

The Value of Massage during Pregnancy and Childbirth: An  
Exploration of Practitioners' Views.

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## **ABSTRACT**

### **The Value of Massage during Pregnancy and Childbirth: An Exploration of Practitioners' Views.**

For many women coping with the demands of pregnancy and childbirth, Complementary therapies are an appealing option. Massage in particular has several uses in pregnancy and research in the field continues to substantiate them. The increasing use of complementary therapies and changing attitudes towards the medical approach to pregnancy and childbirth mean that a greater understanding is needed of those therapies.

This qualitative study explores the views and experiences of three practitioners who provide massage and bodywork to childbearing women, and what they perceive to be the key value of this therapy.

Thematic analysis of data revealed several themes relating to the value of maternity massage, with the key concept of support emerging as the main therapeutic value identified. The concept of providing support was also interpreted to include the woman's partner, their baby, and the primary care providers.

Several key factors were also identified as future needs for the potential integration of massage therapy with mainstream maternity care. These were clarification of roles and boundaries, improved inter-professional communication, thorough practitioner training and increased accessibility to lower income brackets.

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## 1.0 Introduction

The physical and emotional demands of pregnancy can be challenging for women. From early signs and symptoms such as nausea and fatigue to the enormous weight bearing adjustments of the muscular skeletal system; exaggerated lumbar lordosis and pelvis rotation often causing low back pain, the stretching and separation of abdominal muscles as the uterus increases in size, plus huge changes in neuroendocrine functioning and demands on energy metabolism affecting most physiological systems, (Mittelmark *et al*, 1991, Yates, 2010). Beyond this the psychological transition to motherhood, the way one is perceived by society and shifting family dynamics are all uniquely challenging.

In traditional cultures a childbearing woman was cared for by other women in her close community offering touch and support, particularly during her labour, (Pascali-Bonaro and Kroeger, 2004). As western society has advanced and giving birth has moved to the hospital setting, this practice seems to have been lost. In its place a technological approach and medical attitude towards pregnancy and birth has prevailed (Cahill, 2000). Today, it seems this approach is beginning to shift, reflected by the increasing interest in the use of complementary therapies during pregnancy and childbirth.

Specifically, the use of massage as a therapeutic intervention is becoming an increasingly popular form of complementary care for pregnant women. Despite the growing popularity of this therapy, research in the field remains relatively underdeveloped, and a clear understanding of the effects, benefits and value is not yet achieved. So it seems some fundamental questions remain to be answered; Does massage benefit pregnant women? What are the risks? How can it be integrated with mainstream maternity care?

Complementary therapies are often defined as holistic in nature (Micozzi, 2001) and this inevitably means that certain aspects of the therapy cannot be measured within the confines of a randomised controlled trial (Verhoef, 2002). While research continues into more specific uses of maternity

massage, it was considered that a more holistic evaluation considering the broader concept of 'value' was justified.

The aims of this study are therefore to explore how practitioners perceive maternity massage to be valuable, and to gain insight into why pregnant women might use it. It is considered that a deeper understanding of patient demands could also be gained. The aim is also to explore practitioner approaches to treatment and how they are able to work co-operatively with primary care providers. This would allow identification of future needs for practitioners specialising in the arena.

### **Key term**

The term 'pregnancy massage' is often used to refer to this area of complementary therapy. To encompass the scope of this project the term 'maternity massage' will be used as it is considered to encompass the use of massage during the antenatal period, intrapartum care, and the postnatal period.

## 2.0 Literature Review

This literature review summarises some of the research and available evidence for the effects of massage, revealed through the following database searches: Alt Health Watch, AMED, The Cochrane library, BMJ online, NHS library, PubMed, SAGE, Science Direct and Wiley Interscience. Libraries were accessed at The University of Westminster and The CAM Library and Information Service at the London Homoeopathic Hospital. Some open internet searches were also performed. While the review is not necessarily inclusive of all the evidence to date it provides a succinct overview of the current situation.

Adams *et al* (2009) cite 24 studies exploring women's use of complementary and alternative medicine during pregnancy. The authors identify that there is a lack of in-depth understanding of user experiences and their perceptions of risk. Also noted is the lack of research exploring the nature of the therapeutic encounter with complementary practitioners, and this leaves a gap in the literature. This can be seen to give further justification to present research aims.

### 2.1 Measuring outcomes

The focus of research so far into the efficacy of massage during pregnancy and childbirth, is often on measures such as birth outcomes, pain and anxiety scores during labour and use of medical interventions (Chang *et al*, 2002, Field *et al*, 2008, Khodakarami *et al*, 2006, Kimber *et al*, 2008). An identified problem in evaluating the available evidence is that it incorporates various forms of massage including aromatherapy massage, shiatsu and Swedish massage. There are also differences among the existing studies in whether the massage was delivered by a massage therapist, a midwife, or the partner of the pregnant woman (Field *et al*, 2008, McNabb, 2006). This suggests that there would need to be some consistency developed for future research, with matching methodologies employed, and similar cohorts between studies, in order to build a solid and credible evidence base.

## 2.2 Stress, anxiety and pain

A key area of research is the use of massage to reduce maternal anxiety and stress, which is speculated to lead to more positive labour and birth experiences, and improved birth outcomes for the neonate (Field *et al*, 2007). There is a general theme throughout the research that anxiety is linked to pain perception, and these two factors are often investigated together. Burns *et al* (2000) report on an eight-year study of Aromatherapy used in a delivery suite. The finding was that women who used aromatherapy were less likely to require epidural analgesia, and the authors hypothesise that this was due to their reduced level of anxiety. However, it is not specified how many of the women actually received massage so this cannot be evaluated as a unique factor, in addition anxiety levels were not measured using any validated methods, with the women rating essential oils as 'helpful' or not.

Kimber *et al* (2008) designed a trial to test whether massage could relieve pain during labour. 90 women were randomised into 3 groups, either massage intervention, placebo (music) or control group (usual care), the massage was given to the women by their birth partners. The results of the study showed that there were no significant differences between the three groups with regards to pain scores or pharmacological analgesia. Continuity of massage technique may be questionable in this trial considering that massage was administered by birth partners, not professional massage therapists. The authors do note a trend towards more positive views of labour in the intervention groups and suggest massage to be an acceptable coping strategy.

A similar study by Chang *et al* (2002) found reduced levels of pain and anxiety in recipients of massage during labour. The authors emphasise the psychosocial value of massage as a pain and anxiety relieving strategy, and suggest that it may be the caring and supportive aspect of giving massage that carries the therapeutic value. This study differed to that of Kimber *et al* (2008) in that massage was only introduced at phase one of labour, and not during the final weeks of gestation. It may therefore be suggested that when evaluating the evidence base to inform decision making with regards to the

provision of massage therapy, the evidence should be differentiated and considered in two categories: massage during the antenatal period and massage given during intrapartum care.

### 2.3 The biochemical mechanism

Contrary to the view of massage as merely an effective psychosocial intervention some studies have attempted to evaluate the physiological and biochemical mechanism by which it works. Field *et al* (2006) propose a biochemical model of the effects of pregnancy massage on prenatal and neonatal outcomes. In their review of current research the authors propose that massage increases serotonin and dopamine levels, reduces cortisol and norepinephrine levels, thereby reducing maternal depression and anxiety and subsequently the incidence of infant prematurity. In 2009 Field *et al* extends the research with a study involving 200 pregnant women with depression. From this it was found that prenatal and postnatal depression was reduced in mothers following a programme of massage given by their partners. This evidence suggests that massage may be a viable alternative to anti-depressant drugs for pregnant women.

### 2.4 Alleviating suffering

Another topic of debate and interest in the field is the concept of 'suffering' experienced by women who have extreme symptoms during pregnancy or childbirth, and how massage, or indeed other non-pharmacological interventions, may be used to alleviate this. Agren and Berg (2006) investigated the effects of massage on women with severe nausea and vomiting. Tactile massage was administered to hospitalised women and their experiences were qualitatively analysed. It was found that the participants' suffering was alleviated through the caring act of massage. The major methodological design flaw of this study was that the primary researcher gave the massage and subsequently conducted the interviews, making the influence of bias a strong possibility if the participants were aiming to please the researcher. This is comparable to the findings of Chang *et al* (2002) who conclude that the psychosocial aspect of the massage treatment was significantly valuable to the participants.

Simpkin and Bolding (2004) also discuss the concept of suffering relevant to the care of women in labour. The authors conclude that the evidence so far demonstrates that massage is an effective intervention to relieve pain, enhance well being and prevent suffering. The primary goal of midwives to prevent suffering applies across all forms of healthcare, whether complementary or mainstream. It is with this objective in mind that the provision of massage therapy might be considered.

### 2.5 Guidelines for use

The 'Changing childbirth' report (Department of Health, 1993) established that maternity care should be 'woman-centred' and further that it should enable informed decision making by a pregnant woman. Subsequently a set of standard guidelines were produced by the National Institute for Health and Clinical Excellence (NICE) recommending that complementary therapies should be used as little as possible during pregnancy (Dec, 2003). Tiran (2006) points out that despite the available evidence the use of massage to reduce anxiety and stress was not included in the NICE guidelines, which only acknowledged massage as an effective treatment for lower back pain in pregnancy. (This recommendation remained the same in the revised guidelines of March 2008.)

Tiran also raises the issue that women are considered likely to seek complementary and alternative treatments during pregnancy regardless of these official guidelines, and a risk is that women will not disclose their use to their GP or midwife, because they don't consider it necessary or fear disapproval. While these guidelines may adopt a 'minimum risk' policy, it seems that the potential benefits of massage and indeed other complementary therapies have been dismissed, a policy unlikely to encourage informed decision-making.

### **3.0 Methodology**

The following chapter provides a detailed account of the methodological procedures followed for the execution of this research project. It describes the methods of participant recruitment, data collection and ethical considerations. In depth data analysis procedures are given in section 4.0.

The research reviewed to date regarding massage during pregnancy has tended to pursue quantifiable evidence of the benefits of massage during pregnancy and childbirth. This could be attributed to the demands from the scientific community for proof of efficacy of complementary and alternative medicine. Verhoef *et al* (2002) argue that qualitative research methods can provide a greater understanding of how patients experience a therapeutic intervention, beyond efficacy alone. The aim of this research was to pursue a more qualitative view, and reflect the more holistic nature of the therapy. In order to provide insight into practitioners' views and perceptions of the value of maternity massage, it was decided that this would more likely be achieved through qualitative methodology.

The original research proposal was modified in accordance with class 2 research specifications and feedback received from the research supervisor (Appendix VIII). This involved adapting the proposed aims and objectives to a methodology involving the interviewing of practitioners as opposed to patients. The revised research proposal was approved by the research supervisor at the meeting dated 17<sup>th</sup> December 2009 (Appendix IX).

#### **3.1 Recruitment methods**

Purposive sampling was used (Silverman, 2005) in order to select participants based on their perceived ability to provide the most insightful data. Inclusion criteria were massage practitioners, trained specifically in working with pregnant clients and currently working in the field. Contact details for each participant were obtained from a shared practitioner database compiled from the attendance list of a professional seminar and

book launch. Contact details were included on the database with the permission of practitioners. Potential interviewees were then contacted via email and formally invited to participate in the study. A participant information sheet was included with correspondence (Appendix III). A suitable time and place for interviews was then agreed.

### 3.2 Data collection

Semi-structured interviewing (Walliman, 2005) was considered to be the most appropriate form of interview, to facilitate participant led discussion rather than strict question led response, but with a basic structure guiding the interview around particular topics of interest (Appendix IV). Open questioning was used (Payne, 1979) to allow exploration of the practitioners' experiences, perceptions and understandings.

Three interviews were conducted by the same researcher and were 37, 37, and 29 minutes in duration. Interviews were recorded using an Olympus WS-311M digital voice recorder. Immediately following the interview audio recordings were transcribed and formatted appropriately (Appendix V, VI, VII). Thematic analysis was then used to analyse data, and a description of this methodology is further detailed in section 4.0.

### 3.3 Limitations

It is acknowledged that the researcher's attempt at rapport building may have introduced bias to the interview process and the difficulties in remaining 'neutral' were considered. This was largely confounded by the relative inexperience of the researcher and inherent enthusiasm for the subject matter. A further difficulty encountered with the method of semi-structured interviewing was the subsequent analysis of data, and the organisation and management of data which presents in such a loose format.

Keats (2000) advises that pilot interviewing is an appropriate method of refining interview technique, however due to time limitations of this project, this was not possible. Although interview transcripts were revised thoroughly to ensure accuracy, verification from the interviewees would have been

desirable to increase validity of the data. Again, due to time limitations this was not possible.

### 3.4 Ethical considerations

Prior to commencement of interviews participants were provided with a written informed consent form, which was signed in all three cases. A copy of this is provided here (Appendix II) but signed forms are not included to protect the anonymity of participants. The consent forms, audio recordings and transcripts are stored and protected with the researcher in accordance with the Data Protection Act 1998. The anonymity of participants has been further protected by removal of names and places from interview transcripts.

#### **4.0 Data analysis and results**

Data were recorded in the transcribed interview texts (Appendix V, VI, VII) and thematic analysis used as the means to analyse these. Thematic analysis is a process of identifying codes, categories and themes within the data, leading to an emerging broad generalised theory (Braun and Clarke, 2006). The advantage of using this method is the active role of the researcher in identifying key themes, which serve to answer the research question. As the aim of this study was to explore the experiences and views of practitioners and analysis was intended to be largely data driven, as opposed to theory driven, thematic analysis was considered the most appropriate method.

Shortcomings of this method are such that researcher bias can potentially influence which themes are selected for inclusion in the analysis, depending on which themes are considered to be of interest, and the disregard of others. This may impose limitations on the depth and scope of data analysis. As Ely *et al* (1997) points out, themes do not necessarily reside in the data, but in our own thinking and understanding of the data.

The procedure followed for data analysis was a process of six phases, as set out by Braun and Clarke (2006), although this was not necessarily a linear process and involved moving back and forth between the data set, the initial codes, categories and themes, and the relevant literature. Themes were continuously refined and developed. According to Denscombe (2003) there is a point at which saturation is achieved through on-going analysis, where no further themes or theory can be developed from the data. Due to the time limitations of this project, it is considered by the author that saturation point was not achieved and that there is potential for the further development of data analysis.

Familiarisation with the data allowed for key points and initial themes to be identified through word circling, underlining and margin notes. Initial codes were alphabetical and numbered sequentially when a similar word, phrase or topic was repeated. Walliman (2005) advises that coding facilitates the

organisation of data and initiates the process of conceptualisation. In this case an 'open coding' method was adopted to provide an index for the generation of theory. Appendix I displays the initial coding chart, with a summarised extract of corresponding text.

