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TABIB, M. and HUMPHREY, T.

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Bringing presence to the Intrapartum Experience

Mo Tabib and Tracy Humphrey

We have worked together as midwifery practitioners, educators, and researchers for nearly 15 years. Our interest in 'relaxation' and its use in childbirth stemmed from our growing focus on women's experiences and a recognition of the increased incidence of anxiety and fearfulness of the birthing process. Having sought training in meditation and hypnosis, we incorporated many of the principals into our own practice. The results were astounding, with most women embracing this approach and many using no pharmaceutical or regional anaesthesia during childbirth. We also observed that their labour was often quicker than the average for their parity. We went onto work with a colleague to establish a dedicated service to women who had a fear of childbirth and were seeking to avoid a vaginal birth to overcome this. The content of the service focused on the principals of relaxation to make it more accessible and useful for childbirth. Women and clinicians were so positive about this service that it demanded an expansion of the provision and also warranted the training of more midwives. This service has now been accessible to any women in this particular Health Board in Scotland for the last eight years. During this time thousands of women and many partners have attended and most completed an evaluation. This has provided us with rich insights into their experiences of the service and how this has impacted their birth experience. We are now exploring this further in primary research and disseminating this widely. As midwifery educators and researchers, we recognised that we also needed to prepare midwives to support women using these techniques and have incorporated this into undergraduate, pre-registration curricula for student midwives. This has also been rolled out into continuous professional development for midwives building capacity and acceptability in the workforce. This chapter will examine the influence that meditation

and relaxation, may have on childbirth experiences. We will draw on the existing literature and reflect on our experience of embedding the knowledge and skills of meditation and relaxation within the context of antenatal education and midwifery practice in NHS maternity services in the UK. By describing the processes of development, service delivery and sharing research and evaluation, we will bring new insights to this important area of childbirth practice.

Introduction

Contemporary childbirth practices and culture across the globe with an over reliance on technology, stem from a medical model of health rooted in Cartesian medicine. Descartes the French philosopher (1596-1650) exerted a profound influence on modern Western thought and medicine with the birth of philosophical systems known as Cartesianism. Understanding the mind and the body as two distinct entities was the prominent conclusion of Descartes's work which has profoundly permeated the current health care systems including childbirth practices (Mehta 2011, Davis-Floyd 1994). In Cartesian philosophy, the birthing experience, is understood as dysfunction, the pain as pathology, and the birthing body as an object requiring medical treatment and management at the discretion of the technology and childbirth experts (Goldberg 2002). It disregards the close connectedness between the woman's spirit, psyche and biological functions of her birthing body. Both health care system provision and cultural perceptions are entrenched in this paradigm. As a result, women themselves may perceive their bodies as merely a collection of mechanical systems composed of cells, tissues, and biochemistry (Benner 2000). Hence, they may feel alienated and disconnected from their own bodies (Young 1998), perceiving '*here I am and there is my body*' at the mercy of the health care system, medical procedures and medications.

This perceived separation from one own's body diminishes women's confidence in their birthing capability (Reed, Barnes and Rowe 2016), hence generating fear and anxiety around childbirth (Neerland 2018). There is a growing body of evidence suggesting an association between maternal feelings of fear and anxiety with a diverse range of adverse physical and psychological health outcomes for women and their offspring (Kenny et al. 2014). These include rising rates of obstetric interventions, well beyond WHO recommendations (Miller et al. 2016) with escalating and unsustainable costs for health systems (Shaw et al. 2016).

As opposed to a Cartesian paradigm, a holistic paradigm transcends the mind-body dichotomy, recognising childbirth as a biopsychosocial event shaped by the interplay of biological, psychological, and cultural processes (Saxbe 2017). As such, incorporating approaches that enhance maternal emotional wellbeing in and around childbirth may play an influential role on the holistic health of the mother and child. Integrating the ancient practices of meditation and relaxation within childbirth practices and culture may offer a new possibility of shifting the current paradigm underpinning maternity care to a holistic and health enhancing one.

