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Phenomenological study

Experiences of pregnant women receiving osteopathic care

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ABSTRACT

The state of women's health during pregnancy and in the post-natal period can have profound and long-term effects on their own health and that of their children. Women are increasingly seeking complementary and alternative therapies during pregnancy. The aim of this study was to explore the experiences of women who received osteopathic treatment during pregnancy.

Method: This phenomenological study used semi-structured interviews with pregnant patients who were undergoing osteopathic care in northern NSW and south-east Queensland, Australia. Data were analysed thematically.

Results: Osteopathic care provided symptom relief, particularly for low back and pelvic pain. Participants wanted a natural childbirth with minimal medical intervention if possible. Osteopathic care was perceived as helping prepare women's bodies for birth and in so doing helped alleviate anxieties associated with childbirth and with entering the mainstream medical system.

Conclusions: Pregnant women receiving osteopathic care reported experiencing physical and mental health benefits both during pregnancy and in the post-natal period.

1. Introduction

The health of mothers during pregnancy and in the postnatal period can have profound and long-term effects on their own health and that of their children. Pregnancy alters every organ system and every tissue of the body (Butler et al., 1996).

Vulnerability to psychosocial stress and disorder is accentuated in the perinatal period, not only for the mother but also for the infant, partner and family (Wodonga Regional Health Service, 2008). The Australian Government's 2010 National Women's Health Policy identified women's maternal health and women's mental and emotional health as a national health priority (Australian Government Department of Health and Aging, 2010). Data from the 2010 Australian National Infant Feeding Survey showed that one in five mothers of children aged up to 24 months had been diagnosed with depression (Australian Institute of Health and Welfare, 2012). More than half of these mothers reported that their diagnosed depression was perinatal (i.e., the depression was diagnosed from pregnancy until the child's first birthday) (Australian Institute of Health and Welfare, 2012). Kamysheva et al. (2009) investigated the effect on life of physical symptoms experienced during pregnancy and found a significant relationship between pregnancy-related physical symptoms and depressive symptoms. Furthermore, back-pain was one of the symptoms that had the largest effect on women's lives.

Extensive physiological and biomechanical changes often predispose pregnant women to somatic pain, most commonly low back pain or pelvic girdle pain (Smith, 2006). Low back pain has been reported to occur in pregnant women as frequently as 50%–85% (Gutke et al., 2008; Vermani et al., 2010; Vleeming et al., 2008) and at two to three years postpartum 8%–20% of these women still report persistent symptoms (Fagevik Olsén et al., 2009; Mogren, 2008). Pregnancy-related back pain has also been associated with sleep disturbance and can affect activities of daily living and quality of life (Licciardone et al., 2010). Predisposing factors to pregnancy-related low back pain include physically strenuous work and previous episodes of low back pain (Smith, 2006), smoking (Latthe et al., 2006) and imbalances in the muscular, fascial and ligamentous systems (Kofler, 2003). The instability of the pelvic girdle is proposed as the primary cause of pelvic sacroiliac and symphysis pubic joint pain during pregnancy (Depledge et al., 2005). The hormones relaxin and progesterone are major contributors to

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changes in joint laxity and to the significant structural changes required for the birthing process. Smith (2006) found that pelvic pain was related to asymmetrical laxity of the sacroiliac joints rather than laxity itself.

During pregnancy the abdominal organs make way for the enlarging uterus and therefore move cranially and slightly laterally. The thoracic diaphragm moves superiorly which also displaces the heart superiorly and to the left. This upward displacement of the diaphragm decreases the lung volume. As a result, the transverse diameter of the thoracic cage increases and the diaphragmatic excursion increases in an attempt to compensate (Tettambel, 2005). The third lumbar vertebra is shifted posteriorly lowering the apex of the lumbar lordosis. This in turn straightens the pelvis enabling the sacroiliac joints to withstand greater weight-bearing capacity. As anterior weight increases due to the growing abdomen and uterus, the muscular structures are no longer able to keep the pelvis in an upright position. This therefore leads to an increased lordosis in the later stages of pregnancy. To compensate for this the thoracic and cervical spine are stretched and flattened (Tettambel, 2007). Forward tilting of the pelvis and anterior nutation of the sacrum occur as a result of the increased anterior carriage of the enlarging uterus, shifting the centre of gravity forward. This shift in the centre of gravity has been implicated as causing an increase in the lumbar lordosis and changes to gait patterns, which predisposes to conditions like low back pain (Foti et al., 2000; Hensel, 2009; Stone, 2007). Disruptions to normal gait as a result of gravitational strains on an asymmetrical pelvis have been associated with pain patterns in the pelvis (Tettambel, 2007).