Coding was conducted manually which was advantageous in that it allowed the author to become deeply familiar with the data, however it was time consuming and use of a computer software programme such as NUD•IST (Silverman, 2000) may have provided a more efficient method of doing this. Initial codes were then condensed into broader categories which subsequently evolved into two distinct parts: categories pertaining to the value of maternity massage, and secondly categories pertaining to future development and integration of the therapy. These categories were then revised and refined, cross-referenced with the entire data set to evaluate overall context, and a definition of the final key themes was given, as detailed in tables 1 and 2. This continuous process of reduction and interpretation is a typical analytic procedure for qualitative data (Marshall and Rossman, 1999). Key themes were then analysed in depth in relation to the available literature, and a detailed discussion is presented in section 5.0.

Table 1. Part I Final themes: The perceived value of Maternity Massage

<b>The perceived Value of Maternity Massage</b>	
<b>Final sub-themes</b>	<b>Over-arching theme</b>
<ol style="list-style-type: none"> <li>1. Woman centred support through the therapeutic relationship</li> <li>2. Supports health and wellness</li> <li>3. Supports the partner and family relationships</li> <li>4. Complementary: supports primary care</li> <li>5. Supports choice of a non-medical alternative</li> <li>6. Supports the baby</li> </ol>	Support

Table 2. Part II Final themes: Integration and Future Needs

<u>Integration and Future Needs</u>		
<u>Final sub-themes</u>		<u>Over-arching themes</u>
<u>Needs</u>	<u>Potential outcome</u>	<u>Potential outcome</u>
<ol style="list-style-type: none"> <li>1. Definition of roles and clear boundaries.</li> <li>2. Thorough training</li> <li>3. Improved inter-professional communication</li> <li>4. Increased accessibility to lower income demographics.</li> </ol>	<p>Increased awareness Changing attitudes</p>	<p>Collaboration Integration</p>

## **5.0 Discussion**

The following discussion aims to summarize and reflect the perspectives of the participants in a succinct form. The core themes that were interpreted by the author from the data will form the structural framework of discussion. This stage of contextualising the emergent themes with existing theory is central to the analytical process and interpretive act, (Marshall and Rossman, 1999). Within the core themes identified there are sub-categories providing richer detail.

The discussion is in two parts according to the overall key themes identified. Part I provides a discussion of the value of maternity massage, specifically relating to the original research aim, as detailed in Table 1. Part II presents a summary of future needs for integration of the therapy as shown in Table 2. Citations provided in the following discussion are identified by participant number and line number eg: P2:106.

### **Part I**

#### **5.1 Support**

Data analysis demonstrated that the value of maternity massage, as perceived by the participants, was multi-dimensional. Furthermore, a fundamental theme which seemed to encompass and permeate all sub-themes was identified: the concept of support. Explicitly the theme of support emerged through the repetition of the word itself by the interviewees. Bryman and Burgess (1994) advise that themes can be generated through the repetition of words. The more implicit nature of this theme was revealed as analysis evolved.

#### **5.2 Woman-centred support**

All three practitioners identified the asset of time as a key factor adding to the value of care they provide (P1:413) (P2:306) (P3:209,212,224,302,308). A relationship between time and the value of continuous support is considered here. During the antenatal period P3 comments that 'most women will see a different midwife every appointment they get' (198). Whereas, through

regular meetings with the client, P3 felt that 'we're really building up a really good relationship' (217).

Further to this a comparison was drawn to the lack of time available to midwives, comments such as 'there's so many things that go towards keeping birth normal that often the midwives don't have time to do' (P3:307) and 'they have to write so many notes' (P3:301), suggesting that provision of continuous care in labour is not necessarily a reality. Additionally P1 comments that '...a lot of the time in hospital... women are on their own, so there is a role for the bodyworker anyway' (313).

Research into the value of continuous support throughout labour is extensive (deserving discussion beyond the capacity of this paper), particularly in relation to reducing the need for medical intervention (Hodnett *et al*, 2005) such that it is recommended as standard practice for women in established labour (NICE, 2007). However Essex and Picket (2008) suggest that this is not a reflection of reality given the constraints on midwifery services.

The notion of woman-centred support was also prevalent in discussion of the postnatal period. While physical rehabilitation forms a key aspect of this work (Table 3), psychosocial aspects and supporting transition into motherhood were also considered key. P2 considers the potential isolation of new mothers in their community, and from this perspective;

'Massage is useful in that it connects the woman to someone who is local, who for that time, is purely for them, who they can talk to... and be emotional with if they want to, who's job is there to try and help understand them, and because they're local, have connections to other [professionals] who might be helpful for them.' (233)

Emotional support was consistently identified as a key aspect of treatment (P1:79) (P2:254) (P3:300,314). This reflects the holistic nature of the therapeutic encounter, that extends beyond the massage itself and the uniqueness of support provided by the practitioner. As P1 further affirms;

‘It’s more fundamental support for women and their bodies, supporting their changing bodies and their changing emotions in preparation for birth and motherhood.’ (77).

### 5.3 Health and wellness

Massage as a means of supporting health during pregnancy was identified as a motivating factor for some women, ‘they just come as sort of their regular health thing’ (P1:105) with a focus on ‘keeping well’ (P1:117, P2:8).

All three practitioners frequently discussed supporting the physical demands of pregnancy, and physical rehabilitation in the postnatal period. Table 3 summarises the main physical issues identified that massage therapy can aim to treat.

<b>Physical issue – Prenatal period</b>	<b>Text reference</b>
Sickness / Nausea	(P1:101, P3:188)
Oedema	(P1:113, (P2:15) (P3:189)
Back ache / Postural issues	(P1:110) (P2:14,29) (P3:184)
Circulation to and positioning of the uterus	(P3:179)
<b>Post natal period</b>	
Gathering / closing of <i>rectus abdominus</i>	(P2:40) (P3:360)
Aids uterus to involute	(P3:363)
Muscular tension due to lifting and carrying	(P2:260)
Pelvis re-alignment	(P3:360)

Table 3. Physical issues and treatment aims

This summary is representative of some of the treatment aims identified by these practitioners.

Integrating exercise techniques was also acknowledged as a treatment strategy important for supporting long term health (P1:9,332) (P2:44,263), and for preventing issues such as uterine prolapse in later life (P1:341). It was suggested that ‘If the woman is properly supported in the postnatal

period, it's support for her health for the rest of her life'. (P1:339). This theme is cross-linked to the theme 'supporting primary care' (section 5.4) in that preventing future health issues can potentially save future NHS resources.

Relaxation was consistently identified as a key therapeutic value in supporting the health and wellness of pregnant clients (P1:53,115,182,280. P2:8,294,296,299. P3:173,316,364.), in fact P1 considers that;

'relaxation in labour is one of the prime things that actually supports the whole process. So actually it's not a pampering, it's quite fundamental.' (367).

#### 5.4 Complementary: supporting primary care

It is interpreted from this data that by providing a referral option for midwives, the massage practitioner can potentially alleviate some of the demands on maternity services. Midwife referrals were acknowledged by P1 (63,98,100). P3 further discusses this support to primary care service through the therapists' role in the delivery room, '...most of the midwives are really great and are just really grateful, because they're so under-staffed and so over worked' (278).

Also the use of massage in preventing or avoiding medical intervention such as caesarean section was discussed (P1:149,174,302-310.) (P3:259,335,341). This can be considered a potential preservation of NHS resources, particularly the financial costs of procedures such as caesarean section, cited as £760 more than a vaginal delivery by McAleese, (2000).

This concept that maternity massage can support primary care, and should be utilized as a *complementary* not *alternative* therapy, was emphasised; 'Its important ... that my care isn't seen as a substitution for any of her primary care' (255). This emphasis also highlights the need for clarification of roles and boundaries (Table 2). This theme is further discussed in section (5.81)

### 5.5 Choice: a non-medical alternative

It may seem contrary then, that massage can provide a non-medical alternative. In clarification, massage was identified as a useful option when pharmacological drugs are unsuitable 'Often [the midwives] refer the women to me because, if they have sickness or something like that there's obviously not drugs they can take' (P1:100). Providing alternative choices to women at full term when delivery is over-due if 'they don't want to be induced' (P1:69) was also noted.

As previously highlighted (section 5.2) continuous support during labour has been acknowledged to reduce the incidence of medical intervention (Hodnett *et al*, 2005). The concept of 'supporting normality' was a recurrent theme in the data that participants used in the context of avoiding medical intervention (P1:124,432,447), for example P3 states that;

'you can never really say for definite but I feel pretty damn sure that they would've had caesareans if I hadn't been there, keeping the birth normal as it were.' (P3:335)

The interesting issue arising within this theme of normality is the notion that pregnancy and childbirth has become medicalized. Cahill (2000) suggests that the perception of a pregnant woman as 'abnormal', that pregnancy is pathological, requiring medical intervention prevails in society. Jordan and Murphy (2009) further the discussion by suggesting that there exists a distortion of risk factors in pregnancy by the medical profession, thus normalizing the use of technology in caring for pregnant women.

Duden (1993) discusses extensively the philosophical concept that as a result of this medicalization women have somehow become disembodied. Where a woman's intuition and knowledge of her own body was once the most valuable resource during pregnancy and childbirth, this has been replaced by the development of medical technology and monitoring. Interestingly, all three interviewees discuss the concept of the woman's 'connection' to herself and her body (P1:116,183). (P2:311,316). P3

describes the experience; 'I very clearly feel that... they connect to the womb specifically' (311). Further to this P1 asserts that;

'I personally think its time to focus on getting back some of that sense of the joy, and the normality, and the life changing aspect of it. You know, it isn't just about safety.' (446).

### 5.6 The partner and family relationships

Another interesting concept to emerge from the practitioners' testimonies was their aim to facilitate supportive interaction between the pregnant woman and her partner. This often involves instructing the partner in massage techniques and essentially encouraging him to assume a care-giving role (P1:358) (P2:76,94,103,343) (P3:242,305). P2 describes that this has also included older siblings, and using massage as a way of facilitating interaction and bonding within the family, this was inspired by the view that 'there's a lot of families now that have got siblings from other relationships that are much older, so to bring them in and to include them' (67). This can be related to the psychosocial aspect of support discussed in section 5.2.

Further meaning can be added to this aspect of practice by a study from Yim (2000). Women's ratings of partner participation during labour and subsequent maternal outcomes were measured. Among the forty-five participants a positive relationship was found between partner support and reduced pain relief dosages and total length of labour. Interestingly, it was found that fathers were more likely to offer emotional and psychological support with less physical involvement. Fathers were also observed to be less interactive when the mother was in discomfort. The author concludes that it is the midwife's role to prepare fathers to provide practical and psychological support to women.

### 5.7 The baby

The provision of massage and bodywork with maternity services was brought to the forefront of discussion recently, at a seminar delivered by the organisation Well Mother ©. It was suggested by the obstetrician speaker

that a role for the massage therapist in the delivery room was unlikely and potentially detracting from the care of the infant in the postnatal period. When questioned interviewees unanimously felt that on the contrary, to care for the mother is to care for the baby by-proxy (P1:327,352) (P2:239) (P3:175,348,369,383). In particular massage was regarded as a means of supporting breastfeeding (P1:345). This was summarised by P3 who states that;

‘the healthier the mother is, the more able she is to look after her baby properly and well. So she’s more likely to breastfeed, and breastfeed for longer, and she’s more likely to bond with the baby much better. All of that stuff is ultimately better for the baby, because it helps the baby to grow and thrive and be healthy both physically, emotionally and mentally as well.’ (383)

## **Part II**

### **5.8 Integration and future needs**

In addition to the themes relating to the research aim, some other themes emerged concerning the potential for future development in the provision of maternity massage (Table 2). It is considered appropriate that these themes be summarised here, in the hope that they may highlight some relevant issues to professionals in the field.

#### **5.81 Definition of roles and clear boundaries**

The practitioners also expressed a clear referral policy for operating within the limitations of their practice (P1:121) (P2:17,122,136), or discussing treatment strategies with a supervisor (P3:126). P1 states that ‘It’s important for the therapist to know their role. I would never try and take over the role of the primary care giver.’ Furthermore it was highlighted that ‘[the midwife] is ultimately responsible if anything happens the mother or the baby (P1:318).

#### **5.82 Thorough training**

The need for massage practitioners to undertake a thorough training in order to treat pregnant women is clearly demonstrated by the data. All three

participants referred to their training or extensive experience as essential for safe practice (P1:239,330,349) (P2:128) (P3:126,153).

#### 5.83 Improved communication

When questioned regarding communication with other health professionals it was often the case that regular correspondence did not happen (P2:159) (P3:135). Three main reasons for this were identified. Firstly P3 asserts that 'they don't know anything about massage anyway' (P3:140). Secondly, P1 considered that the medical staff are often too busy to correspond (143). Thirdly it was felt by P2 that a lack of medical knowledge and therefore lack of confidence to communicate in medical language was a deterrent (P2:159-166).

#### 5.84 Wider accessibility to lower income demographics

All three participants identified their main client users as being 'educated' 'middle class' and 'professionals' (P1:60,71) (P2:171) (P3:61), and it was consistently viewed as 'as shame' that this was the case (P1:75) (P2:186) (P3:62). This seems to demonstrate that the provision of maternity massage is exclusive to those who can afford it. The option to be subsidised in local family centres was highlighted by P1 (59) as way to expand the provision of service. However, P2 points out the problem that 'they also want you to do it pretty much for free, which I couldn't do either' (196).

It can be speculated that through the development and application of these strategies, some potential outcomes may be reached. These are summarised as: i) Increased awareness of maternity massage, its potential benefits and uses, ii) Changing attitudes of both mainstream and complementary care providers towards each other and the prospect of integration, and ultimately iii) Professional collaboration and integration of massage with mainstream maternity care.

## **6.0 Summary, Conclusion and Recommendations**

The original aim of this research was to explore the value of maternity massage through qualitative interviewing of practitioners in the field. This report has provided a reflection of the attitudes and experiences of three practitioners and also some insights into their current practice.

Thematic analysis revealed six sub-themes embodied by an overarching theme; that of support. The concept of support is identified as the key value provided by maternity massage, not only for the childbearing woman, but also for her partner, their baby, and the primary care providers. Maternity massage is therefore interpreted as holistic by nature, providing physical and psychosocial support.

The results of analysis also revealed a greater clarity of what strategic approach may be implemented to facilitate the further provision of maternity massage alongside mainstream care. This would include a clearer definition of roles and boundaries and thorough practitioner training and education. It would also require a conscious effort to improve inter-professional communication. Consideration must also be given to increasing the accessibility to lower income demographics. It is speculated that implementing these strategies may increase awareness of maternity massage, encourage professional collaboration and potentially improve attitudes towards the prospect of integration.

While the author is satisfied that original aims and objectives have been fulfilled, some limitations are acknowledged. The small sample size is considered the main limitation on validity of findings. Also the short duration of interviews (thirty minutes) meant that opportunity for deep exploration of issues was constrained.

The findings revealed through thematic data analysis were also limited given that saturation was not achieved (Denscombe, 2003). Due to the limited depth and scope of this study it was challenging to discuss each theme in worthy detail without compromising the depth of discussion of others.