Defining Key terms

As the result of our exposure to the feedback collected from thousands of women and hundreds of birth attendants, our understanding of the phenomena of '**relaxation**' and '**relaxation techniques**' has evolved over years. In this chapter we present our current understanding of such phenomena and recognise that this is still evolving. Throughout this chapter the term 'relaxation' refers to a 'particular state of consciousness' in which the mind

is still, and the body is relaxed. The 'relaxation techniques', on the other hand, are considered as the gateways or tools for entering this state. The techniques we have mainly used in our teaching, research and practice include conscious breathing, body scanning, meditation, visualisation, use of silence, and hypnosis. However, we also appreciate other approaches such as yoga, aromatherapy and many more as alternative gateways to the same state. To us, the tools and techniques are secondary to the primary aim of stepping into 'relaxation'.

Ella's story

Please try to engage with the following script, allow the words to become carriers of the presence and allow the silence between the words to create stillness inside you.

'… Breathe in slowly and easily… and breathe out gently and patiently… and listen to the sound of your breathing… allow your outbreath to softly flow over your whole body… inviting the body to relax, to let go. now, feel the sensations of settling in your body… your forehead… eyelids… your jaw… allowing a gentle relaxing wave to softly flow to your neck… shoulders…. arms… your back muscles… thighs… calves… feet…, and… toe tips, relaxing your toe tips one by one… and now allow the visualisation to begin… just turn your gaze to the image of the vast calm ocean in front of you… the clear blue sky above… sense the soft powdery sand beneath and the cool breeze on your skin… remember you don't need to do anything or go anywhere right now… but 'to just be'… to be present and to be at ease with yourself and the universe around you… and to gently breathe with the slow motion of the ocean waves …'

This script is a brief reflection from a midwife caring for 17-year-old Ella[i], when she arrived at the midwife-led unit in the middle of night in a state of utter fear and distress. Ella

was in the very early stage of labour and the priority was to calm her down. The midwife describes what she did:

> ‘As I used the calm slow voice, just using the tone, the pace, I could see her going quiet, her eyes closing, her breathing slowing down, completely sinking into the bed. Then I knew she’d got it and I could go quiet’. (Louise, the midwife)

Ella narrates her experience:

> ‘At the beginning, I was terrified, imagining all the things that could go wrong and the pain, aye, even thought I could die… I was surprised when Louise asked me if I’d seen a cat in labour, what a strange thing to say, I thought. But it made total sense when she explained for the cat’s labour to go smoothly, she hides in a dark and quiet place, you know then something clicked, I wanted to be like the cat… then I went with that meditation thing... it was a strange feeling… my body became a bit lighter and I was like 100% focused on breathing and going into myself… every pain was then a wave bringing my baby a bit closer to me, nothing to be feared…at some point it was just me and him (baby) and nothing else, it felt like everything else had faded away…’ (Ella)

Louise continues:

> ‘With each contraction, she was just going down into herself, really shutting out the world…just disappearing into this little bubble...’ (Louise, the midwife)

Ella remained in the midwife-led unit. Her labour progressed quickly, and she gave birth to a healthy baby boy. Louise adds:

‘When I handed her the baby, she looked into my eyes and said, ‘that was amazing’, and I felt this lump in my throat… it reminded me why I became a midwife…’ (Louise, the midwife)

Ella’s journey and experience describes a childbirth experience with a seamless flow of physiological processes with a positive psychological transformation to motherhood. This points to a particular state of consciousness, when Ella was highly focused and intensely

present in her own body. This has been recognised as an ‘Altered State of Consciousness’ (ASC) in childbirth literature (Reed, Barnes and Rowe 2016, Ozla et al. 2020, Dahan 2021), a state significantly different from our habitual, day to day state of consciousness.

