterosexual, predominantly white and college-educated women I talked to are active collectors and assessors of medical and alternative expertise. As Sara illustrates, “I felt really empowered to seek out what worked best for me. I trusted myself to pick what worked for me and not do things that didn’t work for me. No judgment, but they just didn’t work for me.” Rather than wholly accepting or rejecting one form of expertise (e.g. obstetrical or naturopathic) there emerged an iterative process of piecing together different practices and models of care. A key aspect of women’s narratives was their openness to try a wide variety of therapies, and a willingness to engage with a wide array of ideas about pregnancy and the body. They engaged in a pragmatic quest drawing on intuitive and embodied knowledge alongside complex modality-specific therapeutic systems and beliefs and broader (often biomedically-grounded) models of efficacy and effectiveness.

## Chapter 5: Conclusion

In this thesis, drawing on accounts of a select group of pregnant women who used CAM, I have attempted to unpack the ways in which some women negotiate the multiplicity of prenatal therapeutic options. Through semi-structured interviews, I gained greater understanding of the complex and contradictory predicament in which these women found themselves. The prenatal health care landscape is ever-diversifying with new options and technologies becoming available all the time. Combining both conventional medical therapies with newer CAM modalities is a creative work in progress. The creativity in assembling individualized prenatal health regimes is aided by the age of the Internet and pregnant women's ability to seek out information and resources. This access to this information and the exposure of new CAM modalities in the age of the Internet is historically unprecedented.

The choice for CAM is not simply a rejection of biomedical knowledge and an embrace of alternative holistic lifestyle practices. The pregnant women who participated in this research illustrate the creative and improvisational manner in which prenatal health care decisions are pieced together. When faced with these decisions, women must judge the risk, benefits and efficacy of numerous options set out for them in a consumer-focused marketplace. These decisions are also made in order to maximize the health of the unborn. These parental aspirations for the "perfect" child drive CAM consumption. The therapeutic trajectories of pregnant women are diverse and varied. No two women came to CAM in exactly the same way or have identical assessments of the types of CAM that were most useful or worthwhile. Skepticism was raised regarding conventional medical practice as well as new CAM therapies.

It is important to keep in mind that this individualized approach to health care, while it may destabilize the centrality of biomedical experts and the legacy of patriarchal subjugation of women's bodies, it also simultaneously reinforces scientific legitimacy. Scientific and medical knowledge continues to be respected and legitimated (albeit, in some cases, recognized as incomplete). Pregnant women's decision for CAM does not necessarily indicate a wholesale refusal of biomedical expertise. Decentering health professionals in decisions on therapeutic legitimacy and effectiveness should be understood in a neoliberal context stressing the importance of individual responsibility for health and wellbeing (Rose, 1992, 1999; Emmison, 2003). This process of negotiation and mediation of one's own health care options is therefore a politically desirable turn for neoliberal governments and political structures. This shift away from biomedical expertise re-centers responsibility for prenatal health and the health of the fetus onto the individual expectant mother. I argue that this shift indicates a broader, strategic social repositioning of responsibility for health and wellbeing. It is also likely that any sanctions experienced by women for this creative mixing of medical and holistic therapeutic options will diminish as the practice becomes ubiquitous.

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## **Appendices**

### **Appendix A Recruitment Poster**



**ARE YOU INTERESTED  
IN PARTICIPATING IN A STUDY ON THE USE OF  
COMPLEMENTARY AND  
ALTERNATIVE MEDICINE (CAM)  
DURING PREGNANCY?**

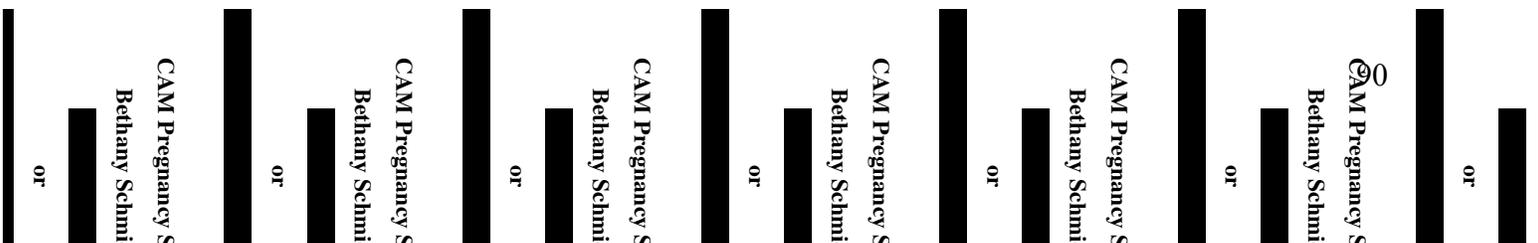
Are you pregnant or have you given birth in the last six months? Have you used complementary or alternative medicine (e.g., yoga, herbal remedies, reflexology, massage therapy, acupuncture, meditation, hypnotherapy, biofeedback etc.) during your pregnancy?

I am a researcher in the MA program in Sociology at the University of British Columbia conducting an interview study about the use of **complementary and alternative medicine** among **pregnant women**.

Participation will involve a **short interview (telephone or in person) in English of approximately 60 minutes** discussing your use of conventional, complementary and alternative medicine during your pregnancy. A \$20 gift card will be offered to all participants.

Please contact me if you are interested in more information or if you would like to participate in this study.

Bethany Schmidt



## Appendix B Consent Form

### Consent Form

#### “The Meaning and Management of CAM During Pregnancy: A Qualitative Study”

My name is Bethany Schmidt. I am a Master’s student in the Department of Sociology at The University of British Columbia. I am conducting a research study on the use of complementary and alternative medicine (CAM) among pregnant women as part of my Master’s Thesis project. The principal investigator for this study is Dr. Becki Ross in the department of Sociology at the University of British Columbia (telephone: [REDACTED]). The findings from this project are intended to contribute to a greater understanding of CAM use and management during pregnancy.

If you agree to participate in this research, your participation will involve an interview that will take approximately 60 minutes. The interview will be conducted in English. The interview will include mostly open-ended questions about your pregnancy as well as your use of CAM. The interview will be recorded and later transcribed word for word. Any personally identifying information will be removed from the interview transcripts. The hardcopy transcripts will be kept in a locked filing cabinet at UBC. Every effort will be made to maintain the confidentiality of the interview material. Any material used in the publication resulting from this study will have identifying characteristics or statements omitted or will be paraphrased to help ensure confidentiality.

Participation in this study is voluntary. You are free to refuse to answer any questions or withdraw your participation in this study at any time and without consequences. In appreciation of your time and effort, you will receive a \$20 gift certificate to a coffee shop. If you later decided to stop the interview, you may keep the honorarium. You may exercise the option of removing your data from the study. There are no known direct risks to you if you agree to participate in this study. You may find some of the topics surrounding your pregnancy and health care experiences difficult or unpleasant. You will have the opportunity to describe and discuss your own personal experiences with both conventional and alternative health care. Others may benefit from you sharing your views and experiences.

If you have any questions about this study or your participation in it, please do not hesitate to contact me at [REDACTED] or email me at [bethany.schmidt@alumni.ubc.ca](mailto:bethany.schmidt@alumni.ubc.ca). If you have any concerns or complaints about your rights as a research participant and/or your experiences while participating in this study, contact the Research Participant Complaint Line in the UBC Office of Research Services at 604-822-8598 or if long distance e-mail [RSIL@ors.ubc.ca](mailto:RSIL@ors.ubc.ca) or call toll free 1-877-822-8598.

Taking part in this study is entirely up to you. You have the right to refuse to participate in this study. If you decide to take part, you may choose to pull out of the study at any time without giving a reason and without any negative impact.

- Your signature below indicates that you have received a copy of this consent form for your own records.
- Your signature indicates that you consent to participate in this study.

Name of Participant \_\_\_\_\_

Signature of Participant \_\_\_\_\_

Date \_\_\_\_\_

Signature of Investigator \_\_\_\_\_

Date \_\_\_\_\_

Would you like a copy of the final report that will result from this study? \_\_\_\_\_

If yes, please provide your mailing address OR email address below.

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## Appendix C Demographic Information Sheet

### CAM Pregnancy Study- Info Sheet

Date: \_\_\_\_\_

Age: \_\_\_\_\_

Ethnicity: \_\_\_\_\_

Country of Birth: \_\_\_\_\_

If not Canada, how long have you lived in Canada? \_\_\_\_\_

Highest level of education: \_\_\_\_\_

Religious affiliation (if any): \_\_\_\_\_

Relationship status: \_\_\_\_\_

Do you live with any disabilities? \_\_\_\_\_

Approximate yearly household income? \_\_\_\_\_

## **Appendix D Interview Guide**

### **Interview Guide**

We will be talking today about your experiences using complementary and alternative medicine during your pregnancy. I just want to repeat again that you can stop the interview at any time or let me know if there are any questions you do not want to answer.

### **Background Information**

Let's start with some background information about you.

1. How would you describe your overall health?
2. Are you currently pregnant?
  - a. If not, when did you give birth?
3. What type of primary care provider are you seeing (did you see) during your pregnancy?
4. Have you given birth in the past?

### **Conventional Medicine**

This next section is all about your thoughts and experiences with conventional Western medicine.

5. What do you consider to be conventional medicine?

6. In your opinion, what is the purpose of using conventional medicine? (i.e., why would someone use this type of medicine?)
7. What do think are the benefits of conventional medicine?
  - a. Did you find these to be relevant in your experience?
8. What do you think are the drawbacks of conventional medicine?
  - a. Did you find these to be relevant in your experience?
9. During your pregnancy have you taken any conventional medication? Which ones?
10. How do you feel after taking this medication?

### **Complementary and Alternative Medicine**

We are going to move on now to discuss the use of complementary and alternative medicines during pregnancy

11. What do you consider to be complementary and alternative medicine (CAM)?
  - a. Examples?
12. Who do you identify as an authority on the use of CAM during pregnancy?
13. In your opinion, why might a woman choose to use CAM therapies during pregnancy?
  - a. Do you know of other women close to you (friends, family members) who have used CAM during their pregnancies?
14. What do you think are the benefits of CAM during pregnancy?
  - a. Did you find these to be relevant in your experience?
15. What do you think are the drawbacks of using CAM during pregnancy?

- a. Did you find these to be relevant in your experience?
16. When did you begin using CAM?
- a. Could you describe how you came to choose this?
17. Can you describe the types of CAM you have used during pregnancy?
- a. How many times/how frequently?
18. What are your expectations for the CAM therapies you are using?
- a. Do you know of any side effects of using these CAM therapies?
19. How do you obtain CAM products?
- a. Are these products/services covered under your medical insurance?
20. How do you feel after using CAM?
- a. Will you continue to use CAM? Why (not)?
  - b. Would you recommend the use of CAM to other pregnant women?

### **Management of CAM During Pregnancy**

The last section of the interview is all about your decisions to use CAM

21. Do you consider CAM to be part of your prenatal care?
22. Where do you go for information about CAM during pregnancy?
- a. Doctor/Midwife?
  - b. Friends, family members?
  - c. Books? News articles? Televisions shows?
    - i. Which ones?

- d. The Internet?
    - i. Which websites?
  - e. Why do you trust these sources?
23. (IF partnered) Did you discuss CAM use with your partner before you started?
- a. If yes, what were their opinions or views?
  - b. Did this affect your decision?
24. Did you discuss CAM use with your friends or family members before you started?
- a. If yes, what were their opinions or views?
  - b. Did this affect your decision?
25. Did you consult with your primary care provider prior to using CAM?
- a. Please explain your reasons.
26. Do you feel comfortable discussing your use of CAM with your primary care provider?
- a. Why (not)?
27. Is your primary care provider aware you are using CAM?
- a. If no, why not?
  - b. Could you describe their general approach/opinions about the use of CAM during pregnancy?
28. Are there thoughts or experiences you would like to add?

That is the end of the interview. I appreciate you taking the time to participate in this project.

Thank you.