Inevitably the author was led to consider some themes in greater detail than the rest. It is therefore recommended that further research should consider the value of maternity massage in four separate categories:

1. The pre-conceptual period
2. The antenatal period
3. Intrapartum care
4. The postnatal period

The findings of this study are based on the perspectives of maternity massage practitioners; a subsequent study exploring the value of maternity massage from a client perspective could serve to further enhance the research. If the ultimate goal is to improve attitudes towards the prospect of integration, then first we must understand those attitudes, and what implications they have on current policy and practice. Further studies could therefore potentially involve midwives, obstetricians and doulas.

A considerable amount of research is available for the uses and effects of massage during pregnancy and childbirth, as discussed in the literature review, yet it seems that relatively few of these studies used qualitative methods to evaluate them. With this in mind it is hoped that this study will add some depth to the qualitative research, and provide a base from which it can be developed further. Such research may serve to inform the practices of healthcare professionals in the field of maternity care.

Finally the author is keen to acknowledge all care workers, mainstream and complementary whose primary aim is the provision of support to childbearing women. Additionally it is emphasised that the utmost respect is given to the midwifery profession and the indispensable role fulfilled by the midwife is humbly acknowledged.

Words 6,094

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## Appendix I Initial coding chart

Initial code	Transcript line number	Key point (Text summary)	Developing category	Defined theme
A1,A2, A4,A5, A6,A7,	(P1:153,171,236, 258,277,287) (P3:220)	My role is secondary to the primary care giver.	Roles and boundaries	Need: Definition of roles and boundaries  Integration
A2,A8, A10, A1	(P1:295,381) (P2:118) (P3:145)	It's important for the therapist to know their role		
A4	(P2:136)	I will always refer the woman if there is a problem.		
A5	(P3:296)	My role is to support the mother.		
A9	(P1:318)	The midwife is ultimately responsible for the mother and the baby.		
B1,B2	(P1:10,69,106) (P3:7-14)	I let people choose the nature of their treatment.		
B3	(P1:283)	I support the woman to make choices.		
C1,C2	(P1:13,167) (P2:308) (P3:128)	I integrate energy work with the massage session.	Energy medicine	Complementary Support
D1,D2	(P1:19,37) (P3:22)	Massage can support fertility.	Fertility	Supports Health and Wellness

E3, E2,E4 E5.E6	(P1:358) (P2:76,94, 103,343) (P3:242,244,305)	I involve the partners and instruct them in massage techniques.	Partners and relationships	Supports the partner and family relationships
E1,E3	(P2:64,85-92)	I have involved other siblings in the giving and receiving of massage.		
E2	(P1:120)	Birth preparation can involve the partner.		
F1,F2	(P1:20,34) (P3:27)	I consider myself / my therapy to be specialist.	Specialist	Need: thorough training  Integration
F6,F7, F8,F1 F2	(P1:239,330,349)  (P2:128) (P3:126,153)	Appropriate training is necessary.		
F5	(P1:223)	Practitioners can be too afraid to work with pregnant women.		
F3,F4	(P1:126,166)	I'm trusted because I'm experienced.		
F2	(P2:164)	I feel that I don't have enough medical knowledge.		
G1,G2, G3,G4, G6,G16	(P1:36,53, 77,109,122, 174,417)	Its fundamental support for women.	Support	Supports health and wellness

G7,G8, G9,G10, G11,G12, G15,G3	(P1:186, 189,274, 281,301, 313,407) (P2:50) (P3:231,288)	I have supported women in labour.		
H2,H3	(P1:64,69)	Some women come to me when they don't want to be induced.	Non-medical alternative. Supports choice.	Supports a non-medical alternative.
H4	(P1:101)	Pregnant women can't always receive medication.		
H5,H6,H7	(P1:149,174,302-310) (P3:259,335,341)	Massage can help to prevent medical intervention, and keep birth natural.		
T2	(P1:314)	Women are often left on their own during labour.	Continuity of care	Woman-centred support
I1	(P3:198)	Women often see a different midwife every appointment.		
I2	(P3:217)	I build strong relationships with my clients through continuous support		
J1	(P1:45)	I work alongside the IVF treatments.	Complementary	Supports Primary care
J2,J3	(P1:158,251)	I work alongside medical care.		
J5,J6	(P1:453,470)	Different perspectives and knowledge can be integrated.		

K1,K2, K3,K4	(P1:53,115,182, 280) (P2:8,294, 296,299) (P3:173,316,364)	Relaxation is a key benefit.	Relaxation	Supports Health and Wellness
O13	(P1:367)	Relaxation in labour is fundamental.		
L1,L2, L3	(P1:60,62, 71) (P2:171) (P3:61)	Most of my clients are middle class, educated, professional women.	Demographics and exclusivity	Integration
L2	(P2:180)	I need to charge fees which are not affordable for many women.		
L4,O4 L2	(P1:75) (P2:186) (P3:62)	It's a shame it's not available to everyone.		
M2,M5 M4,	(P1:9,332) (P2:44,263)	I integrate exercise with massage.	Physical support	Supports Health and Wellness
M1M3, M4,M6	(P1:78,110) (P2:12,19, 28,40,260) (P3:184,188,189)	There are several physical symptoms I can work with.		
N1	(P1:97)	The midwives refer women to me.	Referral option	Supports Primary care
O1,O5 O6	(P1:51,146) (P3:270)	The medical profession don't seem to be antagonistic to it.	Attitudes and awareness. Education	Needs: Improved communication, Greater awareness, Changing attitudes, Collaboration and Integration.
O2	(P1:76)	I think massage should be integrated with maternity care		

O1	(P2:80)	Massage therapists don't have a reputation for supporting women in labour.		
O3,O6, O12	(P1:329) (P2:177,204, 206)	Massage can be perceived as a luxury or pampering not a health support.		
O3	(P1:99)	There are myths and controversies about working with pregnant women.		
O2	(P1:122)	Women with high-risk pregnancy find the medical attitude stressful.		
O1	(P1:291)	Medical staff don't often ask me about my qualifications.		
O3,O12, O6	(P3:140)	Medical staff don't understand about massage.		
O4	(P3:278)	Medical staff appreciate my support.		
O11	(P1:228)	I'm not anti-medicine.		
O10	(P2:143)	I've had bad encounters with medical staff in the past.		
O5		Relaxation can be undervalued.		

O1	(P1:179,394,398,429)	Massage can offer a different approach to pregnancy and childbirth.		
O7		I would like to research the benefits of massage more.		
O2	(P3:79,105,377)	Massage is more understood in other cultures than in ours.		
P1,P2,P3	(P1:105,109,117) (P2:8)	Women come with a focus on keeping well.	Wellness / Health	Supports health and Wellness
P4	(P1:338)	Massage and exercise can prevent future health problems.		
G1,G2	(P2:43,48) (P3:215)	I can advise women about health and maternity issues.		
M1	(P3:359)	Massage and exercise is important and beneficial in the post natal period		
Q2,Q1,Q3	(P1:345)	Massage can support breastfeeding.	Benefits baby	Supports the baby
Q1	(P1:327,352) (P2:239) (P3:175,348,353,369,383,386)	If the mother is supported, the baby will benefit.		

E4	(P1:450)	A woman's experience of child bearing can affect the way she relates to the baby.		
R1	(P1:79) (P2:254) (P3:300,314)	I give emotional support to the mother.	Emotional support	Supports Health and Wellness
S1,S2	(P1:119,357)	I offer birth preparation work.	Birth preparation	Supports Health and Wellness
T2	(P1:314)	The midwives don't have time to be with the women throughout labour.	Fills gap in maternity services	Supports Primary care
T3	(P1:337)	Postnatal care can be very basic.		
P2	(P2:232)	I can connect women to their local community.	Woman centred support	Woman centred support
U1	(P3:7)	I can provide massage to the woman in her home.		
V1,V2	(P1:116,183) (P2:311,316)	Massage treatment can help the women to connect with her un-born baby.	Connection	Supports Health and Wellness
W2,W1	(P1:413) (P2:306) (P3:209,212,224)	I have time to spend with the client.	Time	Woman-centred support
W1	(P1:181) (P2:291,294)	I provide space and time out for the woman.		
W3	(P2:306) (P3:302,308)	I have more time than the midwives.		

X1,X2	(P2:131,135) (P3:121)	I take a thorough consultation.	Risk / safety	Need: thorough training
X1,	(P1:121)	I refer women if necessary.		
X2	(P3:115)	I work with high-risk pregnancies.		
Y1,Y2, Y3	(P1:124,432, 447) (P3:307,336,341)	Massage helps to support the normality of pregnancy and birth.	Normality	Supports Health and Wellness
Z1	(P2:159) (P3:135)	I don't often correspond with medical professionals.	Communication and collaboration.	Collaboration Integration
Z1	(P1:143)	Medical professionals are too busy to correspond with me.		
Z1,Z2, Z3	(P2:281) (P3:138,143)	I can feel confident about communicating with some health professionals, but not others.		
Z2,Z3	(P1:150) (P3:277)	I have collaborated as part of the team in a hospital setting.		

## Appendix II

### Informed Consent Form

'The value of massage during pregnancy and childbirth: An exploration of practitioners' views'

I agree to take part in the above study. I have read the participant information sheet and the researcher has explained the project to me.

I am willing to be interviewed by the researcher for approximately 30 minutes.

I agree that the researcher may audio record my interview.

I understand that participation is voluntary and that I may withdraw up to two weeks following the interview.

#### **Data Protection**

I understand that any information I provide will be kept confidential and that no identifying details will be disclosed in the written report of the project or verbally by the researcher.

I understand that any information I provide will only be used for the purpose of this research project, and any associated academic papers.

Name (Print): \_\_\_\_\_

Signature: \_\_\_\_\_

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

## **Appendix III            Participant Information Sheet**

### **‘The value of massage during pregnancy and childbirth: an exploration of practitioners views’**

#### ***What is the purpose of this study?***

As a final year student on the BSc (Hons) Complementary Therapies degree I am required to undertake a piece of original research. For this project I am investigating the views and experiences of massage practitioners who specialise in working with women during pregnancy and / or childbirth. I would like to understand more about the practice of treating pregnant women with massage, the perceived benefits and potential risks, and any special case management strategies you have employed. I am interested in your views and experiences of how massage therapy can be integrated with normal maternity care.

#### ***What will taking part involve?***

You will be asked to take part in a one to one interview with me that should take no more than thirty minutes. We will agree a suitable time and place for meeting, which can be at your clinic or practice, or at the University of Westminster. If you agree to take part in the study, I will ask you to sign a consent form, a copy of which you can keep. I will need to record the interview and I may also take field notes. The interview will be an informal discussion about your views, opinions and experiences. There are no fixed questions but I have a number of areas relating to the topic which I will highlight.

***What if you need to withdraw from the study?***

My final report for this project is due for submission on 27/05/2010. Due to academic requirements I can accept your withdrawal from the study up to two weeks after the interview. The audio recording and transcript will be destroyed and you are not obliged to give a reason.

***What happens afterwards?***

A transcript of your interview will be typed up, this and the audio recording will be kept on my personal computer but will not contain any information that could identify you. Only written quotes from your interview will be used in my report, not the audio recording, and your identity will remain anonymous.

I will not discuss your identity with anyone.

All data use will be in accordance with the terms of the Data Protection Act 1998.

On completion I will provide you a copy of my project.

**Contact details for further information and/or complaints.**

Researcher: Karen Simpson

Email: [k.simpson@mywestminster.ac.uk](mailto:k.simpson@mywestminster.ac.uk) Telephone 07932 597506

Project Supervisor: Nicky Howard-Kemp

Email: N.J.Howard-Kemp@westminster.ac.uk

## Appendix IV

### Interview Structure

#### Introduction

- Thank you for the opportunity to come and meet with you today.
- Are you clear about the process of the interview?
- Are you happy to begin?

#### Questions

1. So to begin, can you describe a bit about yourself and your practice, for example the type of setting you work in, what kind of massage or bodywork you offer?
2. What brought you to this area of specialist practice?
3. In what way do women tend to make initial contact with you?
4. What are your perceptions of the women who come to you for treatment?
5. What kind of particular pregnancy symptoms or conditions might you aim to treat?
6. How do you perceive that massage and bodywork can support pregnancy?
7. Can you describe the kind of therapeutic relationship that you develop with your pregnant clients? (what is it about the relationship they have with you that differs perhaps from the relationship they have with their midwife or obstetrician?)
8. Can you describe the relationship you might have with your client's primary care givers, for example the GP the midwife?  
(Communication, liason, referrals)
9. Are there any obstacles to effective communication between you, the client and her primary care givers?
10. What are your perceptions of risk associated with treating pregnant women?
11. How do you manage risk within your practice? (eg Complicated pregnancy, how would it affect decision to treat?)

12. How might you discuss risk with your clients?
  13. How does your therapy relate to the preparation for labour and birth?
  14. As a practitioner, have you ever assisted a woman through labour and birth? (Can you describe that experience? Is it part of your regular practice?)
  15. In terms of the integration of massage and bodywork with normal maternity care, what are your views on the current situation?
  16. What do you think are the obstacles to integration? What problems do you face / have you faced in providing your service?
  17. One of the key issues raised at the recent Well Mother seminar was the idea that bodywork / massage therapists may have an important role to play in the antenatal period, but that this does not or should not extend to the delivery suite or the post natal period. What are your views on this?
  18. What value do you think your therapy has for your clients?
  19. What value does it have for you?
  20. How do you perceive your role as a complementary practitioner?
- If time left...
21. I'm interested in the cultural differences between Eastern and Western approaches to pregnancy and childbirth. How do you think our western medical model of maternity care might be influenced or informed by Eastern approaches?

### Closure

- I'm very satisfied with everything we've discussed, before we finish is there anything you would like to clarify or discuss further?
- Are there any questions you would like to ask me?
- Thank you for your time.

## **Appendix V            Interview transcript P1.**

Interview with participant 1 on 10<sup>th</sup> March 2010. Duration: 37:15 minutes

1    **I: So first of all I just wanted to get a bit of background about your**  
2    **practice, the kind of setting that you work in, um, what kind of massage**  
3    **and bodywork you actually offer.**

4

5    P1: Right. Ok. Now I mean I have done more in the past but because I do quite a lot  
6    of teaching, then I have worked in clinics and clinic situations and hospitals but now  
7    I have a room in my house because I need that flexibility because I'm away teaching  
8    and I mostly offer massage and shiatsu so I'm trained in both of those and  
9    sometimes some exercise but I sort of integrate that as part of the sessions but it's  
10   um, I let people choose, often I do a combination of the two so I might do some  
11   shiatsu with a little bit of say massage on the abdomen or specific areas sometimes  
12   I just do massage but even if I just do massage I tend to integrate a bit of energy  
13   work with it as well.

14

15   **I: Yep, ok. Do you just work with pregnant women?**

16

17   P1: No I mean that's how I advertise my work but I do have..(3<sup>rd</sup> party  
18   interruption, P1 loses continuity of sentence) um yeah so, but the majority of  
19   my clients are pregnant or trying to conceive or um post natal. But I don't, it's  
20   not that I don't work with other people but that's what I consider my speciality  
21   so I mean I do have some male clients sometimes partners but actually  
22   sometimes it's the partners of the women that I've been working with but any  
23   advertising I do, I sort of, its in the realm of pregnancy and birth.