An altered state of consciousness (ASC) in physiological childbirth

ASC remains an underexplored phenomenon in childbirth research. This state is often experienced spontaneously, during physiological, unmedicated and undisturbed childbirth. The heightened senses and change in the perceptions of time and space are often the characteristics of this state (Olza et al. 2018). It is suggested that this state may well be the hallmark of childbirth as a physiological, psychological and spiritual event in humans (Olza et al. 2020). Dramatic changes in neuro-hormonal mechanisms including peaks in endogenous oxytocin mark ASC. The rise in endogenous oxytocin during labour is perceived to be the major factor activating the neurohormonal mechanisms involved in ASC (Uvnäs Moberg et al. 2019). Oxytocin rise activates the parasympathetic system (Davis 2017), induces pain relief, and decreases fear and stress levels (Uvnäs Moberg 2014). The neurobiological processes orchestrated by endogenous oxytocin release are considered to be responsible for transformative psychological experiences of labour and a positive transition to motherhood (Davis 2017, Hoekzema et al. 2017).

Hyperactivity of the neocortex (the part of the brain responsible for higher cognitive functions) coupled with elevated stress hormones could interrupt oxytocin release during labour, hence disrupting a positive psychological experience of childbirth for the birthing woman (Odent 2001). A risk averse and fear-driven culture in contemporary maternity services, with increasing maternal surveillance during labour tend to inadvertently stimulate neocortical activity (Odent 2017). The use of bright lights, the foreign environment of the hospital, the presence of unfamiliar birth attendants, restriction to bed, and medical

interventions are also recognised as the stimulants of a stress response (Harris and Ayres 2012, Downe et al. 2018). All can potentially impede the health enhancing effects of oxytocin on maternal physical and psychological wellbeing.

Downe et al. (2020) view a shift of paradigm from the current prevailing technocratic childbirth to a salutogenic one as essential for reversing the trend of escalating interventions and negative psychological outcomes of childbirth. A salutogenic perspective aims to enhance wellbeing first by understanding the origins of health and the assets for it (contrary to the origins of disease and risk factors) (Mittlemark et al. 2017). If ASC is understood as a health generating, health enhancing state in childbirth, the salutogenic enquiry should be at the forefront of childbirth care provision. So, the question is '*how could childbirth education and practices prepare women for experiencing an ASC and foster this state during childbirth even when birth interventions are used?*'

Physiology of meditation and relaxation

Through the millennia of human evolution, the remarkable development of the neocortex has resulted in high cognitive functioning of the human brain. Whilst such high cognitive functioning or sophisticated levels of thinking have brought us cultural and technological advances, involuntary and compulsive thinking experienced in everyday life has had limiting impacts (Tolle 2004). Continuous neocortical hyperactivity in involuntary thinking is often followed by emotional arousal (Krans, Bee and Moulds 2015) that could impede the optimum physiological functions within the body. Some commentators suggest this hyperactivity could be at least partially responsible for the reduced birthing capacity of our species compared with other mammals (Odent 2019). During childbirth, neocortical activity is naturally reduced in the absence of external and internal stimuli, allowing the primitive parts of the

brain to drive the process. Pre-existing fear and anxiety around childbirth are considered as examples of internal stimuli, whilst feeling of being observed and monitored, birth attendants' inappropriate comments, lack of privacy, and need for birth interventions may constitute external stimuli (Odent 1991).

Ancient practices of meditation and relaxation are known for their enabling potential in reducing mental noise, the hyperactivity of the neocortex and inducing an altered and focused state of consciousness similar to the spontaneous ASC experienced during physiological childbirth. Meditation is professed to be accompanied by the release of oxytocin in the brain which in turn contributes to an emotional sense of safety and trust (Ito et al. 2019). During meditation[ii], one's attention is deliberately guided towards the breath and the body, thus shifted away from the thoughts. The awareness of a sense of presence in the body is usually experienced.