Pregnancy-related low back and pelvic girdle pain is often dismissed and consequently inappropriately managed as a minor and common disorder to be endured until after the baby is born (Depledge et al., 2005; Kofler, 2003). This may be in part why women increasingly seek complementary and alternative medicine (CAM) for relief of low back and pelvic girdle pain and other symptoms associated with pregnancy (Adams et al., 2009). In one multinational study the use of herbal medicine in pregnancy was found to be high, most commonly by self-medication (Kennedy et al., 2013). Women also seek CAM for care that promotes healthy pregnancy and post-natal care (Bishop et al., 2007). A study conducted by Warriner et al. (2013), described a perception of CAM as a more holistic approach to health. The participants of this study identified with a sense of empowerment and personal autonomy through the use of CAM. The primary motivation for pregnant women to use CAM was to achieve a natural birth and an emotionally fulfilling experience while avoiding unnecessary intervention (Mitchell, 2013). Levett et al. (2016) demonstrated in a randomised controlled trial that CAM therapies used as part of an integrative approach improved labour and birth outcomes. In this trial CAM therapies significantly reduced the use of epidural and caesarean section.

There is emerging evidence for musculoskeletal approaches to pregnancy and post-natal conditions. For example, a review conducted by Weier and Beal (2004) suggested that maternal and infant massage stood out as the evidence-based complementary therapy for post-partum depression (Weier and Beal, 2004). A number of studies have also investigated the use of osteopathic manipulative therapy in pregnancy and the post-natal period. For example, a clinical trial conducted by Licciardone et al. (2010) confirmed that osteopathic manipulative treatment slowed or halted the deterioration of back-specific functioning during the third trimester of pregnancy. In this study, there was also a decrease in back pain in the group receiving osteopathic manipulative treatment; however no between-group difference achieved statistical significance. A randomised controlled trial conducted by Hensel et al. (2015) found statistically significant treatment effects for pain and back-related functioning during the third trimester of pregnancy, although the osteopathic manipulative therapy group and the placebo group had similar improvement outcomes compared to the usual care group only. This may have been a result of the placebo being a more active treatment then was intended. Research undertaken by osteopaths in the US compared the effects of posture during delivery. Non-supine position during labour and delivery were found to have clinical advantages including perineal integrity, reduced vulvar oedema and reduced blood loss (Terry et al., 2006).

Exercise therapy, particularly pelvic floor muscle strengthening has been associated with a number of benefits for pregnant women. Depledge et al. (2005)investigated the effects of exercise, advice, and pelvic support belts on the management of symphysis pubis dysfunction during pregnancy. The authors concluded that the use of pelvic support belts did not add to the effects provided by muscle strengthening programs and advice and suggested it would be more beneficial in the long term for women to use their muscles to provide stability to the pelvis rather than to rely on an external device. The importance of pelvic floor strengthening exercises after vaginal delivery has also been confirmed (Kofler, 2003; Marshall et al., 2002).

Although many maternity care providers consider CAM a useful supplement to conventional treatments, referral for CAM treatment is hindered by lack of knowledge of CAM treatments, concerns about their safety, fear of litigation and lack of acceptance by colleagues (Adams et al., 2009; O'Regan, Wills, & O'Leary, 2010). Referral for osteopathic maternity care is also limited (Adams et al., 2009; O'Regan et al., 2010), despite low back and pelvic pain being the most common reason for pregnant women to seek osteopathic treatment (Kamysheva et al., 2009; Smith, 2006). The aim of this research was to explore the experiences of women receiving osteopathic treatment during pregnancy to more fully understand the reasons for their choice of treatment.

2. Method

A phenomenological approach was appropriate to explore the lived experience of women who were receiving osteopathic treatment during pregnancy (Todres, 2005). Data were collected using in-depth, semi-structured interviews of approximately one hour duration. Interviews offer participants the opportunity to describe experiences in detail and to give their perspectives and interpretations of these experiences (Clare Taylor, 2005). Two osteopaths who practised in northern NSW and south-east Queensland were invited to assist with recruitment. These practices were selected because they had well-established practices, their practice styles were typical of osteopathic practice in Australia, and their patients were local residents who would be accessible to the researchers for face-to-face interviews. Potential participants were invited to join the study through advertising in the participating osteopathic practices. Participants were aged between 18 and 50 years. They were either currently pregnant and receiving osteopathic care or who had previously received osteopathic care during a pregnancy. Interviews were conducted in person by one member of the research team (AS) at a mutually-agreed location. Interviews were recorded and transcribed with participants' consent. There was no pre-determined number of interviews. Data collection continued until redundancy of information occurred and no new

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