24

25   I: Ok. So that's interesting you actually work with people trying to conceive?

26

27   P1: Yeah, yeah.

28

29   I: Can you tell me a bit about that? Um, I mean, do women come to you with  
30   fertility problems as such?

31

32 P1: Yeah, yeah, and increasingly so I think because people know that I know  
33 about pregnancy, and I sort of advertise specialising in women's health, and  
34 actually with the menopause as well I work a bit with the menopause so,  
35 yeah over the years, I mean I have supported some women when they've  
36 been, some women have come and they've conceived naturally, how much  
37 that's due to the massage or shiatsu, I mean I always think at some point I'd  
38 like to have a centre where I can actually collate much more detail and have  
39 students and supervise clinical practice, but I've just got my client notes and  
40 my memory of the clients, so, but quite a few people have conceived  
41 naturally and then its nice because then they, I think also why they do that  
42 because then they carry on coming to me during their pregnancy because  
43 I've worked with them before. Some people I have supported while they've  
44 been going through IVF as well, so I use the shiatsu and massage alongside  
45 IVF treatments.

46

47 I: Do you think that's something that the IVF clinics, would they encourage to  
48 refer the women to you?

49

50 P1: I haven't specifically had referrals but they don't seem to be antagonistic  
51 to it, I mean as far as I can gather their approach has been well if it helps you  
52 be relaxed and if it supports you then why not?

53

54 I: Yeah, Ok. So what are your perceptions of the women that come to you? In  
55 terms of perhaps social groups or ethnic groups?

56

57 P1: Yeah I mean that's the thing that's why I, ultimately I'd like to have a  
58 centre, and do more kind of outreach work and subsidised in local clinics  
59 because it is true, the majority of my clients do tend to be middle class, you  
60 know obviously they've got to be able to afford the massage so they do tend  
61 to be generally professional women or yeah, generally, but I do occasionally  
62 have, sometimes the midwives do refer people for, at the end of pregnancy

63 more for sort of one off sessions if they're going overdue. Because I've been  
64 working in this field quite a long time so a lot of the midwives in [REDACTED] know  
65 me, and so they'll say "well why don't you go and have a shiatsu or a  
66 massage?" and then they might just come for a one off session. So I do have  
67 some, sometimes I do have you know more sort of working class women who  
68 just come because they don't want to be induced. But generally the women  
69 that tend to come more through the whole pregnancy tend to be much more  
70 middle class women who have the money to be able to afford to do that.

71

72 I: Yeah. Yeah. Like many of the complementary therapies, I think.

73

74 P1: Yeah. It's a shame. Which is why you know I have this idea about them  
75 being integrated because I think it should be. Because often its seen as a  
76 luxury and pampering, whereas I think its, its more fundamental support for  
77 women and their bodies, supporting their changing bodies and their changing  
78 emotions in preparation for birth and motherhood. Its kind of a form of  
79 antenatal preparation and childbirth classes which used to be offered more  
80 on the NHS. That could be a way in to offering it, through the Sure Start  
81 centres and things like that as we heard the other day. So I'm always happy  
82 when some of my students can offer in that situation because I don't really  
83 work in that kind of context at the moment it is just private work and that's  
84 why I attract those kind of clientele really.

85

86 I: Yeah I was very interested in the Sure Start projects, I hadn't actually heard  
87 about it.

88

89 P1: Oh didn't you know about those? Oh yeah, maybe you should try and  
90 interview [REDACTED] or, I'm sure she wouldn't mind you using some of the  
91 material she presented in the talk. Because she's on the MSLC.

92

93 I: Yes I'll bear that in mind. So are there any kind of particular pregnancy  
94 symptoms or conditions that you work with?

95

96 P1: Oh ok, the whole lot really! So, I mean actually some of the midwives in  
97 █████ refer women even in the first trimester, which is great because as  
98 you're probably aware there's all kind of myths and controversies about  
99 working in the first trimester. But often they refer the women to me because,  
100 if they have sickness or something like that there's obviously not drugs they  
101 can take, so they say "Well why don't you go and have a massage or a  
102 shiatsu?" So I do get a lot of first trimester women, so that would be, first  
103 trimester tends to be if they have sickness, although if I've worked with them  
104 before they've conceived then they just come as sort of their regular health  
105 thing. So it does depend on the woman's motivation for coming so that's, but  
106 generally that will often be what motivates them if they've not come before.  
107 Second trimester there are likely to be less issues, so again if they've come  
108 in the first trimester often they want to just keep things ticking along, in the  
109 second trimester. But sometimes things arise in the second trimester, like  
110 back ache or, carpal tunnel syndrome, or something like that so sometimes  
111 people do start coming in the second trimester. Um, and then I suppose a lot  
112 of people will come in the third trimester when they might be getting things  
113 like oedema or back ache or, all those sort of pregnancy things. But some  
114 people do just come for relaxation, for connecting with their baby, especially  
115 if its their second or third pregnancy, just for a bit of space, to connect with  
116 that particular pregnancy and baby. Some people come more with a focus on  
117 just keeping well in pregnancy, they don't necessarily have a problem but  
118 they come to be well. Some women come for more sort of birth preparation  
119 type work, which, and involving their partner which they tend to obviously do  
120 that more in the third trimester. Some women do come with high risk  
121 conditions because they want the support of a complementary approach  
122 really, they're getting, they get quite stressed out by the whole medical  
123 attitude towards them and they want something that kind of helps them stay  
124 with the normality of the pregnancy, and they like to come to me I suppose  
125 because they know that I'm experienced, and um, yeah, so I get the whole  
126 range of people really. Do you want me to say post-natally as well?

127

128 **I: I am interested in post natal work, but I just wanted to take you up on**  
129 **the risk management aspect of it--**

130

131 P1: Oh right, the higher risk yeah--

132

133 I: So, you do treat women who are considered high risk, complicated  
134 pregnancies, how do you kind of manage that within your practice? Perhaps  
135 in terms of your relationships with their obstetrician or their midwife?

136

137 P1: Yeah it's interesting I mean I've actually started, as the obstetrician said  
138 the other day, I have a letter, and I'll say "put that with your notes" and it just  
139 says that they've come to see me and if their care giver has any questions  
140 then they can refer back. But the reality is that, you know, much as  
141 [REDACTED] said do that, so its included in their notes, they're busy, and they  
142 don't really have the time to do it. And I always say to them you know, "tell  
143 them that you're having massage and shiatsu and see what they think", but  
144 actually again they seem to be, they don't seem to be hostile, towards it. And  
145 also I mean, in terms of, so I don't have actually, a lot of dialogue, unless I'm  
146 there at the birth, which sometimes I am, then obviously, sometimes I have  
147 gone in with clients who've perhaps wanted a natural birth and they've been  
148 fairly high risk, and then we've had meetings with the managers, so they can,  
149 we can kind of set up a care plan for labour, so they can work out what I'm  
150 doing, and how, so I'm not going to be interfering or anything like that, but  
151 what support I can give and what my role is and the woman can express  
152 what she wants, from the birth. So on that sort of level I've had collaboration,  
153 but in terms of sort of day to day actual exchange of information, not really.  
154 But, what I do with my high risk clients is, they'll tell me what's relevant, um,  
155 and you know I'll ask them information, and a lot of them will let me look a  
156 their notes, if there's you know quite a lot of information. My bottom line is  
157 really if they are receiving appropriate primary care from their consultant  
158 then, you know that's fine, if I had any concerns about something, then I  
159 would always refer them back, and say you know either, if its not particularly  
160 an urgent concern I'll say you know "mention that next time you see your

161 midwife or obstetrician”, but obviously with a high risk one, they’re usually  
162 being monitored quite a lot anyway, to be honest so, and they usually know  
163 quite a lot about their condition anyway, and what to expect, so in that  
164 respect, you know I have an understanding of most of the conditions, so I  
165 don’t tend to need to ask lots of information from the client. I, so because I do  
166 energy work then I’ll support the relevant organs and things, or I’ll, you know  
167 depending on what the condition is I might modify the body work approach,  
168 but I’ll always encourage, you know I’ll never try and... that’s why I see it as  
169 complementary, I’d never try and take over any of the role of the primary care  
170 giver. I see my role as, in those situations... I mean it depends what the  
171 condition is. Sometimes, something like with pre-eclampsia, I find that you  
172 know I am aiming I suppose to try to support them to stop, to have a normal  
173 birth, and hopefully for it not to develop into eclampsia, and I’m always aware  
174 of you know warning signs and things like that to look for, but a lot of it’s also  
175 about just supporting the normality of it in a way, and kind of, because they  
176 do often get quite stressed by all the medical procedures and tests so in my  
177 work I don’t want to focus too much on the medical side. I mean obviously I  
178 need to know what I need to know in order to work safely but I don’t tend to  
179 dwell on it because I think its quite important they have a space where  
180 they’re not thinking about the result of this test or that test, just being relaxed.  
181 They can connect with their baby, you know they could focus on, because a  
182 lot of the time, it’s a risk factor, so actually they could end up with a normal  
183 birth so I’d still, obviously sometimes its very clear cut, they may need a  
184 caesarean so then I’ll support them in preparing for a caesarean but other  
185 times the outcome isn’t known. But it may well be that they have a vaginal  
186 birth and they don’t have any interventions they’re just being monitored, so I  
187 think its quite important to kind of keep supporting, that that’s a possible  
188 outcome as well.

189

190 I: Mm. I mean I’m wondering about how the women might perceive the risk,  
191 of having a complementary therapy, having a massage treatment or a body  
192 work treatment and whether they have an appreciation of risk, because  
193 obviously the concern with integration, perhaps the orthodox practitioners are

194 concerned that we're not competent to deal with the complicated pregnancies  
195 and um, I'm just wondering if your clients would ever be nervous about  
196 having a massage or body work if they were in a, if they were having a  
197 complicated pregnancy, does that make sense?

198

199 P1: Yeah, no it does, I'm just trying to think... I mean, basically if they were  
200 they wouldn't be coming to see me though. I'm just trying to think how I could  
201 answer that in a better way. I mean, sometimes people, I suppose it depends  
202 when they develop the complications. I mean if they know me quite well, and  
203 they've built up a relationship with me, then even if they have a complication,  
204 they have confidence because they know that I've been working for a while,  
205 so they would tend to come back. So I suppose its, because of where I am in  
206 my work that, people do tend to have confidence in me where as I'm sure if I  
207 was just setting, starting up they'd probably be less confident, and they might  
208 think 'oh well she probably doesn't know what she's doing so maybe we  
209 won't go back', and I suppose sometimes if people just come to me for one  
210 offs, then I can't always know, some complication may happen and they may  
211 not feel happy coming back for a massage.

212

213 I: Yeah, So there's trust, there's trust in your relationship, which obviously  
214 helps the process.

215

216 P1: I think also I mean I have had those, someone came, she's actually one  
217 of my case studies in the book because she is a particularly high risk client  
218 and she knew she was high risk when she came, but she had a background  
219 in complementary therapy herself, and so she was really keen on using what  
220 she could out of complementary therapies, and she had rung around quite a  
221 lot of people and they, it was the therapists that were scared, of working with  
222 her, she wanted something, but they were all like 'oh no no we can't work  
223 with you you're too complicated', and she said it was a real relief when I said  
224 that, you know obviously I have to see what's going on but come and we can  
225 talk about it and see how I can work with you. She was also quite happy that

226 I knew, you know I wasn't anti... Because the other thing is either  
227 complementary therapists can be a bit scared and they won't work with  
228 somebody, or they can a bit overstep their role I think, if they don't really  
229 know the implications of the conditions and maybe be kind of critical, overly  
230 critical of orthodox medical care, and I think she was quite, she felt really  
231 happy that she could have both and not feel that I was being critical of or you  
232 know feeling that she'd failed because she did need orthodox medical  
233 treatment as well. So I think it's important for complementary therapists to, for  
234 me that's the integration because we have to know what we can't do as well  
235 as what we can do. For me there's very few cases where I wouldn't actually  
236 work with somebody even if they're high risk, but there are you know, certain  
237 times when, obviously you know like with any client, but there's a few extra  
238 things with pregnancy that you have to watch out for, and so um obviously in  
239 those situations I would refer them on and say you know you need to see  
240 such and such...

241

242 I: So on the one hand it's that the therapists need to have the confidence to  
243 work with the pregnant women, but then also know where the boundaries lie?

244

245 P1: Yeah, and when it's not ok. But there's, I mean to be honest there's very  
246 few cases, it's more when they need emergency medical treatment really  
247 when its getting sort of life threatening and there is a treatment that can help  
248 them that they need, but otherwise you know I find that I can work alongside,  
249 you know if they're receiving drugs or they're being monitored, but it's a  
250 question I always say to people that I train, they're always asked when they  
251 last saw their midwife? What did the midwife say about such and such?  
252 When are they next going to see their midwife? and you know I think its  
253 important to be, even though I don't directly collaborate so much with the  
254 midwives and obstetricians, but I'm encouraging the woman to make sure  
255 she goes and sees them regularly and she's not substituting, that my care  
256 isn't seen as a substitution for any of her primary care.

257

258 I: Yeah, yeah. Um, I feel like you've already said so much about what I was  
259 going to ask you!

260

261 P1: Oh have I? Right ok!

262

263 I: So that's great! Um, there was one topic which came up during the Well  
264 Mother seminar which was the idea that the bodywork therapist or the  
265 massage therapist has a role in the antenatal period but not in the delivery  
266 room, and not in the postnatal period. What are your views on that?