In spiritual terms, this state of presence is interpreted as connection with self and the universe, sensing self as a part of the totality of existence (Tolle 2006). Often, a subtle sense of stillness and calmness is experienced. In physiological terms, meditation is predominantly associated with reduced sympathetic activity and dominance of the parasympathetic nervous system (Manocha 2000). This effect is known as 'Relaxation Response'.

The term 'Relaxation Response' was first coined by Herbert Benson (1975, 2011). He explained that when the mind is focused or silenced through meditation, the body reacts with a dramatic response in heart rate, breathing rate, blood pressure and metabolic rate, the exact opposite effects of the fight-or-flight response. Evoking the relaxation response seems to facilitate the flow of physiological functions in the body of which childbirth is one. Figure 1 intends to demonstrate the proposed relationship between practice of meditation and an ASC during childbirth.

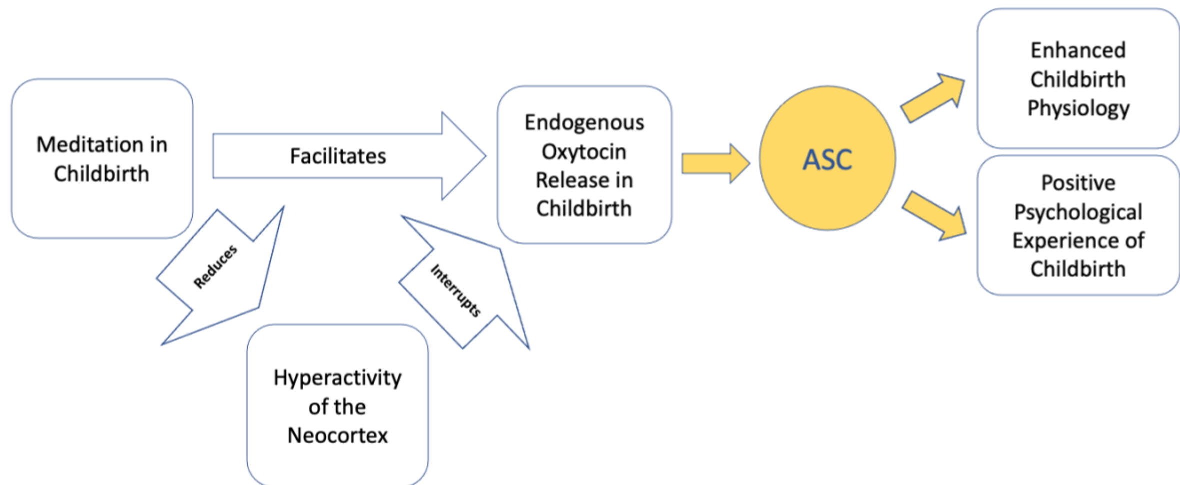

Figure 1. The proposed relationship between meditation and an ASC during childbirth

Antenatal education: a window of opportunity

All education provided during pregnancy is recognised as a window of opportunity to make a positive impact on women's health behaviour and prepare expectant parents for childbirth (see also chapter xx). However, a more holistic approach, that is mindful of the interconnectedness between body, mind and spirit may have the potential to enhance both birth experiences and outcomes. Current Education for Pregnancy, Birth and Parenting in the context of NHS maternity services in the UK is primarily focused on providing information regarding childbirth processes and parenthood. Education on childbirth physiology and self-help methods such as meditation or hypnosis are not generally included in the mainstream antenatal education (NCT 2021). In 2011, a single session Antenatal Relaxation Class (ARC), was introduced in our local NHS tertiary maternity hospital. The class was first established in response to the increasing number of women seeking medical interventions in the absence of clinical indicators, due to a fear of childbirth. Over time, the class has evolved into a 3-hour session which is underpinned and continually improved based on theoretical and empirical literature and evidence from evaluations. The class is now available to all women and their

birth partners during the third trimester of pregnancy with a maximum of 16 participants per session. It is delivered by midwives trained in relaxation techniques. ARC does not overlap with routine antenatal classes and is supplementary to them. The class starts with a comprehensive explanation of the physiological responses of the body to emotions particularly during childbirth. This is underpinned by theories of Fear-Tension-Pain (Dick-Read 2013) and physiological/hormonal processes in childbirth (Buckley 2015). The theory is then followed by several relaxation exercises including breathing and visualisation meditation, hypnosis and meditation in labour. In addition, two one-minute on-the-go techniques are introduced to allow practice during the busy daily life too, particularly when encountering anxiety-provoking situations.

