The Meaning of Biomedical Technology for Pregnant Women within the New Zealand Context.

A thesis presented in partial fulfilment of the requirements for the degree, Master in Psychology at Massey University,
Albany Campus,
Auckland,
New Zealand.

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February 2010

Abstract

This thesis is interested in critically exploring the meaning of biomedical technology from the perspective of pregnant women, relative to their pregnancy and childbirth (PCB) healthcare and the factors surrounding these constructions. Currently there are significant structural changes occurring within biomedicine and western society that have implications for pregnant women as healthcare users. Accompanying these changes is the introduction of new forms of PCB technology. However there is a lack of knowledge about the mediation and subsequent consequences of these social, psychological and cultural events for pregnant women in New Zealand. Comparatively speaking, interest in the social and psychological context relative to health related behaviour is gaining popularity within mainstream health psychology (Lyons & Chamberlain, 2006).

This research was guided and examined using a Foucauldian Discourse Analysis approach. I interviewed ten pregnant women about the meaning of biomedical technology, the influences and the consequences of the technology. Subsequently six discourses were identified after analysis of the transcripts. These discourses included morality, biomedicine, consumerism, risk, the good mother, and naturalism. Overall, the analysis revealed that the women constructed technology as a beneficial tool for use during PCB healthcare because it provided assurance and knowledge. Concurrently though, it was also constructed as harmful, dangerous, stressful and unwanted in some cases. The women essentially framed technology in ways to justify and normalise their use and acceptance of technology during their PCB healthcare. Consequently, the discourses positioned the women as moral and rational actors in relation to their construction and use of technology. They framed themselves in the role of the good mother, to take care and protect their child through pragmatic technological practice.

In summary, constructions around technology were shown to be locatable within a problematic healthcare context that has a strong, social mediation. Women were in support of using technology in spite of concerns around the effect of the technology.

Acknowledgements

Firstly, thank you to the women participants in this study. Without your time and commitment this study would not have been possible.

A huge thank-you to my mum, Ngaire and Kerry Chamberlain, my supervisor, for sticking with me and giving me the impetus to complete this research

And finally, to all my wonderful family and friends, with your kind words and sage advice, I am truly grateful to have had you on board

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List of Abbreviations

ART	Assisted Reproduction Technology
D & C	Dilation & Curettage
FDA	Foucauldian Discourse Analysis
IVF	In Vitro Fertilization
MSS	Maternal Serum Screening
NT test	nucal tubal test or nucal fold test
PCB	Pregnancy and Child Birth

Chapter One Introduction

> *"...health psychologists are seriously reflecting on their discipline and attempting to articulate theories and methods so that they can participate in the broader movement for social justice and health." (Murray & Campbell, 2003, p.235).*

> *"How have certain kinds of interdictions required the price of certain kinds of knowledge about oneself? What must one know about oneself in order to be willing to renounce anything?" (Foucault, 1988, p.16)*

I start with a brief reflexive account regarding why I developed an interest in social and psychological matters relating to health.

On a personal accord, I am keenly interested my own health and ongoing relations with western healthcare as a resource for achieving better health. My subjectivities as a young Pakeha female who draws on biomedical practices and understandings, makes me very aware of the pressure to be invested in my health as part of good healthcare practice. This is reflected in my care around daily practices that I link to better health outcomes such as losing weight, becoming fitter and feeling better. These practices and understandings take on different forms such as ingesting a vitamin tablet, buying women's magazines that have sections on improving health, searching via Goggle for answers in reaction to a sore Achilles tendon, using medicated shampoo, drinking two litres of water per day for hydration, or going to a Yoga class. Subsequently, I am frequently reminded of the link between health, absence of disease, and my identity. It

echoes Lupton's (2003) appraisal that "self-control and self-discipline over the body ... (it has) become the new work ethic" (p.35). This vigilance has profound consequences in terms of reorganising how I see myself and how I go about looking after myself.

My health management is mediated in terms of control over knowledge and behaviour, but is placed within a larger cultural and social background that allows for certain ways to see and to be. Furthermore my health is subject to change, dependent on dominant science and social norms. "Subject and object always come into existence together in a reciprocal process" (Easthope, 1990, p.76) is one way of understanding how health is mediated within other social, political and cultural lens. In particular, I am intrigued by the growing social and cultural emphasis on healthisim whereby it is important to not only live in the absence of disease and be healthy, but to place an imperative on optimum health (Crawford, 1980). Another example of socially mediated health related behaviour that is of interest to me is fetishist adherence to diet fads.

Due to these growing critical turns in my perspective, I have become more aware of power relations at work in healthcare over ownership of health and identity.
In particular, healthcare allows people to be judged as moral beings in the context of their health related behaviour. These developments are problematic due to the jurisdiction afforded to biomedical healthcare and associated dominant positions in western society. Due to the centrality of health and people's approaches to health in western cultures (Lupton, 2003) the consequences of these political movements can affect large numbers of people.

In concordance, I also have an interest in Eastern cultures and their healthcare approaches, particularly Hatha yoga and Ayurvedic healthcare practices. Subsequently, I enjoy being able to step out of my culture to 'see' the western cultural systems in place from a distanced perspective. These insights encouraged me to look into research problems interested in the social and psychological context of contemporary western healthcare with an idea of the multiple layers at work across time and space. The pivotal Dahlgren and Whitehead 'layers of

causation' healthcare model (1991) didn't just make sense; it resonated in me due to my greater appreciation of health. This model revealed the subverted orthodox views that reduce health to the level of the individual and also dislocated health from the social, cultural, embodied and historical context.

Consequently, I got angry. Although the value of scientific neutrality has been valued within orthodox psychology research as routine practice (Murray & Campbell, 2003), by taking that position I believed I would be reinforcing the very dogma and social control that I was trying to disrupt. I was directed into finding ways to deconstruct these subverted powers at work within health. Although I recognise the value of institutions, I believe we need to question the assumptions society has in regards to medicine and scientific value of truth within healthcare. Lyon and Chamberlain (2006) have also commented on this pragmatic need for researchers to be aware of what exactly are they critiquing in regards to institutional influence. My basis for engaging in bio-politics is neatly summarised in the following passage by Parker and Shotter (1990, p.4)

> For this we feel, in the end, is the subject matter of politics: a struggle to do with the scarcity of opportunities to be someone, i.e. of opportunities to speak about who and what one is, and about what one feels one needs in one's future in continuing to be oneself, and to have what one says taken seriously and responded to by the others around one. Only in such circumstances, in which one can play an influential part of determining one's own future, can one be said to be leading one's own life and not to be oppressed.

Consequently, due to my political awareness of social and cultural factors involved in western healthcare and engagement with health on a personal psychological level, it was highly foreseeable that I would merge these interests within my academic research. Essentially, I decided I would like to investigate possible social injustices within a given research problem focusing on medical institutions, people and their health.

In the proceeding chapters I will contextualise the research problem, and then introduce the research question that is drawn from this problem.