267

268 P1: (Laughs) Yeah yeah. No, I do completely disagree with that and I think  
269 quite a lot of the people there did as well. Because you know as I've said, I  
270 have, obviously I don't get a lot of chance to go in, to people in labour,  
271 support women in labour, in fact it's a real shame there's one of my clients  
272 was being induced on Sunday and she really wanted me to be there but  
273 because I was teaching on Monday I couldn't. But I find, I tend to try to stay  
274 in the background and I don't interfere with any medical decisions that are  
275 being made and I see my role is to support the mother, to stay connected  
276 with herself, and be relaxed, and be in tune with her body, and support her if  
277 she's got to make any decisions, but not so much in an intellectual way but  
278 support her so that she's not afraid, so that she can be relaxed. I mean  
279 sometimes its also supporting her so that she knows that she can chose or  
280 just buying her time if she's being told well you've got to have this now, then  
281 saying, "well how about in half an hour? Is it ok for me to have some  
282 massage or how about in half an hour or something like that?" And often  
283 having a bit of extra time is enough. But I wouldn't sort of really question the  
284 medical treatment. I see my role more as to, you know, very much in the  
285 background, and I let the midwives or obstetricians get on with what they're  
286 doing, and they actually seem quite happy with that. I mean even if they're a  
287 bit sceptical to start with, and I must admit I'm always surprised they don't  
288 ask more about my insurance and this and that but they seem to be sort of  
289 well if the mother wants you to be there then that's fine. I mean that's my

290 situation in my hospital, I don't know how much that is the situation in other  
291 places, but I do think it's important for the complementary therapist to know  
292 their role and obviously not interfere with things. I mean one woman, um, the  
293 anaesthetist was explaining that the, they have to explain all the risks of  
294 general, of epidurals and I was saying to, when they weren't there, I said to  
295 my client well "You know if you're having a contraction and they're explaining  
296 this and you feel it's interfering with you, it's fine to say look I can't talk you  
297 know, you'll have to tell me in between contractions." So I'll support them in  
298 that kind of way but I won't be directly confrontational. Actually this woman  
299 that I was, one woman I was supporting they wanted her to have a blood  
300 pressure drug because they thought her blood pressure was high and she  
301 said "oh, well I've just had my shiatsu and I'm sure my blood pressure will be  
302 low" and they said "no, no, no, we're not going to re-check it because it  
303 definitely at this stage of labour it can't have gone down", and she said "well  
304 look I want you to check it", because she didn't want to have the drug, so it  
305 wasn't me that was saying it, and they checked it and they were like "Oh, oh  
306 well it has gone down and you don't need to have the drug." So by  
307 sometimes just by being there I can support people, but I wouldn't myself say  
308 she doesn't need it because such and such, I always kind of try and get the  
309 mother to communicate and I'm just like I say there supporting the mother.  
310 But I find you know that a lot of the time anyway in hospital unless its really  
311 high-risk, women are on their own. So there is a role for the body worker  
312 anyway. And the midwives, if you're kind of there you know I always ask  
313 "Where shall I position myself? Am I in your way?" and you know, as long as  
314 you're giving the main, you're allowing the midwife to be the main care giver  
315 and in charge, which she is because she is ultimately responsible if anything  
316 happens to the mother or the baby, then they seem ok. So I think there can  
317 be quite an important role during the birth. It's harder in a hospital and it's  
318 easier if you're supporting someone at home but I think a lot of women, you  
319 know if they've been having massage throughout the pregnancy, they find it  
320 quite reassuring to have it during the birth as well. And then certainly the  
321 postnatal period, I completely disagree. Because I think you know, yes the  
322 focus is on the baby but who supports the baby? Who's providing the breast  
323 milk if they're breastfeeding? Who's physically carrying and lifting the baby?

324 It's the mother. So of course you don't want to be taking... I mean I think it  
325 also came from, the obstetrician more had an idea that massage was just for  
326 relaxation, and it was a bit of a self indulgence. But I think an appropriately  
327 trained therapist is doing more than just relaxation. Its you know its helping  
328 with posture awareness and helping remind the mothers about abdominal  
329 exercises, pelvic floor, helping her get back her state of health, encouraging  
330 her to rest and relax. You know even if you're not a nutritionist, just basic  
331 common sense dietary information, things like keeping fluids up, things like  
332 eating nourishing foods and not snacking on sugary snacks. Women often  
333 need that sort of other support person especially because post natal care  
334 these days is very basic. Women don't get a lot of post natal care and to my  
335 mind, a lot of the long term health issues for women, you know if the woman  
336 is properly supported in the post natal period, its support for her health for the  
337 rest of her life. If she's not, she may not, she doesn't do abdominal exercises  
338 she may have uterine prolapse twenty years later. If she doesn't do proper  
339 work after having a caesarean you know she may have issues later on. So I  
340 actually think it is quite, for me it doesn't detract from looking after the baby  
341 or detract from the well being of the baby. In fact, also I find it often enhances  
342 and even things like breastfeeding, you know I'm not a specifically trained  
343 breast feeding counsellor but I find often just the mother, the mother's having  
344 problems because she's tense when she's feeding the baby or she's in an  
345 awkward position, and as a massage therapist you know we're more than  
346 appropriately trained to support the mother to be relaxed whilst she is feeding  
347 the baby and often that's all she needs. So actually it may well even have  
348 very direct effects like being able to support breastfeeding, which obviously is  
349 going to have a direct influence on the baby. So no I don't agree with that, I  
350 think it's quite important to work. The reality is, the labour work obviously  
351 most massage therapists, in terms of managing their practice, even if they're  
352 not teaching like me, realistically they're not going to be able to attend that  
353 many births. So for me that's why I developed all the birth preparation work.  
354 So I was working with teaching the partners so that they've got a role and  
355 they can be supporting the woman with massage during the labour. So I  
356 mean I see realistically, I'm not going to be personally as a massage  
357 therapist there much at the labour, but some people do choose to do that and

358 make that a focus of their work. Then also I've started, I train midwives to use  
359 some body work skills as well. So I mean while I think it's absolutely, can be  
360 very helpful for women in labour, the reality is obviously that's not going to be  
361 a large part of the massage therapist's work but that doesn't mean that  
362 massage per say isn't helpful. Again I think that comes from the perspective I  
363 think the obstetrician was thinking, well it's kind of relaxation, but actually  
364 relaxation in labour is one of the prime things that actually supports the whole  
365 process so actually its not a pampering, its quite fundamental.

366

367 I: Yeah, a key issue really.

368

369 P1: Yeah exactly,yeah.

370

371 I: How are we doing for time? I think, I think we're just about done.

372

373 P1: Yeah? Ok, but if you've got any other questions that's fine.

374

375 **I: So we've talked about risk and--**

376

377 P1: So it's important for the therapist to know when not to work. I mean that's  
378 I always underline, but there aren't many situations to be perfectly honest,  
379 the situations, the woman would probably not come. 99.9% of women would  
380 know themselves that it was risky and go to hospital or to see their midwife.

381

382 I: Yeah. There was just one other area that I wanted to ask you about. It  
383 might seem like too huge a subject for now but you mentioned in the seminar  
384 about the Eastern approaches to pregnancy and childbirth and I'm wondering  
385 how they might inform our western practice, you know the medical model of  
386 maternity care. You know how the two might influence each other?

387

388 P1: I mean that's mainly why I started teaching midwives because that's  
389 actually one of the things apart from the actual bodywork skills. It's just a

390 different way of looking at pregnancy and birth. So I think that's, it is  
391 ultimately through education, it's the women, sorry it's the midwives probably  
392 who are going to be more open than many of the obstetricians but you know,  
393 getting the midwives to see things in a different way. Which a lot of them are  
394 quite receptive to, and then with the women just having a different approach  
395 because a lot of the care that we have is also of course, determined by what  
396 women are wanting. If women are asking for epidurals, then it's a complex  
397 reason why do they ask for the epidurals? Ultimately if women want massage  
398 or women decide they want something else or women decide that post natal  
399 care is important and that's what a lot the eastern approach is... and I've  
400 often thought is there not another way of saying eastern and western, it's  
401 kind of like the traditional approach in a way, and it's a kind of common sense  
402 and it's a sort of basic supporting the body. But the eastern approach  
403 specifically has got quite a lot of things so I'm not suggesting we go back,  
404 and specifically in the book I've tried to talk about the things that I think can  
405 be relevant, um, and where eastern and western thought converges as it  
406 were. So I think it's partly the massage therapist can have a role, I mean how  
407 that can be integrated is if massage therapists have some of those ideas  
408 when they're working and as the obstetrician said massage therapists can  
409 potentially have quite a lot of time, with the client. So its not indoctrination but  
410 it's just showing that there's, you know there's another way really, that can  
411 make sense, like especially in the post natal period resting, or just being  
412 aware of... I'm trying to think of something specific, but, a lot of the emphasis  
413 is on supporting the mother, to support the baby. It is a very different way, I'm  
414 trying to summarise how it's a different way, of looking at things, but, I  
415 suppose it's ultimately its more, for me its more respectful of the baby, rather  
416 than just seeing the baby as, and tests and doing things to the baby, it's more  
417 about relating to the baby as a person. I mean the western view is aware of  
418 that, that the senses are developed and this and the other but often in the  
419 actual practice the baby isn't really treated so much like a baby, but as this  
420 thing that needs this that and the other, and so bring in that more sort of  
421 humane approach, and actually really just relating to the baby as a person,  
422 even in the womb, already is quite a fundamental thing. So I think there's a  
423 lot of that traditional knowledge, I mean for me that's why I wrote it out as

424 well because I think once it's written and once people start talking about it  
425 that's kind of the first step of maybe beginning to shift away from such a  
426 medical approach, to pregnancy and birth, and ultimately yes its helpful to  
427 have, you know some tests are more helpful than others, but it has become a  
428 bit overly focused on what can go wrong I think, whereas the eastern  
429 approach can bring about how to support what's going right.

430

431 I: Which is exactly what [REDACTED] was saying about focusing on the joy  
432 of the pregnancy and the birth--

433

434 P1: Because yeah as you said, safety, we went through a historical period  
435 where safety was an issue, and a lot of women did die in childbirth. I mean  
436 how much that was changed just because of medicine and how much it was  
437 to do with lifestyle changes and improved sanitation and you know other  
438 things as well, it's also questionable in fact, whether it was all just down to  
439 medicine, I think probably not, although obviously medicine does save lives,  
440 you know it does save lives, of course it does have a role, but the mortality  
441 rate is, for both mothers and babies, is actually quite low, and maybe it is  
442 time, well I personally think time to really focus on getting back some of that  
443 sense of the joy, and the normality, and the life changing aspect of it and  
444 preparing.. You know it isn't just about safety. Because how the woman  
445 experiences her pregnancy and how she experiences her birth and the post  
446 natal period will affect how she relates to her baby and how she is as a  
447 mother, so you can't really separate that out from everything. And that's what  
448 the eastern view and the more sort of.. because I mean [REDACTED] was  
449 talking about in the Amazon, but I think that kind of thing is valid, its that  
450 whole kind of traditional perspective on pregnancy and birth which is quite  
451 different from the modern perspective, but which we can learn from. Without  
452 being, you know trying to transplant something that was relevant to people  
453 living in a jungle or people living in China, so that's why I don't like to quote  
454 too much from old texts because its more about taking some of the essence  
455 out of it rather than, you know not being too literal about how we bring it to--

456

457 **I: What's appropriate to our age and our development--**

458

459 P1: Yeah yeah exactly. So we can't, I mean, some people just translate the  
460 old Chinese texts and I think, you know that's got a historical interest, but you  
461 know how people did things then, to a large extent, we can't just copy, we're  
462 going to have to.. (laughs) you know like not having a bath for a month! After  
463 having a baby. But you know there'd be quite real reasons why they wouldn't,  
464 because they wouldn't have central heating you know the mother could get  
465 cold, you know now, we can have a bath and not be worried about getting  
466 infections and things so you have to sort of contextualise. But there is an idea  
467 about maybe not having a bath, you know maybe you don't have to have a  
468 bath straight away, you know baby isn't, birth isn't dirty, you know its ok,  
469 you're not going to get ill just because you don't have a bath straight away.  
470 We've almost gone from one extreme to the other, you can't have a bath to  
471 you've got to have a bath, maybe we can find something more.. You know  
472 like traditions like washing hair, in many cultures they didn't wash hair when  
473 women were menstruating, but again I'm sure that's because they didn't  
474 really have the space, or it was you know they might get cold or whatever,  
475 yeah.

476

477 I: You made me think of um, in some Eastern European countries, like in  
478 Bulgaria for example, when the woman gives birth she's not allowed to have  
479 visitors, or see anyone, other than her mother and the father for like forty  
480 days.

481

482 P1: Yeah yeah, but you know because you don't want infection, you want to  
483 keep the baby calm, and the mother needs to recover.

484

485 **I: But how tough?**

486

487 P1: Yeah. But on the other hand, you know a lot of women, you know it can  
488 be quite tiring having visitors and making cups of tea and this that and the  
489 other and actually quite a lot women think well actually its quite nice to just be

490 with my partner, and just get to know the baby, and not have to worry about  
491 entertaining people. So there's an element that actually that can be quite  
492 helpful, but if it's the choice of the mother. It's sort of seeing what's behind it,  
493 you know you do need to focus on, you know, establishing breast feeding,  
494 you know it is helpful if women don't have too many visitors but maybe they  
495 can chose which visitors, if she's got supportive friends then obviously, that  
496 kind of know how to support them, but actually it isn't very good to have too  
497 many visitors. You know it's not a party in that sort of respect! You know it  
498 can be quite distracting and quite tiring for the mother, if she has lots of  
499 visitors. A lot of women think they might want lots of visitors but when the  
500 reality comes they find it quite stressful, and actually quite like just being with  
501 their baby, and their partner, maybe you know just one or two close friends,  
502 yeah.

503

504 I: Yeah. Well, thank you very much, I think that's covered everything I wanted  
505 to and it's been really informative.

506

507 P1: Oh good! Great.

508

509 **I: So thank you!**

510

## Appendix VI Interview transcript P2

Interview with participant 2 on the 6<sup>th</sup> of April 2010. Duration: 37 Minutes

1 I: Ok so maybe we could start with you telling me a little bit about your  
2 practice, what kind of massage therapy you offer.