Related research and service evaluation of ARC

Our ongoing primary research suggests the theory on childbirth physiology presented in ARC is seen by participants as new, liberating and challenging the traditional societal and health professionals' views (Tabib et al. 2021). This theory is filled with the notion of 'lived body' (Merleau-Ponty 1965/2013) underpinned by a holistic paradigm, evidencing how intertwined the emotions and physiological functions of the body in childbirth are. Women report that understanding the self as a lived body that is capable of influencing the physical body at a physiological level shifted their thinking about childbirth and led to feelings of confidence and empowerment whilst alleviating fear and anxiety. Lara describes:

> '…realising that the womb is a muscle, and you can work with it' as 'liberating'.

Sara comments,

> 'I felt really nervous and truthfully scared of labour, but after the class I felt much more confident, labour became something I looked forward to experiencing and no longer fearful of it.'

Whilst the theory provided an intellectual understanding, practice of the exercises in the class led to an appreciation and experience of their ability to step into an ASC. They describe this ASC as '*a heavy feeling, a deep sense of calmness'* (Charlotte), or a sense of '*physical presence and awareness of my body'* (Lara). Some depict it as the cessation of compulsive mind activity resulting in a sense of relaxation in the body,

> 'To start off, my mind goes like 20 million places but then I get to the point that I stop having such an active mind, I then feel my whole body relaxes with it'. (Rosie)

This state was considered a 'respite' that they could enter whenever they experienced fear or anxiety. The 'Fear-Confidence Seesaw' (Figure 2) may well describe the relationship between the two phenomena of fear and confidence that are indeed two sides of the same coin. The gained confidence from the combination of theory and practice in the class seem to be alleviating fear. Furthermore, as fear is a product of mind activity, a mental project of something that 'might' happen, deliberate diversion of the attention from the thoughts to the breath and body during the meditative practices creates pauses in the thoughts stream, thus easing fear.

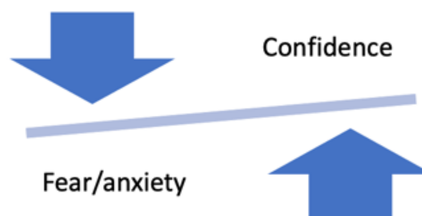

Figure 2. Fear-Confidence seesaw

During pregnancy, the techniques were used for a wide range of purposes of which management of anxiety, panic attacks, insomnia, minor ailments of pregnancy and

preparation for childbirth were a few examples. The practice of meditation was also associated with a rise in positive feelings, a sense of wellness, “*you could just switch off and feel good about being pregnant, so it’s just a lovely experience.” (Angela)*

Women reported approaching childbirth feeling equipped, empowered and excited about the upcoming birth.

> ‘Having attended the class, I felt reassured, positive, and equipped to give birth. I was given that confidence, kind of, I was almost given a toolkit of how to mentally prepare myself for the birth, whatever scenario’. (Liz)

Although discussion on birthplace is not included in ARC, some women related their eventual choice of homebirth to their understanding of childbirth physiology discussed in the class.

> ‘Something clicked, and it was just like, you know…this is not an illness, like you go into hospital when you're ill...this is natural, this is what I was born to do.’ (Louise)

Those whose labour started spontaneously at home felt confident to apply relaxation techniques for some time at home before seeking hospitalisation. Auditing electronic notes of 93 ARC participants having their first baby showed 74% of them with spontaneous onset of labour were admitted to hospital with cervical dilatations of 5 cm or more, with some being in advanced stage of labour (Stevenson and Tabib 2020). These women expressed feelings of pride and satisfaction with their own performance.

Women used the terms ‘*the zone*’ or ‘*the mood*’ spontaneously and repeatedly to refer to an ASC which seemed to be the ultimate aim of using the techniques. Amy describes this state as,

> 'For me, labour was like a tornado, the force of it was really powerful … getting myself into the zone was like moving to the centre, to the eye of tornado and find that sacred space that nothing could touch me'. (Amy)

Taking oneself to '*the zone'* was to allow and trust the body to do whatever it needed to do, gaining control by relinquishing control, a conscious transfer of control from the mind to the body. Conscious meditative breathing was repeatedly identified as a simple yet powerful technique influencing the experience of labour pain. Angela explains,

> '… the whole experience was so positive ... pain was there, but not nearly as bad as when I first gave birth. Throughout the breathing, I couldn't believe how much it did help with the pain. The first pregnancy the pain at the time seemed extreme 10 out of 10. This time, five.' (Angela)

Likewise, women who underwent medical interventions, such as induction of labour, reported feeling confident in excerpting their learnt skills to alleviate labour pain. Charlotte, a primiparous woman whose labour was induced and had an instrumental birth comments,

> 'I really felt I got myself into the zone, went into a total, really focused, a calm kind of state. I took gas and air but, that was it, I didn't have anything else. I never ever felt the need to ask for anything stronger. I think I could've coped with more. I do put it down to the breathing techniques.' (Charlotte)

What was noticeable in our research findings was that all women who were contacted after birth, irrespective of their mode of birth and the clinical picture of their childbirth experience, had creatively applied the relaxation techniques for a range of purposes including coping with stressful medical procedures and emergency situations. Liz who underwent a planned Caesarean Section, explains how the breathing techniques she used helped her to cope with the epidural insertion,

> ‘Another thing that I practiced and used when I was getting the epidural, was the breathing exercises. I didn't feel anything, and I am not good with needles. I can hardly get bloods and I do think a lot of that was just being in the right mental space, just letting go, letting go of the idea of pain, just allowing things to happen, almost like turning it off, I suppose it (breathing exercise) just helped me do that’. (Liz)

Another finding was that all participants described their overall experience of childbirth as positive, despite some experiencing a range of childbirth complications. Neave who underwent an emergency c-section and a major haemorrhage in the theatre comments,

> ‘… we went through a lot, but I feel quite pragmatic about it. It was something that happened, people helped me, and I helped myself with using different techniques …I think because I had so much that I could use and rely on, I feel like I've had a really positive experience from the start.’ (Neave)

The literature suggests women experiencing childbirth complications are at greater risk of developing negative psychological outcomes such as posttraumatic stress (PTSD) or increased fear and anxiety following birth (Olde et al. 2006). Our service evaluation (Tabib and Crowther 2018) and primary research (Tabib et al. 2021) to date indicates that the practice of meditation and relaxation techniques in and around childbirth may have a buffering influence against the adverse effect of childbirth complications on maternal psychological wellbeing.

Ito et al. (2019) suggest psychological effects of oxytocin (released during meditation) as upregulating wellbeing and downregulating stress and anxiety. This makes one wonder whether it is plausible that inducing an ASC (through meditative practices) in complicated births imitates the same health-enhancing effects of a spontaneously occurring ASC during undisturbed childbirth. Is it a plausible conjecture that the endogenous oxytocin released through practice of meditation could compensate for the neuro-hormonal interruption occurring during complicated births? Such questions seem to be highly relevant in the

context of contemporary maternity services particularly in light of increasing medical interventions and their subsequent influence on maternal psychological wellbeing.