3

4 P2: Ok. I started with holistic therapeutic massage back in 2001 and then  
5 through teaching in Primary schools became quick to be interested in  
6 children, and then backtracking towards baby massage and then eventually  
7 conception and babies in utero, so it's grown mainly from an idea of if there's  
8 any time in your life when you want to feel well, and importantly I think  
9 relaxed it's during your pregnancy when everything that happens to you can  
10 affect the baby. So I trained with Well Mother in, I think it was 2005, so since  
11 then I found it quite slow to start but actually since focusing on it more I find  
12 that most women that I get are in second trimester and they're beginning to  
13 feel the effects of that transference of weight and point of gravity on their  
14 body shifting forward so your getting all the lumbar curve issues um, and  
15 then also just finding that their energy's a bit lower, um and I get a lot of  
16 women asking about swollen ankles and swollen calves and feet and hands  
17 um, and if its very bad then I either refer because I suspect other  
18 complications or I refer them on to a manual lymphatic drainage practitioner  
19 who would deal specifically with that, if its something that I actually feel has  
20 gone too far. So mainly what I work with are um, probably what would be  
21 seen as weaknesses in the body which are then accentuated by the  
22 pregnancy, and I've not really had anything too complicated over the last few  
23 years I think the only complication was a women who, she came with severe  
24 and very sharp pains to the lower back, but not where you would normally  
25 expect it right down in the lumbar and sacral area, it was a little bit high and it  
26 was very hot and tender to the touch and I said to her "There's, you know I  
27 can massage you elsewhere but I'm not going to massage that particular  
28 area and I think you need to get checked out", and it turned out she had a  
29 kidney infection. So it's usually lower back pain, relaxation and then help also  
30 with posture. So working across the chest into the arms to try and keep the

31 rotation in the shoulder joint as they start to stoop a little to try and keep  
32 balance and also just because of the strain across the back as their bearing  
33 the weight and then a few cases of cramps and restless legs, I've had as  
34 well. So that's pre-natal and then postnatally it has tended to be almost later  
35 than I would like, I'd like to see women sooner after their birth but I think  
36 partly because their whole world gets tipped upside down, they tend not to  
37 make it out the door or they haven't worked out how they would manage  
38 feeds, so even though I offer them to bring the baby along, they more often  
39 than not want to have some time away from the baby so they wait a couple of  
40 months before they come for any treatment, and then looking much more at, I  
41 always check the gathering of the recti muscles, whether the muscles are  
42 beginning to close enough. I've found times when the woman's come six  
43 months or nine months even and they're still an open enough to fit a finger or  
44 a finger and a half in, so then I would advise them to start taking exercise or  
45 go to specialized post natal Pilates and work through some exercises with  
46 them there and then if they want to. Other things with post natal are shoulder  
47 ache from all the lifting and the carrying and the holding, so sometimes I'll  
48 ask them to show me with a pillow if the baby's not there, how you, what  
49 position you're in when you're breast feeding and try and advise other ways,  
50 or at least speak to their health visitors to try find other ways for them to be  
51 while they are feeding. I have assisted at one birth, but this was a friend so I  
52 haven't done it through the business as such, and that was a home birth,  
53 water birth, and that was great--

54

55 **I: And in what ways were you using massage during her labour?**

56

57 P2: In the early stages, so while contractions were still irregular and I did one  
58 long massage, which she found helpful for me to keep massaging during the  
59 contractions, although other people prefer you to stop, she found it good to  
60 have, because by that point we found a rhythm, and she found it good to  
61 have something else to focus on and have me keep the rhythm going for her  
62 that she would follow that same rhythm. So I gave her a whole body  
63 massage at that point, and then when things were slowing down we tried a  
64 few induction points, but they didn't seem to work, and what did work was

65 actually going out for a walk. They suddenly came every two minutes! I also  
66 massaged her older daughter and I had been doing so, she'd been, in fact  
67 the older daughter, which was my project when I was training in the  
68 pregnancy massage, my project was to include other siblings because  
69 there's lots of families now that have got siblings from other relationships that  
70 are much older, so to bring them in and to include them. So she'd been  
71 massaging her mum with me before the pregnancy and then because the  
72 focus had shifted, I then, she then got a massage for herself so that she was  
73 involved in some way, and then after the birth we talked about baby  
74 massage, but she didn't do anything in particular in the first weeks, she lived  
75 in [REDACTED] at the time, but she did go for baby massage after, which had  
76 I lived there, I would've offered to her, so it was mainly during the earlier  
77 stages. And then once she was actually in transition, then her partner was  
78 there taking over and I had worked with him previously as well, to go through  
79 the points but also certain areas that are good for pain relief, so he was  
80 working with those during the transition natural birth, so it was all very  
81 exciting and I would like to do more of it. But its quite difficult to crack into,  
82 Doulas have a better reputation for it if you like.

83

84 I: So it seems like, in that situation, you perhaps had, almost a cohesive role  
85 to maybe help some interactional bonding between family members.

86

87 P2: Yes, I mean that was the idea behind my project, particularly as  
88 sometimes, as was in this case, some of the other children don't share the  
89 same parent, and it might well be the mother. So maybe a feeling of being  
90 divorced from the situation or even a fear that somehow when the baby  
91 comes that the mother, if it's the mother that they share, then Mums attention  
92 will be diverted as any sibling might feel, but if its not their mother then a fear  
93 of, 'well what if she prefers this new child to me?' So that was the idea behind  
94 the work I was doing and also when, you know you often hear, particularly in  
95 hospital births, that men or birth partners are sidelined in the process, and for  
96 them, even if they don't use those techniques to feel that 'Don't worry there's  
97 something that I can do', and also from talking to women that when they're  
98 giving birth, they want to be touched but the partner doesn't know how to,

99 and then they get fed up with the partner and the partner then feels a little  
100 unwanted, and the idea of working with them before hand was so that also  
101 the woman could feel confident in asking for that help, if and when the time  
102 came. And one of the main things that I noticed actually with men when they  
103 are applying pressure is that they're used to being a bit more pushy about  
104 things, in life in general, so the urge is to just press and push, and the thing  
105 that I find and have to go back to again and again is to lean the weight in, use  
106 the body weight, so in that birth situation it was, you know I had a lot of  
107 background with them in the first place, a lot of background work, and it was  
108 very much about, you know, I was on the outside and less emotionally  
109 involved, although obviously being a friend of mine, I was, but just making  
110 sure the older daughter felt she was in the right place and it was ok for her to  
111 say yes or no to whatever was asked.

112

113 I: You mentioned complications, do you ever feel nervous about working with  
114 pregnant women?

115

116 P2: I do, and sometimes I feel nervous with anyone who walks through the  
117 door because I do work with deep tissue techniques as well with non-  
118 pregnant clients, so its not specific to clients who are pregnant, although it  
119 does feel like the stakes are kind of higher, I suppose if I were nervous its  
120 slightly more heightened sense of nervousness, but what I have learned  
121 through the therapeutic massage generally is that it really is no good to  
122 pretend you know more than you do, and there have been times where I've  
123 said to someone six sessions is a good amount of time to spend, but I've got  
124 to session 4 and I've said I think you need to see someone else, you know  
125 very elderly clients who are more fragile, and also even from a personality  
126 point of view, that sometimes you just don't get on and that that's ok and  
127 you're better off saying "try someone else" or just asking "Do you feel  
128 comfortable when you come here?". With the pregnancy specifically as with  
129 the woman who had the kidney infection it turns out, that was really a gut  
130 instinct not to go to that place, but it had all the hallmarks that you learn  
131 about in your first diploma. So you know, if its inflamed, which it felt like, or if  
132 there is a sense of swelling, which there was, so you follow those basic rules

133 and you can't really go wrong and I think also what can help make you feel  
134 more confident is the consultation and that you really feel that you follow a  
135 path of questioning to its end if that's what it seems needs to happen, and to  
136 not think 'oh dear I really ought to get started' and keep looking at the time.  
137 So I think gut instinct is the first thing and then just going back to your training  
138 really, because you do know it, (laughs) and if in doubt, you refer or you steer  
139 clear from that localised area, if there's a doubt there.

140

141 I: So when you talk about referral, do you liase with perhaps the midwife or  
142 the obstetrician yourself or would you just advise--

143

144 P2: No, that was something that came up that day, wasn't it? I haven't, partly  
145 because, I've never felt that, I've never really had that good an experience  
146 with people working in mainstream medicine and I have baggage from my  
147 sister who has been very ill, so I go to them with a feeling of 'Well you just  
148 think I'm talking rubbish anyway.' So I don't have a feeling that it would be  
149 welcomed or even taken seriously, so what I've done in the past, and I don't  
150 know whether that's right or wrong, but what I've done in the past, like with  
151 that client with the kidney infection, is to say, ask 'When are you next seeing  
152 your midwife?' and if it's in a week or more time I will say 'I'd prefer it if you  
153 rang her to arrange a meeting' So I'm quite firm if I'm worried about  
154 something, and if it's a long time, because some women only come once a  
155 month, because that's all they can afford, if its going to be a long time before  
156 they next come to see me I'll call up a week later and say "Is there any  
157 update on what-" and if they say "Oh I haven't got round to speaking to her" I  
158 will say again, you know, "you really need to speak to her". I do take  
159 midwives numbers, and a contact for, a birth partner contact. That I do mainly  
160 in case if they are very close and they go into labour on the table, which  
161 hasn't happened yet! But no I've never referred in writing. I think some of that  
162 is the sort of nervousness of 'Wow, they know that part of the body inside out  
163 with sometimes decades of experience, and there is a little bit of a sense of,  
164 would I be losing face by mis-naming something? Or what if I've got the  
165 wrong end of the stick? So even though the massage training we get is good  
166 for the massage, for the background stuff we're not medical, or that

167 experienced in the physiology, and I would feel very nervous about referring  
168 to that or suspecting anything, because I don't have the medical background.

169

170 I: What of your perception of the type of women that come to you for  
171 treatment in terms of social groups?

172

173 P2: Definitely middle class. Usually first birth, well first pregnancy they are  
174 carrying to full term hopefully, and professionals. I've had two women who  
175 were on their third and one was even on her fourth birth, and I've only ever  
176 really had one client who wasn't in that demographic, who was in lower paid  
177 work, in 'care' so a career still, but lower paid and the kind of work that you  
178 don't need to spend as many years qualifying for, so would be in a lower  
179 income bracket, and she came because the first one she got was a gift from  
180 her mother-in-law who had received a lot of therapies herself, and she felt  
181 that it had really worked for her and seemed to have limitless funds, so she  
182 was obviously getting, it wasn't her own income that was paying for it. I think  
183 it was her partner and then maybe mother-in-law a few times as well, and  
184 she was the only one who came from that other demographic. But definitely  
185 middle class, and particularly around here, you know stockbroker belt! But  
186 with the baby massage actually that is a little bit more varied, but I would still  
187 say predominantly, even after, even though the price comes down as it's a  
188 one off payment, it is still middle class, yeah, which is a shame.

189

190 I: Yes that's why I was interested in the Sure Start project. That seems like a  
191 good way of perhaps integrating into the community a bit more--

192

193 P2: Yeah, its quite hard, because obviously you know being a teacher as  
194 well, I've been up to date with all the changes, you know, the departments  
195 and the funding and so on, so I thought I'd be well up there to get a foot in  
196 the door, but what has been found and it was mentioned that day at the book  
197 launch was that a lot of centres are bringing in their own, or training up their  
198 own, in the baby massage, and I couldn't get in our local one at all and they  
199 also want you to it pretty much for free when you do get there, which I  
200 couldn't do either.

201 With the pregnancy massage, the other tricky side with the Sure Start you  
202 tend not to get women pre natally, they start to go there after the baby's born,  
203 so you don't have that time before, then like I say the baby arrives and it's  
204 'Ah, what's going on? My world's completely opposite to what it was before'  
205 and in a way sometimes it's too late, usually if I'm working post natally, its  
206 because I've seen her pre natally as well. So I get fewer post-natal enquiries  
207 and it's been often the Father or again Mother-in-law or Mother has wanted  
208 to give a gift, because they have had a baby fairly recently, they look to see if  
209 there is anyone, they prioritise a person who specialises, but otherwise I  
210 don't really think they think of it as a post natal massage.

211

212 I: I wonder about when you're working post natally, at the seminar the  
213 obstetrician speaker spoke about the idea that there is a role for the massage  
214 therapist in the ante-natal period, possibly in the delivery room but not post  
215 natally because it interferes with the care of the baby, I wonder what your  
216 views were on that?

217

218 P2: Well I had a little chat with him afterwards actually, I said "You were very  
219 brave to be saying that in front of all these women!" (laughs) Yes, I  
220 completely disagree and I would say actually that in a way women need more  
221 support after, physically and emotionally, and I think that he completely  
222 missed the point. When you're pregnant, I've never been pregnant myself but  
223 from everything I've read, everything about your body is to make that  
224 pregnancy work, all the changes, and as you become more visibly pregnant  
225 the world shifts, society shifts in its perception of you and you become  
226 someone who deserves a seat on a bus, someone who should be allowed to  
227 take rests, so in a way you are more supported naturally in your body, but  
228 also from a society point of view whilst you're pregnant, and after, it's like a  
229 lot of that drops away and you get a lot of women, particularly around here  
230 who have been pregnant in London, have managed to find a house in the  
231 country at the last minute, they're moving the month before the baby's born  
232 and they land here and they have no-one. They have no network, their  
233 partner now has a commute to work of an hour, hour and a half each way, so  
234 the time that they are on their own is longer, and so that's when they ring up

235 for the baby massage, less for the baby, and more to have somewhere they  
236 can meet people. So I think from that point of view, massage is useful in that  
237 it connects the woman to someone who is local who, for that time is purely  
238 for them, who they can talk to and who they can be emotional with if they  
239 want to, whose job is there to try and help and understand them, and  
240 because they are local, have connections to other people, who might be  
241 helpful for them, other professionals. Then from a physical point of view  
242 you've got hormones that are still hanging around the body, you've got, the  
243 idea of it all being about the baby is completely insane because whose  
244 looking after that baby? Well it is the mother usually unless something has  
245 gone wrong, and I think when it comes to post natal depression, something I  
246 would be interesting in looking at is the effect of post natal massage for  
247 women with post natal depression, although I've not read anything that is  
248 about massage for the mother, I have read a lot about massage for the baby  
249 and encouraging the mother to massage the baby because the drop in  
250 physical contact between the mother and the baby, and the touch that she  
251 uses can become just managerial, picking up to change, to feed, and not  
252 actually about the caring because she can't feel that. And then there's a lot of  
253 research into oxytocin levels that are between people sharing massage that it  
254 actually increases, not only in the receiver but also the giver, so again the  
255 baby massage being the good carrier for that really, that the mothers feelings  
256 may actually change towards the baby. So I think, and for her to feel looked  
257 after, if you're very low then what you need is for people to be looking after  
258 you, and I think that on an emotional level its really important. Then for the  
259 body the, I mean I don't know what these designers of these car seats and  
260 buggies, I don't know who they think these women are, obviously some kind  
261 of Sheera, Princess of strength! Because they are so heavy and awkward  
262 and bulky and they're forever, I mean the biceps on these women are just  
263 extraordinary, but you feel a lot of tension in at the elbows, almost as though  
264 the muscles are fused at the elbow, and to use the sessions as a way of, yes  
265 you receive your tlc and your time to talk and you massage that is good for  
266 you at the time, but also to then encourage exercise which I don't think is  
267 done enough. You know you're still finding these split recti muscles months  
268 and months later and I think its because women kind of go into a free fall,

269 and if they don't have a background of keeping fit before then it's even harder  
270 to start after. So to start that dialogue, to ask about pelvic floor muscles, to  
271 look at their posture and how they're moving around or get them to keep an  
272 eye on things or to change one or two habits, so I think he needed a bit of a  
273 talking to really!

274

275 I: So what you are saying is your role extends beyond just the effects of the  
276 massage on the treatment couch and actually it can be more about the wider  
277 community and the relationships, the support for the mother in the wider  
278 sense.

279

280 P2: Yes absolutely. And I always ask, post natally as well, "What's your  
281 support like at home in the care for the baby?" and I'll ask about the partner,  
282 whether he is still around, the kind of days she'll have like a typical day, and  
283 how's she's feeling about her child, and I do, by accident really, have links  
284 with the local PCT and the health visitors there, because one happens to be  
285 my neighbour and one's a friend of mine, and I wouldn't hesitate to, by phone  
286 call or in writing, work with them. Which is interesting given the question you  
287 asked earlier. And I think its partly because it's a very female dominated  
288 department, and because their training isn't medical, it's more about the  
289 caring social side, as well as that physical and mental health. But yes I would  
290 definitely contact them if I had concerns about a mum.