Although the data suggested that women were capable of inducing an ASC for short episodes of time for a range of purposes during childbirth, maintaining this state through the whole labour process was highly dependent on the birth space. The birth space is defined as, '*the physical environment, people who are with the woman and what happens and is done to her*' (Joyce 2020). Physical surroundings such as lighting, privacy, or an environment that allowed freedom of movement were frequently highlighted as influential factors on women's ability to sustain that state. The space was also influenced by the clinical picture of the experience including procedures such as induction of labour. Nonetheless, midwives' impact on the space was perceived as the most influential factor, a '*game changer'* (Sandra) (see also chapter xx).

Midwife, the game changer

In the UK and many other countries, midwives are the primary care providers for all women during labour and birth. The significant impact of the midwife on childbirth experience and environment has been well demonstrated throughout the childbirth literature. The word 'midwife' means 'to be with woman', to be attentive to her needs including the subtle psychological needs. In the context of dominant biomedical childbirth care, however, the role of the midwife is more focused on 'the doing' and what she is expected to do from institutional and medicolegal perspectives. Midwives often find the two roles of 'being with the woman' and 'the doing' in conflict, particularly when providing care in obstetric-led units, most likely to reduce their ability to 'be fully there'. Meeting the institutional expectations and performing the exhaustive list of to do tasks, naturally demands the midwife

to be in a sympathetic-dominant state with the rise in stress hormones. Now, s/he is occupied, stuck in a utilitarian mood, in a conditioned pattern of behaviour to meet the obvious job demands, compromising her full attentiveness to the subtle emotional needs of the woman in her care.

In addition, emotions are contagious (Hatfield, Rapson, and Narine 2009), the midwife's sympathetic-dominant state is likely to be transmitted to the woman within the birth space and impede the physiological processes in her body (Fahy et al. 2011). Creating a birth space that radiates calmness and emotional safety, particularly in the context of obstetric-led units, requires an extraordinary level of emotional intelligence in the midwife. Emotional intelligence comprises the ability of being aware of one's own emotions and managing them effectively, recognising the emotions in others and developing nourishing relationships with others (modified from Goleman 1996). A high level of moment-to-moment awareness of own emotions and having the skills to manage these emotions, enables the midwife to be mentally and emotionally present, open, available and attuned to the woman, recognising her emotions and responding to them consciously (see also chapter xxx). This creates reciprocity and nourishing relationships that foster a health-enhancing birth space (Crowther et al. 2019). Emotional intelligence can be learned and developed (Serrat 2017) and practice of meditation is suggested to increase emotional intelligence and reduce perceived stress in workplace (Valosek et al. 2018). Meditation creates mental space for conscious responses instead of conditioned reactions.

Despite the ethos of midwifery discipline being deeply grounded in a holistic model of care, in line with the dominant technocratic birth culture, the focus of both undergraduate midwifery programs and midwives' mandatory continuous professional development (CPD) programs seem to be more on 'the doing'. This culture does not seem to recognise that

‘doing’ is never enough if ‘being’ is neglected (Tolle 2006). We started implementing education on the concepts of emotional intelligence, meditation and involved psychological and physiological processes in both undergraduate Midwifery program and CPD programmes for midwives in 2014. It includes educating the practitioners on how ‘to be’ in the world and how ‘to be’ with others, a state of ‘being’ out of which a different quality of ‘the doing’ can flow. A practical example of such approach is dealing with and managing an obstetric emergency whilst remaining attuned to the psychological needs of the woman in the moment. Such an approach to care may reduce women’s fears and anxieties. The positive influence of this approach for many women including those at risk of birth trauma became evident in the data collected from hundreds of women, midwives and student midwives.

To date approximately 100 midwives and over 400 student midwives have undertaken the education. The feedback collected suggests that similar to ARC participants, they had applied their learning to their personal lives for a wide range of purposes such as dealing with anxiety, conflicting relationships at work or home and even insomnia. In their practice, they had creatively tailored the skills to different clinical scenarios. Helping women with needle phobia, providing psychological support prior to or during the medical procedures, facilitating physiological childbirth and use of the techniques as a pain relief method were a few examples. Midwives’ ability to contribute to women’s positive experiences seemed to have contributed to a high level of satisfaction with their own performance.