291

292 I: What value does your therapy have for you, and what value do you think it  
293 has for your clients?

294

295 P2: Well for my clients I think predominantly I think it's about time out really,  
296 you know considering most women are working sometimes up to two weeks  
297 before they give birth and sometimes if the baby comes early, up until the  
298 day they give birth. So I think time out first and foremost, and then relaxation,  
299 and then with specific things because your working slightly differently,  
300 probably more gently most of the time, because of the relaxing in the body  
301 and getting a feel for what their real level of tension is becomes quite  
302 different to when you're treating someone who is not pregnant. I think that

303 they, the reason why I say its for relaxation is that there is a real difference  
304 between the drifting off of a non pregnant client to a pregnant woman. It feels  
305 completely different and it feels deeper and it feels more enclosed, like it  
306 feels like it would be harder to reach them if you wanted to disturb them, or  
307 needed to disturb them for any reason, yeah, it's really different. I noticed it  
308 from really early on so it's not just something I've just made up (laughs). And  
309 I think also that they get a chance to talk about their pregnancy without  
310 feeling like they're boring the pants off people, and that you will be interested  
311 and it's not just about ticking boxes and questions that people need to ask  
312 when they go for their appointments. And with the energetic work which I  
313 don't do with women who I feel like won't want to receive it or find it all a bit  
314 sort of white witchcraft type, but sometimes I'll disguise it as some breathing  
315 exercises with a visualisation to help, and I very clearly feel that when they  
316 do that they connect to the womb specifically, which I think, well from what  
317 they've said they don't have that experience when they're just on their own  
318 and thinking about the baby. It surprised me because I've never trained in it  
319 particularly, except for a little bit with [REDACTED], and that I think is really  
320 helpful that they get to, that they deepen that connection while the baby's  
321 there, so it's not just this umbilical cord that just does it. Then for me I just get  
322 a bit 'woohoo!' (laughs) when things like that happen or when you feel the  
323 baby moving under your hands and you just kind of get a bit amazed by the  
324 fact that there's life within life you know, and then you get to see them when  
325 they pop out! (laughs).

326

327 I: I wonder if its that you're allowing some space for the woman to really  
328 connect and, actually she has a massive task ahead of her which is to give  
329 birth, and to have that real sense of connection and like right this is what I  
330 have to do and to get into that really focused place to prepare for birth--

331

332 P2: Yeah I mean one thing I've never asked actually which I should start  
333 doing is, If I've worked in that way with a woman, whether when she goes  
334 into labour, whether she uses that for herself to recreate it, to try and find her  
335 way back to that again or whether it happens automatically because we've  
336 been using it.

337

338 I: Perhaps that's also something, you know you spoke earlier about  
339 educating the partner or other family members so that they could then have a  
340 part in that role?

341

342 P2: Yeah. I think if they know about the kind of things we've shared in  
343 session and then even better if they do come along to one which often isn't  
344 the case because of work and things, that they, you know even if there is just  
345 one trigger word, so it might be 'think of the waves' or some women think of  
346 things opening, flowers opening, sunshine, things that are spreading and  
347 opening, and if the partner just needs to remind her of that, yeah, I haven't  
348 asked enough about that because you don't always see them after,  
349 sometimes they just disappear into babyland and never to return. In fact I'd  
350 love to be back in the position where I could just research certain things. Just  
351 from things that have cropped up you start asking questions but, someone  
352 would have to pay me a lot of money, I can barely afford to live here as it is!  
353 (laughs).

354

355 **I: Well that's absolutely wonderful, thank you so much!**

356

357 P2: That's a pleasure! It's nice to talk about it actually.

## **Appendix VII          Interview transcript P3**

Interview with participant 3 on the 8<sup>th</sup> of April 2010. Duration: 29:20 Minutes

1    **I: So first of all I just wanted to ask you a little bit about your practice**  
2    **really, the kind of setting that you work in, I mean I can that this is**  
3    **where you practice--**

4

5    P3: Yes this is the main place that I practice from, just from home but I do go  
6    out to peoples houses for a bit of extra money, but its very rare that I do that.  
7    But I do insist in the first six weeks post natal that I'll just go to their house  
8    because it just gets a bit chaotic, because often with people with new babies  
9    its really difficult for them to be on time and they're stressing out and they get  
10   here and they've only got half an hour before I've got the next client coming  
11   so it works much better if I go to their home in the first six weeks to two  
12   months post natally. You know then it doesn't matter if the baby needs  
13   changing or if the baby needs feeding or if the baby's asleep or whatever  
14   else so that's the main time.

15

16   **I: OK, and um what's the, can you tell me a little bit about the actual**  
17   **massage or treatment that you offer? You know what kind of massage**  
18   **or body work that you actually do?**

19

20   P3: OK, I mean I do sort of basic Swedish massage but I don't advertise that  
21   I do that, I only advertise that I do pregnancy massage, post natal massage,  
22   and something called Maya abdominal massage which is also really good for  
23   fertility and pregnancy and post natal work, massive list of other things but  
24   they're the only things that I sort of advertise that I do, so I would say  
25   probably eighty five percent of my clients fall into that category, and the odd  
26   couple sneek through and manage to have just an ordinary massage with  
27   me, but I like to very much specialise, but then I also, I don't know if this is  
28   kind of relevant to what you do but I'm also a birth educator as well so I do  
29   birth preparation. I also teach baby massage classes to private groups and  
30   I'm a fertility awareness teacher as well.

31 **I: So it's a real spectrum of things.**

32

33 P3: Yeah but its all to do with women and women's issues particularly the  
34 child bearing year.

35

36 **I: What was it that brought you to this area of specialist practice?**

37

38 P3: Probably the birth of my son! I think it's probably the same for a lot of  
39 people! I just had a really positive experience of pregnancy and giving birth  
40 and that led me to want to work with other women and try and help other  
41 women have such a positive experience, and from that I did the Doula  
42 training, so that's the other thing that I do. I work as a birth partner  
43 occasionally, so I started off just doing that and then I did the birth educators  
44 training, and then when I was on the birth educators training I found some  
45 flyers for [REDACTED] pregnancy massage course but you had to be a  
46 massage practitioner and I was like, oh, I'm not a massage practitioner and  
47 then, (laughs) It's a bit silly, I went and saw a psychic for completely other  
48 reasons but half way through she just said "You've got to go and do massage  
49 training you're a born masseuse you've got to go and do it." So three days  
50 later I'm sat in the massage course at college and the year later I did the Well  
51 Mother pregnancy massage training because it meant I was able to do that  
52 because I didn't really want to do you know just massage, because  
53 pregnancy and birth was what I was really interested in. So yeah birth of my  
54 son was definitely the main sparking factor.

55

56 **I: So in terms of your clients, what are your perceptions of the women  
57 that you treat in terms of social groups or ethnicity?**

58

59 P3: For the most part um, this is possibly to do with the location I'm living in,  
60 living in [REDACTED] and being in north [REDACTED], so I tend to get mainly middle  
61 class women because they're the only people who can really afford it. Which  
62 I always feel really bad about because I'd love to just have it there for  
63 everyone, and obviously anyone can come and see me and I don't charge  
64 anywhere nearly as much as what the clinics in [REDACTED] charge for a

65 pregnancy massage, but its still generally still out of the financial bracket of  
66 people in more working class incomes, unless those people are of that more  
67 sort of holistic mind set and they really appreciate the value of the massage,  
68 then they will pay, but it tends to be the more middle class educated women  
69 who've got the money to spend on that kind of thing and they've also got the  
70 (pause) intelligence isn't the right word at all (pause) they're educated  
71 enough to really understand the benefits of complementary therapies and  
72 particularly massage during pregnancy and feel that its worth spending that. I  
73 get a lot of foreign women; I would say that fifty percent of my clients are  
74 non-English. But I think that's an [REDACTED] thing, because being a University  
75 town we get a lot of foreign people coming and spending a year or two living  
76 here, to do with the University and then going off so I do get a lot of foreign  
77 women. I also get quite a lot of Asian women and I wonder if that's, we've got  
78 quite a large Asian population in [REDACTED] and I think that massage is more  
79 part of their traditional culture in any case so they sort of understand it.

80

81 **I: Yeah. I mean do you have any impressions that it's a different way of**  
82 **seeing pregnancy and birth than to perhaps our western view of it?**

83

84 P3: The Asian people?

85 **I: Yes**

86 P3: In terms of the massage?

87

88 **I: Yes I mean something that interested me at the seminar was that**  
89 **there's a sort of Eastern approach to pregnancy and giving birth, in the**  
90 **west we have a very medical model of giving birth and I wonder if that**  
91 **is perhaps something that influences the clients that come to you, if**  
92 **they come from a culture where there's a slightly different approach to**  
93 **pregnancy?**

94

95 P3: I think with my Asian clients what tends to be the case is that they're very  
96 westernised in terms of medical care, so they, they don't want to do  
97 homebirth and that kind of thing, they're quite happy to go into hospital and  
98 do everything that the doctor says, um, they tend to be second generation

99 Asian clients so their parents came to England and they've been brought up  
100 in England but in very sort of traditional Asian households, but because  
101 they've grown up in England they've got all the western stuff here and I think  
102 that it kind of comes through that the whole medical model is better than not,  
103 so they tend to be, you know I do get the odd one that wants a home birth  
104 and all that kind of thing, but I think that because massage is a kind of bigger  
105 part of their culture traditionally, and you know their Mums might massage  
106 them during pregnancy and then massage them afterwards and then Mums  
107 often do a lot of baby massage on the babies, and they have a whole sort of  
108 diet thing, they're very in to their foods and eating particular foods through  
109 pregnancy and birth so they appreciate that, but they're still quite keen to do  
110 what the Doctor says often, so it's a funny kind of mix.

111

112 **I: Mm. Have you ever had any clients with complicated pregnancies?**

113

114 P3: Yeah, yeah. I get quite a lot of people with supposedly high-risk  
115 pregnancies.

116

117 **I: How do you feel about treating a woman who is perhaps considered**  
118 **high risk?**

119

120 P3: I don't have any problems with it, as long as, because you know I do a  
121 really comprehensive case history with them, and as long as I understand  
122 exactly what's going on for them and I've done [REDACTED] high risk pregnancy,  
123 I think it's a day workshop that she does for high risk pregnancy, so I've done  
124 that, and I've got books, and I can say to the women I just need to check with  
125 my teacher and just research and make sure that what I'm going to do is ok.  
126 But there's very few people that you can't do anything with, most people,  
127 there's at least something that you can do even if its just energy work, you  
128 know to help them, and often it's the high risk clients that need the work more  
129 than the low risk clients so you know as long as I'm really really clear about  
130 what's going on for them then I don't have any problems.

131

132 **I: And do you actually liase with the client's midwife or obstetrician in**  
133 **those circumstances?**

134

135 P3: It depends, for the most part not, but I have very close links with a couple  
136 of the independent midwives within [REDACTED], so if there happened to be a  
137 client of one of the independent midwives and the massage client, the  
138 woman herself has given permission, then I will sometimes liase with them  
139 and say ok you know "What's your feelings? How is it for you? Is there  
140 anything that you think that I should be doing?" But for the most part if its an  
141 ordinary midwife, NHS midwife or obstetrician they don't know anything about  
142 massage anyway, so I feel like I'm better off, and often if I'm sort of, If I've got  
143 questions then there's [REDACTED] who I can be asking at any point and I can  
144 always ring my independent midwife friends as well and just sort of get their  
145 feedback. My general motto is if in doubt don't, so if I'm in any doubt about  
146 anything then I won't do it and I'll be very clear with them that I can't do  
147 certain things. But [REDACTED], she's very very broad and she's done a lot of, I  
148 don't know if research is quite the right word, but she's really made a big  
149 point of looking at what complications there are and what massage  
150 techniques you can still do, and what things you mustn't do and to really try  
151 and include as many people as you possibly can. Because obviously on most  
152 basic massage courses you're told don't massage pregnant women anyway,  
153 on a lot of pregnancy massage training you're told you can do women as  
154 long as they fall into x,y,z category, anything outside that don't touch,  
155 whereas [REDACTED] has really sort of gone well ok, so this person's got this  
156 complication going on but it doesn't mean that we can't work on them at all it  
157 just means that you have to be very careful of this that and the other but this  
158 particular thing is fine to do.

159

160 **I: And I guess as long as the woman is well informed she's entering into**  
161 **a contract with you of trust and I guess it is her choice as well and as**  
162 **long as there's clear communication then, it seems that she shouldn't**  
163 **be excluded from being able to have a treatment just because there's a**  
164 **complication.**

165

166 P3: And it must be said that the women who have the very complicated  
167 pregnancies, they don't tend to come anyway, I think it's a little bit like with  
168 regular massage the people who've got the massive health complaints they  
169 don't kind of come generally in any case I find so, yeah.

170

171 **I: So in what way to do think that the work you do, the massage can**  
172 **actually support the pregnancy? What therapeutic value can it have?**

173

174 P3: I guess the biggest most obvious one is relaxation, by helping the Mum  
175 to relax and lessening her stress levels, which lessens all those stress  
176 hormones and adrenaline in the body, which obviously supports the baby. I  
177 specifically do a lot of work on the abdomen, I always include the abdomen  
178 unless the women has specifically said that she doesn't want to have her  
179 belly done. Because I think that the belly massage is really important for  
180 helping to make sure that the uterus is in a really good position and it helps to  
181 get the baby into a good position later on in the pregnancy, it helps the  
182 circulation to the uterus which is obviously then really good for the uterus  
183 itself and also for the baby, because you've got all the blood supply coming in  
184 via the placenta on the uterus so that's really important. Then you get  
185 through to all the things that you know if she's got back ache, if she's got  
186 postural issues going on sometimes the baby can sit in a funny position  
187 because posturally she's not very well aligned and just by bringing the hips  
188 back into alignment it just helps give a bit more space for the baby to be able  
189 to turn. Things like in early pregnancy you know if there's any nausea, heart  
190 burn issues, if there's oedema going on it can be helpful for that, um I'm sure  
191 there are a lot more but I can't kind of um--

192

193 **I: The list goes on! I'm interested in the therapeutic relationship itself**  
194 **and other than the actual body work what is it about the relationship**  
195 **that you have with the clients that perhaps she doesn't get from her**  
196 **midwife for example?**

197

198 P3: I think its massive in a lot of ways because for most women, unless  
199 they're having an independent midwife most women will see a different

200 midwife every appointment they get. They might be lucky and get to see the  
201 same one twice or maybe three times during the pregnancy, but most people  
202 don't get to see the same midwife. And generally their appointments are  
203 lasting five or ten minutes and the midwife's there she's you know trying to  
204 take blood pressure and urine samples and blood samples and listen to the  
205 baby and feel for the baby and that kind of thing, and there isn't very much  
206 time for the woman to be building up a really good relationship with the  
207 midwife. And having time to ask about you know things to do with the birth  
208 talking over any worries that they've got that kind of thing. Whereas I give an  
209 hour and a half sessions to all my pregnant clients and all my post natal  
210 clients, and so it means we've got more time by spending a good twenty  
211 minutes if not more when they come, talking to them about what's going on  
212 and then some of my clients like to be really quiet when they're being  
213 massaged but others often they'll use that time to talk to me and ask me,  
214 because they tend to know that I'm a birth educator and that I work as a  
215 doula and that kind of thing, so they'll talk to me about things that they're  
216 worried about or ask for information to do with things like the birth and all that  
217 kind of thing. And particularly the ones that choose to come regularly through  
218 their pregnancy, we're really building up a really good relationship so I get to  
219 know them really well, they get to know me, so they can have that connection  
220 and ask all those questions that they can't ask the midwife. I mean obviously  
221 I can't sort of talk about any of the more sort of medical things with them but I  
222 can certainly talk about birth preparation, sometimes just putting their minds  
223 at ease about things. Sometimes women have worries that they haven't been  
224 able to talk to the midwife about, or the midwife hasn't had time to explain  
225 properly, and I can just sort of explain it because I've got more time to be  
226 able to explain it to them.