> “I started to use my relaxation skills with her, in this situation we ended up being transferred to theatre but even in there, we did the gentle breathing techniques, and it was the nicest c-section I had been in, as it felt like we were in our own little bubble…” (Megan, the student midwife)

Implications for practice

The contemporary role of the midwife is identified as emotionally demanding with many midwives across the UK experiencing high levels of stress, burnout, anxiety and depression (Hunter et al. 2019) and a great number considering leaving the profession (Harvie et al. 2019). This is of critical concern to the profession and has serious implications for the delivery of high quality, safe maternity care. One of the major factors compromising the midwives' emotional wellbeing and contributing to their intention to leave the profession is the conflict between midwives' aspiration of truly 'being with the woman' and the medicalised and mind-dominated institutional expectations of the role which is mainly focused on 'the doing' aspects of the job. The current medicalised culture has led to rising rate of unnecessary childbirth interventions coupled with adverse health outcomes, unsustainable costs and an emotionally exhausted workforce. A substantial shift in this risk-focused, fear-generating culture to a holistic, health-focused and health-enhancing one is deemed to be long overdue.

The philosophical essence of meditation is to recognise an ASC, a state altered from our habitual and mind-dominated state. Stepping into an ASC is to be here in the now, is to step back from conditioned thoughts, judgements and interpretations, and all those mind-made stories. It is to consciously see the self and the world as they really are, with fresh eyes. This new and pristine way of seeing then opens us up to new possibilities, we become more aware of the conditioned patterns of the mind and 'the doing', not only at an individual level but at organisational scales too.

Embedding the philosophy of meditation and relaxation in maternity services at an organisational level, has the potential to permeate the 'being' of the system and that of the humans operating in it. Such an overarching approach could create and protect 'the space'

where the health and wellbeing of the workforce, childbearing women, their families and the next generation can flourish in. After all, we are all connected!

Implications for future research

To date, the research in the field has mainly concentrated on the effect of antenatal relaxation (or meditation) education on short-term childbirth outcomes. There is little known about the potential influence of such education on long-term health outcomes for the mother and child. In addition, there is a paucity of evidence around the influence of all-encompassing and complex interventions comprising antenatal education, education for the birth practitioners and revisiting institutional ethos. Such overarching interventions are more likely to meaningfully impact the outcomes at statistically significant levels. They would also allow investigating the impact on workforce's emotional wellbeing, emotional intelligence and their job satisfaction levels. Nonetheless, simultaneous implementation of and researching such complex and overarching interventions demands a strong will and support from the policy makers and funding bodies.

Conclusion

In this chapter we have introduced the concept and theories behind maternity care provision leading to the medicalisation of childbirth and subsequently a lack of confidence in women's ability to birth without it being distressing or requiring unnecessary or iatrogenic childbirth interventions. This means that some women approach childbirth with emotions of fear and anxiety. Relaxation and meditation could improve women's confidence and experiences of childbirth. As demonstrated by our own initiative, even a single session on bringing meditation and relaxation into childbirth can bring women back into the presence of their own birthing experience without apprehension. If such education is to be effectively

translated into practice, then midwives must be adequately prepared to facilitate a birthing space that is conducive to the sense of presence. Incorporating education on the ancient practices of meditation along with the contemporary understanding of their physiological, psychological and spiritual impact into pre-registration midwifery curricula and post-registration professional development will build and sustain midwifery capability and capacity in this area. Of course, more research is needed; particularly into the longer term or unintended benefits to women, families as well as health professionals providing maternity care.

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[i] All names in this chapter, other than the authors and cited sources have been given pseudonyms to ensure anonymity.

[ii] Meditation in this sense refers to mindfulness practice