227

228 **I: So it's a kind of continuous support as well. So when you're, you**  
229 **work as a doula as well, so when you actually assist women in**  
230 **childbirth do you use massage during labour as well?**

231

232 P3: Yeah I don't think there's been a single birth where I haven't, I mean I  
233 always ask them and if there's someone who doesn't want to be massaged I  
234 wouldn't use it, but, yeah!

235

236 **I: Can you describe the sort of techniques that you might use or how**  
237 **you might interact with the woman during labour?**

238

239 P3: I mean one of the big things is if the Husband is present, or the partner's  
240 present then one of the main things I do is try not to disturb their connection  
241 with each other, because I think it can be really easy just to kind of barge in  
242 and take over and the guy is standing in the corner kind of going what about  
243 me? So often what I'll do is I'll encourage the husband to be massaging but  
244 often the women are like you do it so much better I want you doing it, so I'll  
245 be encouraging the husband to be doing more sort of holding hands and that  
246 kind of thing. But the main thing massage wise is a lot of sacral pressure and  
247 work around the sacrum because that's where its all going on, its all in the  
248 pelvis and lower back, so that tends to be the main place that I'm doing  
249 massage. But you know it'll come up to the shoulders and top of legs you  
250 know it really depends on what's going on for the woman, and some women  
251 don't want to be touched during labour at all, and some women just don't  
252 want you to take your hands off them and sometimes that will change  
253 throughout the labour as well, so there might be periods of time where they  
254 want lots of touch and periods of time when they don't. But as well as the  
255 more traditional massage techniques there are lots of other, what I call tricks  
256 of the trade, that I know, so if something's going on with the birth like maybe  
257 the contractions have slowed right down, maybe the baby has gone into a  
258 funny position, maybe the baby's not moving down during second stage,  
259 there's a whole heap of different things that you can do to help change those  
260 kind of situations before medical intervention is used.

261

262 **I: So when you assist through labour and birth is that usually in a**  
263 **domestic setting or do you go into hospitals?**

264

265 P3: I go into hospitals yeah it's about half and half I would say.

266

267 **I: And how do you find it is for you interacting with the medical staff?**  
268 **Do you find that they welcome you there? Do you find there's any kind**  
269 **of hostility?**

270

271 P3: It very much depends on the individual midwife. The community  
272 midwives tend to be very welcoming, I don't know if I've ever had a problem  
273 with any of the community midwives. Obviously my independent midwife  
274 friends are brilliant, absolutely no issues there at all, yeah and as I say the  
275 community midwives tend to be really good and afterwards they'll do things  
276 like they'll show me the placenta and go through how to check the placenta  
277 with me, so almost kind of teach me things a little bit which is really nice, and  
278 there tends to be a very good rapport and they sort of see me as being part  
279 of the team helping the woman. Once you get up into the hospital most of the  
280 midwives are really great and are just really grateful, because they're so  
281 under-staffed and so over worked, they're like ah, there's somebody there  
282 who has an idea of what's going on so we don't have to worry about that  
283 room because she'll ding the buzzer if she needs us and we can just come  
284 back as and when's needed so they kind of relax a bit more. But then you get  
285 the odd midwife who is a bit like and who do you think you are? Thinking that  
286 you know anything about birth, I'm the midwife, I've done my years of training  
287 and I'm in the hospital day in day out what do you think you know about  
288 birth? and so they can be a little bit funny so you have to tread very carefully  
289 with that kind of midwife. Because I think its really important that the main  
290 thing is supporting the environment that the woman is giving birth in, if I start  
291 getting all funny with the midwife its not creating a good environment, so I do  
292 have to work really hard with that type of midwife, but they don't come up that  
293 often, so yeah.

294

295 **I: How do you see your role in that situation? Or even throughout the**  
296 **whole pregnancy?**

297

298 P3: On some levels my sort of role, in terms of being a birth partner its very  
299 much about what the women has asked me to be there for. So if you've got a

300 single parent or someone who the Husband is not going to be there for  
301 whatever reason then I'm going to be main birth partner, and its really just  
302 about being emotional support for her, you know getting the flannel to wipe  
303 her brow, offering her a drink. Because often the midwives, they have to write  
304 so many notes whereas I don't have to take notes in that way, I do tend to  
305 write up the births afterwards, but I don't have to be doing the note taking in  
306 the way that the midwives have to, so I can be completely focused on the  
307 Mum. Also there just to support the Father in keeping him nice and calm and  
308 relaxed and keeping him connected with the Mother. Helping I guess,  
309 keeping birth normal, and you know there's so many things that go towards  
310 keeping birth normal that often the midwives don't have time to do particularly  
311 up at the hospital, because you know often they're going between rooms and  
312 they're looking after two or three women at a time and so they can't be there  
313 to keep reassuring the mother that everything's ok. And as a doula, just my  
314 presence and the fact that I'm staying calm is enough to keep the mother  
315 calm, and thinking well everything must be ok because if it wasn't ok [REDACTED]  
316 would be panicking! And that kind of thing so, yeah, just very much about  
317 emotional support and the massage too and all those little things to keep  
318 Mum happy and comfortable and relaxed in that space, yeah.

319

320 **I: I think what you say about normality, that came up in the seminar**  
321 **didn't it? About finding the way back to it being normal and you know,**  
322 **she's not sick, she's not ill, it's a normal process, and nurturing the joy**  
323 **in it--**

324

325 P3: Yeah, that's it. Absolutely.

326

327 **I: There was one other thing which came up which I was quite**  
328 **interested in, which was when the obstetrician was speaking he**  
329 **suggested that the massage therapist or the body worker can have a**  
330 **role ante natally, but not necessarily in the delivery room and not post**  
331 **natally. You said earlier that you do work post natally quite a lot, so**  
332 **what are your views on that suggestion?**

333

334 P3: I very much respected him but I didn't agree with him on that one, at all! I  
335 think that the massage therapist can play a massive role in the birth space or  
336 the doula, whichever you want to say. I know that I've worked with several  
337 women who, you can never really say for definite but I feel pretty dam sure  
338 that they would've had caesareans if I hadn't been there, keeping the birth  
339 normal as it were. So I think that we can be very very valuable because  
340 there's things that I know that the midwives don't know, sure there's an awful  
341 lot that the midwives know that I don't know, but there are things that I know  
342 that they don't know that can be really really helpful that can change things  
343 for a woman, and help to keep things on a normal track rather than  
344 descending into that intervention spiral. And then post natally I tend to find  
345 that I don't get so many women post natally because they do tend to get very  
346 focused on the baby and they forget about themselves because its all about  
347 the baby, but it doesn't mean that its not a good thing. Because the way that I  
348 work, like my next client who's coming this afternoon is post natal, her baby  
349 is four months old, so they'll bring the baby with them and we'll work with the  
350 baby, so baby will be lying next to her, she can be feeding the baby while I'm  
351 working on her. I just think that its really important that Mums look after  
352 themselves, because how can you look after somebody else if you're not  
353 taken care of yourself, you know we're expected to look after this completely  
354 helpless being, and we're not getting proper sleep, and its very overwhelming  
355 particularly as a first time Mum. So I think its really important to get that  
356 nurturing. Also the physiological change from being pregnant to not having  
357 baby is a very sudden one, because the pregnancy, obviously its quite a  
358 gradual move from when the sperm and the egg first meet up until the point  
359 that the baby's going to be born, so there's plenty of time for the body to  
360 adapt and adjust, whereas that baby gets born within the space of twenty  
361 four hours and it's a very sudden change so there's a lot going on. So there's  
362 all sorts of things you know getting the recti muscles back, getting the pelvis  
363 to come back into alignment. One of the things that I didn't say that I do is  
364 something called Indonesian post natal massage and abdominal binding and  
365 that again is really good for helping everything come back together, for  
366 helping the uterus to involute, all of that kind of thing. And also just relaxation  
367 as well again because a lot of new Mums are very stressed out, and just

368 helping to calm them down, because the babies often really pick up on the  
369 mothers state of mind so if you've got a Mother who's very anxious and very  
370 stressed out the baby is more likely to be very fractious, so if the Mum's  
371 getting some regular massage so that she can relax a bit better then the  
372 baby's more likely to be more relaxed, so I think its really important. I'd love it  
373 if everyone had post natal massage.

374

375 **I: Yeah. I think perhaps what the obstetrician suggested was that**  
376 **perhaps it would be indulgent in some way, you know like its**  
377 **pampering, and really it shouldn't be about the mother now, it should**  
378 **be about the baby, but you just can't separate the two.**

379

380 P3: No you can't absolutely and in traditional cultures you know women, they  
381 have a thirty to forty day lying in period where the Mum is massaged every  
382 single day, and looked after, and helped back to her full health again as it  
383 were. It's a bit of a funny way of saying it because I don't want to make it  
384 sound like she's not in full health when she's given birth, but it is a big  
385 process and it is a big change physiologically so helping to sort of, help the  
386 body to balance back out again. Because the healthier the mother is the  
387 more able she is to look after her baby properly and well, so she's more likely  
388 to breast feed and breast feed for longer, and she's more likely to bond with  
389 the baby much better and all of that stuff is ultimately better for baby,  
390 because then it helps baby to grow and thrive and be healthy both physically  
391 and emotionally and mentally as well.

392

393 **I: Well that's wonderful I think we're at time now, and I want to make**  
394 **sure that you get your lunch.**

395

396 P3: Have you asked enough questions because I don't want you to have  
397 come all the way out here and then go oh I wish I'd asked that!

398

399 **I: No! I'll just have a quick read through and make sure, I think we've**  
400 **talked about most of the things that I was interested in. I think that's**  
401 **plenty, so thank you!**

3CMR633 Research Proposal - Karen Simpson

'How do women value the experience of receiving massage during pregnancy and childbirth? An explorative study'

Feedback on 'doability' & relevance to therapy.

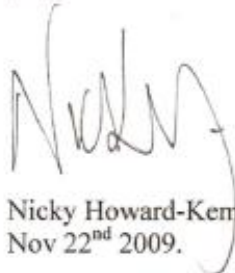
**\* Needs a revision of method concerning where/how data collected**

Karen,

This is a highly relevant topic that will be of benefit to yourself and the wider community, and you have done some interesting exploratory reading.

Unfortunately you cannot interview patients directly for your undergraduate research and therefore will need to look at alternative ways of collecting data relevant to your aims. You might consider interviewing practitioners with experience in this field however I would like you to seek further advice via supervision and Damien Ridge as I wonder if it may be possible to send out questionnaires...

You mention exploring grounded theory as part of the data collection and I would caution against getting too carried away as this is an exceptionally complex method of analysis that far exceeds the remit (both in time and depth) of an undergraduate project.



Nicky Howard-Kemp  
Nov 22<sup>nd</sup> 2009.

Appendix IX Supervision Record Sheets

Supervision Record Sheet

Student's Name: Karen Simpson Date of Meeting: 17th Dec 2009

Supervisor's Name: Nick Howard Key Duration of Meeting: 1/2 hour
(NB: The maximum number of contact hours is FOUR, which includes time spent on Project Proposal or reading sections e.g. prior to meetings)

Summary of discussion: Disappointed not to be able to interview users but can see potential of interviewing practitioners. Need to re-do standard paperwork to acknowledge change to practitioners not patients.

Comments on Student's performance to date (has the student achieved the objectives set in the last supervision?). Initial meeting to discuss proposal feedback. Student has looked at means to identify potential practitioners (via website). Will produce some more work over next 4 weeks.

- Agreed student action before next meeting:
1. Explore register of practitioners specialising in pregnancy massage for purposive sampling
2. Explore literature to identify key topics as focus for semi-structured Q's
3. Re-do questionnaires with focus on practitioners
4. Prepare correspondence - intro email, participant info + consent form
5. Formulate time-line for work to supervisor.

Signature of Student: [Handwritten Signature]

- Agreed Action by Tutor:
1. Look at lit reviews + sample questionnaires as needed
2.
3.

Signature of Tutor: [Handwritten Signature]

Date of next Meeting: TBC Additional information:

## Supervision Record Sheet

Student's Name: KAREN SIMPSON Date of Meeting: 24/02/10

Supervisor's Name: HEATHER SELLER Duration of Meeting: 45 mins  
(NB: The maximum number of contact hours is FOUR, which includes time spent on Project Proposal or reading sections e.g. prior to meetings)

### Summary of discussion:

Reviewed documents (which had been emailed but not seen by MK!). Discussed how best to contact potential interviewees (phone/email).

### Comments on Student's performance to date (has the student achieved the objectives set in the last supervision?).

Work is proceeding well. Literature review given today for comment and new guidelines/questions. Requests for interviews to be sent by beginning of March.

### Agreed student action before next meeting:

1. Amend contact email + Participation Info per discussion.
2. Send/Phone potential interviewees.
3. Follow-up contacts @ forthcoming seminar.
4. Look at theory of methodology.
5. .

Signature of Student: [Signature]

### Agreed Action by Tutor

1. Computer software for audio typing.
2. Check if need to specify Data Protection licence.
3. Read lit-review + Q's.

Signature of Tutor: [Signature]

Date of next Meeting: 10/3 Additional information:

## Supervision Record Sheet

Student's Name Karen Simpson Date of Meeting: 13<sup>th</sup> May 2010

Supervisor's Name Nicky H-K Duration of Meeting: 1 hour  
(NB: The maximum number of contact hours is FOUR, which includes time spent on Project Proposal or reading sections e.g. prior to meetings)

### Summary of discussion:

Discuss comments on Lit Review following onmail contact. Talked about how to refine themes and present in final project. Will write all sections in 3<sup>rd</sup> person.

### Comments on Student's performance to date (has the student achieved the objectives set in the last supervision?).

Karen has felt frustrated by time constraints from other module assessments however has continued to work on the project at a steady pace. The background information is now all in place and a good start has been made with the thematic analysis. Completion is visible.

### Agreed student action before next meeting:

1. Review changes to Lit Review.
2. Consider diagrammatic representation of themes.
3. Refine Thematic headings (produce table).
4. Email draft data analysis section for review.
5. .

Signature of Student K Simpson

### Agreed Action by Tutor

1. Email example of Thematic diagram.
2. Review data analysis section.
3. .

Signature of Tutor Howard Kemp

Date of next Meeting: TBC Additional information: