

Running Head: INTEGRAL CHILDBIRTH

An Integral Approach to Pregnancy & Childbirth

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INTEGRAL CHILDBIRTH

Abstract

Introducing the Integral Model of Pregnancy and Childbirth (IMPC), this paper illustrates how childbirth professionals and pregnant women can better understand and consciously engage with the complex influences that most deeply impact pregnancy, birth and postpartum experiences. Calling for an Integral Paradigm of Maternity care, Radloff outlines the need to move beyond the fragmented and flawed models of maternity care that currently co-exist in the West. Outlining the many internal and external factors that influence the experience and outcome of a birth, Radloff introduces the six key components of the IMPC, and posits that by utilizing an Integral framework, and specifically the IMPC, pregnant women and the practitioners that support them have the potential to elevate the experience of pregnancy, childbirth, and the transition into early parenthood to a level that can bring about a greater sense of well-being while simultaneously serving as a vehicle for personal growth and psychospiritual transformation.

INTEGRAL CHILDBIRTH

“To be pregnant is to be vitally alive, thoroughly woman, and distressingly inhabited. Soul and spirit are stretched--along with body--making pregnancy a time of transition, growth, and profound beginnings.”

– Anne Christian Buchanan and Debra K. Kingsporn

For most women, giving birth is an extremely trying and moving experience, not only physically, but also emotionally, mentally, relationally, and spiritually. Childbirth typically includes great emotion, physical pain, as well as unparalleled physiological and psychological transformation. Patty Simkin (1992) states:

The birth of a child, especially a first child, represents a landmark event in the lives of all involved. For the mother particularly, childbirth exerts a profound physical, mental, emotional, and social effect. No other event involves pain, emotional stress, vulnerability, possible physical injury or death, permanent role change, and includes responsibility for a dependent, helpless human being. Moreover, it generally all takes place within a single day. It is not surprising that women tend to remember their first birth experiences vividly and with deep emotion (Simkin, 1992, p. 64).

After giving birth, some women are left with unresolved sadness, wounds, and negative associations related to their experience. Further, some women come out the event of childbirth exceptionally traumatized, not just physically, but also psychologically (Reynolds, 1997, p. 834). On the other hand, other women cite the experience of childbirth as profoundly positive and empowering. These women hold the birth of their child or children as *the* most wonderfully transformative experience of their lifetime, an event that brought about significant personal growth and development. In these cases, the experience of pregnancy and childbirth ultimately had a positive influence on how these women relate to themselves, others, and to the world (Simkin, 1992; Radloff, 2012b).

Whether positive or negative, the intensity of the emotions surrounding a woman's birth

INTEGRAL CHILDBIRTH

experience is often unparalleled and is carried along with her as she moves through the rest of her life. Dr. Gayle Peterson (1996) explains that the fact that women can express “extremely negative or incredibly positive experiences of childbirth is evidence of the generic power of the experience itself” (para. 1). Peterson (1996) describes:

Labor is not by its nature, a neutral event. Our experience of ourselves and our sense of personal identity is in constant flux with our life's unfolding. Because of the intensity of such an experience as childbirth and all that it entails, it is one that will help formulate a woman's identity. Like any powerfully significant event in our lives, it has the potential for mastery or overwhelm, empowerment or devastation. (para. 6)

When one considers that literally every person on the planet was once a fetus carried within the womb of his or her mother, and that this mother had to "birth" her child somehow, either naturally or surgically, then the incredible impact that the experience of childbirth has on the planet starts to come clearer. Paradoxically, childbirth is seemingly ordinary, being that it is literally one of *the* most common events that take place in human life.

According to the Population Reference Bureau's "2010 World Population Data Sheet" approximately 260 babies are born every minute. Approximately 500,000 pregnant women are laboring in the world on any given day (Population, n.d.). In fact, it is likely that five babies were born in the amount of time it took you to read the last sentence. Yet, for being such a common experience, as seen above, the event of childbirth tends to hold an *anything but* common place in the life experience of a woman.

I ask the reader to imagine for a moment the collective global impact that all of these women have on their children, on their cultures, and on the planet. It is my strong opinion that the collective influence of pregnancy and childbirth should not be underestimated, and the commonality and number of childbirths that take place on a daily basis throughout the world does not decrease the

INTEGRAL CHILDBIRTH

event's significance, but instead validates the magnitude of its importance. Common, yes. Ordinary, no.

The overall purpose of this paper is to explore and present an Integral Paradigm and Approach to pregnancy and childbirth. By putting forth this Integral Paradigm and the groundbreaking Integral Model of Pregnancy and Childbirth (IMPC), I aim to provide an integral framework for women and childbirth professionals to increase the chances for more positive pregnancy, birth and postpartum experiences, as well as act as an applicable model to approach pregnancy, birth and early parenthood as a catalyst for personal growth and psychospiritual transformation.

In the course of this paper, I will begin by contextualizing the need for an Integral Paradigm and Approach to pregnancy and childbirth. I will then outline the theoretical framework, background and the Integral Research study that informs my work. This will be followed by a brief overview of what I see as the different childbirth related paradigms, including the approaches and problems that currently co-exist in the West. From here, I will look ahead toward a new solution to these flawed and fragmented approaches to maternity care, and present my vision of an Integral Paradigm as it relates to pregnancy and childbirth. With this as my foundation, I will present the IMPC, which I have developed, specifically with the intention to address the question, “How can pregnancy, childbirth and the transition into early parenthood be approached in a conscious and integrated way that helps bring about a greater sense of health, well-being, personal development, and psychospiritual transformation?”

It is undoubtedly possible for an individual to approach their pregnancy and birth from an Integral perspective, and there are certainly integrally-informed health care providers practicing throughout the United States. However, from my own intensive search, there are virtually no mainstream approaches to pregnancy and childbirth that are truly “Integral.” Over the last several

INTEGRAL CHILDBIRTH

decades, experts in the field of childbirth, such as Ina May Gaskin and Pam England, have begun to articulate the role and importance of the woman's internal dimension during labor (England, 1998; Gaskin, 2003). This is a vast improvement to the upper-right reductionism that has dominated maternity care for the past century, however, I have yet to find a complete approach to pregnancy, birth and postpartum adjustment that holds all of the perspectives involved.

Even if the role of the woman's internal state, "we-space" and the environment are taken into account, few authors or approaches penetrate into the depths of this dynamic interplay. I have yet to find any authors or approaches to maternity care that hold the complete picture, let alone explore and engage all of the quadrants, levels, lines, states and types, as they relate to the pregnancy, birth and postpartum experience.

Therefore, as I see it, the IMPC has the potential to be used within both psychological and obstetric disciplines, and ideally would be applied both practically and academically. More specifically, I envision this model being put into use by anyone in the field of childbirth, including childbirth educators, psychologists, counselors, obstetricians, midwives, doulas, and pregnant women and their partners. Further, for greater accessibility and application in the field of childbirth, the IMPC was developed specifically for those with little or no background in Integral Theory, although for the purposes of this paper, I am assuming the reader has a basic understanding of Integral Theory and the work of Ken Wilber.

As I see it, modern maternity care in the United States is in need of vast improvement. In many ways it is a disjointed, flawed and failing system that is crying out for reform and integration. The alarming rise in maternal death rates, the routine use of unnecessary medical interventions, the great incidence of birth-related emotional trauma and fear, and the high frequency of postpartum depression and increase of birth-related PTSD are all clear indications of a diseased and failing maternal care system. (Amnesty, 2010)

INTEGRAL CHILDBIRTH

However, due to the limitation of this particular paper, I am unable to address these important topics as they so deserve. Fortunately, there is already a great deal of literature, research and social commentary that is dedicated to exploring the complex challenges and problems currently found in the American maternal care system. That being said, although my paper and model are not directly focused on the many problems associated with present-day maternity care, by presenting an Integral Paradigm of pregnancy and childbirth, this paper strives to point toward integration of the flawed and fragmented approaches of maternity care that are currently operating in the United States, thus making strides toward a healthy restoration of the cultural landscape of pregnancy and birth.

Theoretical Framework and Background

Integral Theory largely influences the theoretical framework from which I have built the IMPC, as presented by Ken Wilber (2006). I have systematically identified and engaged both Meta and multiple perspectives, and therefore believe that I have been able to generate a comprehensive analysis that informs a much more veritable and holistic approach to pregnancy, childbirth, and early parenthood than the current approaches that are found in the West. Further, a great deal of information, disciplines, and approaches have been synthesized in order to create the structure and content of my model. The many sources and works that I have resourced, benefited, and drawn from include: Midwifery, Obstetrics, Integral Theory, Psychology (i.e. Somatic, Transpersonal, Developmental and Cognitive Psychology), Anthropology, Sociology, World Religions, Mindfulness Meditation, Yogic Philosophy, Integral Life Practice, Life Coaching, and various Conscious Movement Practices. Within these fields, I have drawn from countless experts to whom I am incredibly grateful for their work and contributions to their prospective fields.

The impetus for developing the IMPC is grounded in both personal and professional experience. I have spent nearly two decades passionately studying and working with others in many

INTEGRAL CHILDBIRTH

facets of transformational growth and development, and throughout my journey, pregnancy and childbirth support have remained at the core of my heart's passion. Further, from an early age, largely due to the influences of my parents and upbringing, I have been dedicated and actively engaged in the quest to create and embody an "Integral Life Practice."

In 2012, I completed a MA degree in Integral Psychology at John F. Kennedy University. As a culmination of my studies I created the IMPC and also conducted an extensive mixed-methods Integral Research study focusing on what makes a childbirth experience positive. Prior to my graduate studies I was involved with the Integral Institute in Boulder, Colorado. I also supported Dr. Barrett Brown of the Integral Sustainability Center in the application of Integral Theory research and analysis to the field of sustainability, specifically for the United Nations Development Programme report titled, "Leadership For Results," which focused primarily on communicating to people of different worldviews about HIV and AIDS.

In terms of childbirth, the first time I assisted a woman in pregnancy and labor was at the age of fifteen. Since then, I have served in a support role for women and their families, assisting with births at homes and in hospitals. In 2005, I was officially trained as a Labor and Childbirth Assistant at the Sierra Childbirth Institute. I later completed both the Basic and Advanced Intensive Midwifery Training Programs through the Hearts and Hands Midwifery Intensives, along with completing several other pregnancy and birth related trainings.

Currently, I am the Founder and Director of the Center for Integral Pregnancy and Childbirth (CIPC), where I am applying the model directly with pregnant women and childbirth professionals. Through the CIPC I provide Integral pregnancy, childbirth & postpartum counseling, consulting and trainings, optimal pregnancy programs, mindful pregnancy and postpartum mother's groups, as well as occasional birth assistance to women and their families before, during and after labor.

Integral Research

From October 2011 to April 2012 I conducted a mixed-methods Integral Research study that focused on the question, *"What makes a woman feel positive about her childbirth experience?"* The study itself was incredibly extensive and converged both qualitative and quantitative data through the use of first-, second-, and third-person methodologies (i.e. phenomenological, hermeneutic and empirical research methodologies) and it resulted in an extensive 70 page report with significant findings. The research data that was produced proved to be incredibly informative, and the analysis provided clear and consistent themes relating to the primary internal and external influences that make a woman's experience of childbirth positive or negative (Radloff, 2012b). As a part of this study, empirical survey data was collected from approximately 500 women about their birth experience. This methodology alone generated a great deal of valuable qualitative and quantitative data. (Radloff, 2012a).

Based on the analyzed results of my study, I concluded that although highly individualized, there are certain key elements that tend to help bring about a more positive, empowering and transformational experience in pregnancy and birth (Radloff, 2012b). Further, when the empirical data was cross-analyzed with various factors, my research findings showed that when these particular elements were in place, especially in synergistic combination, then there was a greater sense of well-being, empowerment, personal growth and transformation experienced by the woman (Radloff, 2012a). These findings were instrumental in the development of this Integral Approach and will be referred to in the course of this paper and presentation of the IMPC. Unfortunately, detailing the methodology and methods, as well as defending the validity of this study is beyond the scope of this paper, although the report, in its entirety, will soon be accessible via the Integral Research Center Website (Radloff, 2012b).

Different Paradigms of Maternity Care

Maternity care in the United States is demonstrative of the divergent paradigms that currently co-exist in American culture. The varying perspectives on childbirth are a clear illustration of these different worldviews (Wilber, 2000). For example, pregnancy and childbirth is often approached as a purely physiological condition that requires extensive testing, drugs and medical interventions in order to ensure a safe and successful delivery. In contrast, the natural birth movement promotes birth as a normal, healthy process to be engaged in sans medication or intervention, often apart from and critical of a hospital-based birth setting. Others perceive pregnancy and giving birth as a direct illustration of our true mammalian nature; hence the experience is seen as being parallel to that of any other creature in the animal kingdom.

From yet another perspective, the act of giving birth is seen as a significant rite of passage for a woman, in which the challenge of childbirth is thought of as being beneficial and even necessary to a woman as she transitions into her new role as a mother. Finally, born of a completely different paradigm, pregnancy, childbirth and the transition into early parenthood is seen by some as a spiritual experience that can be profoundly self-transcending, transpersonal, and transformational for the birthing mother. These divergent paradigms and approaches to pregnancy and childbirth, and their opposition to one another, are illustrations of the fragmentation and disjointedness of birthing culture as we currently find it in the United States.

Cultural Anthropologist, Robbie Davis-Floyd (2001) identifies three main paradigms of healthcare that influence childbirth in the West. She names these paradigms: the technocratic, humanistic, and holistic models of medicine. She describes them as follows:

The technocratic model stresses mind-body separation and sees the body as a machine; the humanistic model emphasizes mind-body connection and defines the body as an organism; the holistic model insists on the oneness of body, mind, and spirit and defines the body as an

INTEGRAL CHILDBIRTH

energy field in constant interaction with other energy fields. (p. S5)

Modern Obstetrics throughout much of the country is based on the technocratic paradigm that Davis-Floyd refers to. As values have changed over time, the demand for a more humanistic approach to Obstetrics has been adopted in some places, though overall it is this scientifically-based and technological approach to the childbirth experience that is dominating much of Western culture, insurance, hospital, and social systems (Davis-Floyd, 2001).

A New Integral Paradigm of Pregnancy and Childbirth

Although these different worldviews and perspectives are most often at odds with one another, as I see it, each of these approaches has something of value to offer. Therefore, instead of pitting these different perspectives against one another, they ought to be evaluated critically, so the gems of truth can be extracted and integrated in order to form a new, integrated approach to maternity care. I believe that with an Integral approach and framework, the best of these perspectives can be brought together in order to create a revolutionary approach to pregnancy and childbirth.

Suggesting a very similar notion of integration, Davis-Floyd (2001), in reference to the technocratic, humanistic, and holistic paradigms, explains, “Practitioners who combine elements of all three paradigms have a unique opportunity to create the most effective Obstetrical system ever known” (para. 1). She writes:

Contemporary Obstetrical practitioners have a unique opportunity to weave together elements of each paradigm to create the most effective system of care ever designed on this planet. Information is available about indigenous childbirth practices from many cultures, some of which (such as massage and upright positions for birth) are highly beneficial and should be incorporated. More information than ever is available from scientific studies that tell us much of what we need to know about the physiology of birth and the kinds of care

INTEGRAL CHILDBIRTH

that truly support women to give birth. And technologies exist to support every kind of labor choice. If we could apply appropriate technologies, in combination with the values of humanism and the spontaneous openness to individuality and energy chartered by holism, we could in fact create the best Obstetrical system the world has ever known. (para. 80)

In my opinion, in order to more effectively engage pregnancy and childbirth one must take a “Meta-perspective” and rise above the bands of consciousness that are currently informing the various approaches and paradigms of maternity care. It is from this higher vantage point that we can best see the various gems of truth within the larger context of maternity care. By systematically evaluating and integrating the truths from these different perspectives, as opposed to solely embracing one and rejecting the other, there is an opportunity to enhance the overall understanding and approach that pregnancy, childbirth and postpartum care are met with in the United States.

This does not simply mean humanizing Obstetrics or medicalizing Midwifery. However, since these are the two main models of care that are currently operating in the West, this is where most of the gems are to be found. While the Midwifery Model has a great deal of value to contribute to the Integral Model of maternity care, it is also my opinion that this approach has some blind and weak spots as well. And though the Obstetric Model of care should not be under or overvalued, it certainly needs to be modified.

Integral Model of Pregnancy and Childbirth (IMCP)

Having touched on what I see as the new Integral Paradigm that I envision for maternity care, I now move forward with the presentation of the Integral Approach and Model of Pregnancy and Childbirth. It is worth pointing out that although the IMPC has been influenced and built upon an integral framework, drawing parallels between quadrants, levels, lines, states and types, is not the primary purpose of the model or presentation. The parallels that did arise between the IMPC and AQAL did so organically, and therefore, some components of the IMPC correspond directly with

INTEGRAL CHILDBIRTH

AQAL (4 S's/quadrants) and others more loosely (Uniqueness of Mothers and Births/types.) Further it is worth mentioning that although not modeled directly after ILP, the IMPC can be seen and used as a specific Integral Life Practice for the motherhood journey (Wilber, Patten, Leonard & Morelli, 2008). Due to the limitations of this paper, I will only briefly touch on each element of the model. The IMPC contains six key components, which are as follows.

1. Four S's (i.e. Self, Science, Support & Systems)
2. Potential for Psychospiritual Development
3. Levels in Birth (Needs and Stages)
4. Childbirth as a "Peak" State Experience
5. Uniqueness of Mothers and Births
6. Integration of the Birth Experience

The Four S's of the IMPC: SELF-SCIENCE-SUPPORT-SYSTEMS

The first component of the IMPC is what I call the "Fours S's" and corresponds directly with the four quadrants. As Wilber (2006) presents, these relate to the four primary dimensions or perspectives through which we experience the world (i.e. subjective, intersubjective, objective, and interobjective). An Integral Approach recognizes that all of these dimensions are tetra arising, are involved in a dynamic interplay, and that they can be worked with consciously. As described by Lewis E Mehl, M.D., Ph.D (1980):

By learning how to approach an integration of the mind, body and environment, a woman can move into harmony with her own natural body processes... We call this process of harmonizing the various parts of ourselves psychophysiological integration. This is because we are integrating our body function with the functioning of our inner selves. The result is personal growth and change, a sort of transcendence toward what we can become. (Peterson, 1981, p. x)

INTEGRAL CHILDBIRTH

The first “S” in the framework is what has been named *Self*, and corresponds to the upper left quadrant. (Wilber, 2006) This dimension relates to all of the laboring woman’s subjective processes and experiences. This includes her consciousness, stories and beliefs, as well as her thoughts, emotions, states of mind, and perceptions. This dimension of reality has an enormous impact because it is the woman’s meaning making center. Therefore, working with the internal dimension greatly affects how a woman *feels* about and *grows from* her journey through pregnancy, childbirth and into new motherhood (England, 1998).

There are many childbirth techniques that tap into and work with *Self* which have been proven to assist with labor pain and emotional turmoil (Gaskin, 2003). It has been shown that the woman’s interior processes (i.e. how a woman engages with the emotions, thoughts, and perceptions that arise during pregnancy and labor) not only influence how the woman feels about the labor experience, but can also dramatically influence the physical progress and outcome of the birth itself for the better (Gaskin, 2003). Further, a woman's general outlook on life, attitude and disposition will largely influence how she relates to and feels about her birth experience postpartum. Essentially, whatever a woman is carrying internally, the texture of her life, will very likely influence the experience of her birth (E. Ray, personal communication, January 10, 2012).

The second of the Four S’s is *Science*, and corresponds to the upper-right quadrant. This is the objective dimension that includes all of the physical manifestations, elements, influences, as well as outward behaviors and actions involved in pregnancy and childbirth (Wilber, 2006). This includes complex body mechanics, tests, techniques, prenatal practices, medical interventions, and physical pain reduction and coping techniques, both natural and pharmaceutical.

There is usually a great deal of pain involved in the process of childbirth, and this pain is most often addressed through upper right techniques and methodologies, either natural or pharmaceutical. These pharmaceutical substances act on the body’s systems to either numb or block

INTEGRAL CHILDBIRTH

the pain. However, if the choice is made to deliver naturally, there are also many non-pharmaceutical approaches to pain relief that fall into the upper-right dimension of Science (Goer, 1999). The most common upper right approaches to the pain and difficult mechanics of childbirth include pharmaceutical medication, technological intervention, breath work, movement, changing positions, touch, use of gravity, and hydrotherapy. (Balaskas, 1992). This quadrant also includes proper prenatal care, nutrition, exercise and bodywork during pregnancy, and has a significant impact on a labor proceeding normally without physical complication (Davis, 2012).

The third “S” in the Four S’s of the IMPC is *Support* and relates to the lower-left quadrant. This dimension is where we find collective, interior experiences, such as shared values, relationships, meanings, language, and cultural background. This also includes shared experience, and in the context of pregnancy and childbirth, it relates heavily to the level and quality of physical and emotional support that a woman receives before, during and after birth. This is what Wilber refers to as “we space” (Wilber, 2006). “We space” during labor can prove to be either a hindrance or a support. It can also tremendously impact the progress and outcome of the birth (Gaskin, 2003).

Support is often the key element that influences how a woman feels about her birth environment, birth provider, and experience as a whole. By and large, a woman needs to be emotionally and physically supported by others during labor and birth, as she needs to feel safe, supported and empowered by those around her. As my and others’ research shows, the more respected and empowered that a woman feels, both in the birth environment and by her providers, the better she will feel about her birth experience (Simkin, 1992; Radloff, 2012b). Ideally, a birthing mother would feel supported and empowered in any setting that she chooses to labor in, and she would feel this support from *everyone* around her, which may include her partner, family, nurses, midwives and/or Obstetricians.

INTEGRAL CHILDBIRTH

Not only does a woman tend to feel better about her birth experience when she receives continual labor support, but the presence of a non-medical birth assistant (doula) in labor has been shown to influence both how women feel about their birth experience (Self/upper left) as well as the actual outcome of the birth (Science/upper right). There have been numerous studies conducted that clearly indicate that psychosocial support in labor and birth are correlated with shorter labors, reduction in epidural requests, reduction in the Cesarean rate, and oxytocin use (McGrath, 2008). Conversely, the lack of support or a disturbing presence in the shared space of labor can also impact the labor process negatively. Gaskin (2003) explains that she has witnessed countless occasions in which labor has been slowed or stopped completely by the presence of “a strange person” in the birth room.

The cultural background and perceptions of a woman, her family, community, and culture all influence her approach and experience of childbirth. American pop culture, specifically movies and television, largely influence the perception of childbirth, which perpetuates a great deal of fear around the experience. These images and perceptions of labor all have an impact on a woman’s subjective experience, influence the decisions she makes for her birth, and determine the type of maternity care she seeks out in pregnancy. Therefore, it can prove useful for a woman to engage in deep inquiry practices that aim to differentiate herself from her cultural “stories,” assumptions and beliefs, and authentically connect into the setting, support and self-inquiry practices that will be most supportive to her before, during and after her labor.

The last “S” in the Four S’s is *Systems*, which corresponds with the lower-right quadrant. This is the interobjective domain, or the exterior of the collective, such as systems, networks, government, technology, institutions, and the natural environment (Wilber, 2006). In terms of pregnancy and childbirth, this manifests primarily as the larger maternity care system and birth environment. This involves the medical, financial, and insurance systems, as well as the particular

INTEGRAL CHILDBIRTH

health care institutions and standard policies that a woman intersects with during pregnancy and birth. All of these elements, especially those related to the place of birth, have a direct influence on the physical, subjective and intersubjective dimensions, i.e. *Self, Support* and *Science*.

My research shows that a woman can have a positive and empowering birth experience anywhere, but it is more challenging in certain circumstances and settings (Radloff, 2012b). In the hospital, a woman has to be incredibly strong in her convictions to stick to her desired birth plan, specifically if her desire is to birth naturally. Most hospital environments are deeply intertwined in the complex maternal care system that is largely operating out of what Davis-Floyd (2001) would call the technocratic paradigm. Therefore, the woman is more likely to be subject to the many external elements and influences that are a result of this impersonal, financially driven, and technology-based maternal care system. All in all, in the hospital there is more for a woman to contend with for her to have an empowered experience in labor, as women are subject to standard hospital policies and protocols. However, it is absolutely possible to have a positive, empowering, and transformational birth experience in this setting.

Some particularly interesting survey data collected from the study highlights the dynamic interplay happening between each of the 4 S's. For example, the data clearly indicated that women who had unmedicated, vaginal births were two times as likely to report that they felt more positive, self-empowered, self-confident and transformed by their birth experience than women who had vaginal deliveries *with* the use of pain medication (Radloff, 2012a). For example, 75 percent of women who delivered naturally said they felt "very positive" about their birth experience verses 40 percent of women who reported that they used pain medication in labor. Overall, women who delivered naturally (without major physical complications) were approximately twice as likely to report strong feelings of positive transformation, empowerment, self-confidence, and insight than those who labored with pain medication or planned C-section (Radloff, 2012a).

INTEGRAL CHILDBIRTH

Further, women who delivered vaginally *without* pain medication reported that the most helpful factor in their labor and birth was working with their internal state (i.e. thoughts, emotions, mind/body connection, etc.). From this information, I have concluded that giving birth without medication requires that a woman draw more on her internal resources to cope with physical pain (Radloff, 2012b). Yet women who delivered vaginally *with* pain medication reported that receiving support from others was the factor that helped them the most in labor (Radloff, 2012a). The fact that pain medication numbs the physical pain of labor but does not ease the intense anxiety and fear a woman may experience before and during labor, suggests that aside from medication to cope with the physical sensations of labor, women still benefit a great deal from the emotional support of another person in order to help them pass through the momentous transformation of childbirth (Radloff, 2012b; Peterson, 1981).

Further, the statistical data showed that there was a direct correlation between the birth environment and how satisfied a woman was with her overall birth experience. Specifically, women who gave birth in the hospital were significantly less satisfied with their birth experience than those who gave birth in other settings. The majority of women who reported that they were unhappy with their hospital birth experience cited a feeling of a lack of support, lack of control, respect, and empowerment with hospital staff. Although manifesting as complaints and dissatisfaction with the hospital system and birth environment, it is my conclusion that many of these complaints actually stemmed from issues in the lower-left quadrant of *Support*. (Radloff, 2012b).

Potential for Psychospiritual Transformation

The next component to the IMPC is the idea that pregnancy, childbirth, and the transition into parenthood have the potential to bring about psychospiritual transformation. As I see it, spiritual transformation can constitute a shift in the mother's interpretation and understanding of both herself and her life in general. Spiritual transformation, as explained by Psychologist Raymond

INTEGRAL CHILDBIRTH

Paloutzian, "Constitutes a change in the meaning system that a person holds as a basis for self-definition, the interpretation of life, and overarching purposes and ultimate concerns" (Paloutzian, 2005, p. 334).

In his book, *Integral Spirituality*, Wilber (2006) identifies four different meanings of the word "spiritual," which can mean the highest level on any lines, a separate line itself, an extraordinary peak state, or a particular attitude (p. 100). It is my opinion that each of these meanings of spirituality has the potential to be activated in pregnancy and childbirth and can therefore help facilitate spiritual awakening and development.

Speaking about this subject in a personal interview, Midwife Ellah Ray, explained that she sees pregnancy, labor, birth and the weeks immediately after the baby is born as "a window for transformation," for both a new mother and mother's partner. Ray explained, "I think that in my experience it's one of the places in these lives where true transformation happens. I think meditation on long retreats, childbirths, and having a newborn are the places that I know from firsthand experience that transformation happens" (E. Ray, personal communication, January 10, 2012).

Levels in Birth (Needs and Stages)

The next component of the Integral Approach to pregnancy and childbirth relates to the hierarchy of needs in childbirth, as well as the level of development, worldview and paradigm of the birthing mother. This component of the Model relates to the hierarchy of needs that arise during pregnancy and labor, which I have translated into a *Hierarchy of "Birth" Needs*.

According to Abraham Maslow, people's needs span from *deficiency* to *being* needs, which start at basic biological necessities and build toward self-actualization. These stages flow upward from survival, safety, belongingness and love, esteem, and finally, self-actualization. Maslow referred to *deficiency needs*, as needs that motivate a person out of a feeling of lack as opposed to *being* needs which are characterized by drives of self-actualization and self-transcendence. Being

INTEGRAL CHILDBIRTH

needs are driven out of a feeling of fullness and abundance (Wilber, 2003). By applying Maslow's Hierarchy to the experience of childbirth, it becomes clear that a woman's needs in pregnancy and birth also span from *deficiency* to *being*.

It is my opinion that each of these levels of needs is important and valuable within its own sphere. In terms of the IMPC, needs along the entire spectrum of the Hierarchy ought to be recognized, tended to, and ideally, met. That being said, there would be appropriate orientation around the fact that the lower (*deficiency*) needs have to be met before putting focus on the higher (*being*) needs. Although it is important to point out that each of these needs, especially during labor, arise simultaneously and fluidly, the intention ought to be one of meeting all of the needs along this Hierarchy, starting with basic safety and survival, while continually moving higher up the ladder toward the fulfillment of higher being needs that relate to empowerment and self-actualization.

Further, corresponding to levels in the AQAL framework, the birthing mother's altitude or "stage of development" will largely determine and dominate her perspectives, perceptions, expectations and desires in both pregnancy and birth. It is from here that she will prepare for, approach, understand, value and organize her childbirth experience (Wilber, 2006). However, due to the limited scope of this paper, I cannot detail each of these levels of development and how they are likely to influence a woman's pregnancy and childbirth experience.

Childbirth as a "Peak" State Experience

The fourth element of the IMPC holds the perspective that the experience of childbirth can manifest as a powerful "peak" or state experience. In this context, states refer to the aspects of consciousness that are temporal, passing, experiential, and phenomenal. Mark Forman (2010) explains, "At certain times there are pronounced—albeit temporary—shifts that occur and that push the person, biology, culture or system out of its homeostatic state. These states introduce new factors, new information, and new forces" (p. 24). This is certainly how I would describe my

INTEGRAL CHILDBIRTH

childbirth. In fact, I would identify it as being the longest, most powerful, painful, and transformative state experience that I have had in my life.

Maslow (1971) spoke a great deal about the transformation and growth that can take place as a result of a powerful peak experience. He explained:

The term peak experiences is a generalization for the best moments of the human being, for the happiest moments of life, for experiences of ecstasy, rapture, bliss, of the greatest joy. I found that such experiences came from profound aesthetic experiences such as creative ecstasies, moments of mature love, perfect sexual experiences, parental love, experiences of natural childbirth, and many others. (p. 105)

Although sustained practice and work is typically considered most effective in terms of facilitating permanent developmental growth and leaps, Maslow (1971) also presented the idea that if approached consciously as an opportunity for growth, then peak experience can be effective vehicles for transformation. He explained, “Peak experiences often have consequences...They can do the same there as psychotherapy, if one keeps his goals right, and if one knows just what he is about, and if one is conscious of what he is going toward” (p. 177).

Uniqueness of the Individual, Birth & Situation

The next component of the IMPC relates to the fact that every woman is her own complex constellation of biology, traits, history, background, and personality type. Keeping this in mind, the IMPC is highly adaptable to the individual. Further, there is a recognition that no birth process is the same (i.e. the 4 S's are always manifesting uniquely), and therefore a fluidity must be maintained that flexes and flows with the uniqueness of the individual and circumstances.

Further, this aspect includes “Types,” and a recognition that approaching birth and pregnant women with an awareness of different personality typing systems may prove helpful. Using the enneagram typing system as an example of this, an approach that gives one enneatype the feeling of

INTEGRAL CHILDBIRTH

safety and security may bring about the exact opposite in another. In the case of a “enneatype six,” the mother may feel more secure if she strategizes and prepares as much as she can before the birth of the baby, including possible complication. On the other hand, an “enneatype seven” may feel more secure as she faces birth if she only focus on the positive and will not be supported in her process if too much attention is given to potential complications. (Riso and Husdon, 1999).

Integration of the Birth Experience

The final foundational aspect to an Integral Approach to Pregnancy and Childbirth, is recognizing and supporting the need for a woman to process and integrate her birth experience. Integrating the experience of childbirth, particularly giving space to "be with," reflect on, and process what happened during labor and delivery has an enormous impact on how a woman feels about and grows from her childbirth experience.

The birth experience a woman will have is unpredictable. Childbirth is usually incredibly difficult, and labor is typically painful, even in the best-case scenarios. When physical complications arise in labor, genuinely threatening survival, safety and security, then these and only these issues rightfully become the focus of the experience. In this case, resolving and healing trauma needs to be the focus of the woman’s work postpartum (Reynolds, 1997).

If the necessary attention, nurturing, time, and space are given for this process, then the difficulty in labor can be healed, transmuted, and integrated. This includes facing the grief, sadness, or disappointment that a woman may feel after a birth experience did not go how she imagined or hoped that it would. This process in itself can be incredibly difficult, yet if given the needed attention, it can help address the needs that were not met during her labor. This process, although a different path, can still result in positive growth and transformation (Peterson, 1996).

In her article, *Childbirth: The Ordinary Miracle: Effects of Devaluation of Childbirth on Women's Self-Esteem and Family Relationship*, Gayle Peterson (1996) states:

INTEGRAL CHILDBIRTH

To not take a woman's needs seriously, is to contribute to a lowered sense of self esteem which may also have effects on her available energy for bonding and enjoying her baby, and may even contribute to postpartum depression. Without a way to integrate the experience, *women are left to try to feel better by denigrating childbirth*. This approach serves the overall social structure which itself devalues the process. But in the end it undermines a woman's sense of the worth of her own significant life events. (para. 4)

Even if a woman's labor was not traumatic, it is still highly likely that it was *the* most intense and difficult experience of her life. It is also likely that most women have expectations or hopes for what their birth will be like, and even if their birth experience was not *bad* per se, it often does not match up with the idea that of what it would be like. Therefore, the relationship to what *was* has to be processed and reintegrated into the new reality of what *is*. All of this said, the need to process and integrate the birth experience is an important part of an Integral Approach to Pregnancy and Childbirth, regardless of whether or not the mother's experience was positive or negative (Peterson, 1996).

Conclusion

As we have clearly seen above, there are the many internal and external elements that influence the process and outcome of a birth, as well as determine how a woman feels about and is able to integrate her childbirth experience postpartum. These internal and external elements include how the woman experiences and works with her internal state during labor, the length and level of complication involved in the labor and birth process, the birth setting and environment itself, as well as the kind of support that the woman receives from those around her before, during, and after birth. These factors also influence how the woman thinks about pregnancy and labor, largely determine how labor is responded to by health care professionals, shape the paradigms and cultural norms involving pregnancy and childbirth, and fuel the standard maternal health care system's policies and

INTEGRAL CHILDBIRTH

procedures.

As I conclude this exploration (and at the risk of unduly elevating myself to “Integral”), I will present an illustration of my own pregnancy and birth experience, as throughout my journey, I attempted to utilize an Integral Approach, which would later inspire the creation of the IMPC.

During my pregnancy, as I prepared to give birth, I felt as if I was training to climb a mountain. It also felt like I was on the top of a rollercoaster that I no choice but to go down. It was exciting and scary. Although I anticipated it as being more demanding and frightening than any other physical undertaking that I had ever faced, I also saw the promise for childbirth to be a challenging mental, emotional, and spiritual journey. Since I have an inherent value for doing inner work on myself, and recognize the possibility for challenge to translate into growth, I welcomed the potential for my childbirth to be a self-transcending and transformative experience, and I approached giving birth from physical, mental, emotional, and spiritual orientations.

I took childbirth preparation courses, received concurrent care from an Obstetrician and midwife, read books on childbirth, practiced prenatal yoga, clarified and visualized my ideal birth, practiced mindful meditation, sought counseling, and ate impeccably with all of the best supplements. I also had a clear birth and back-up plan, chose the birth environment and companions that I knew I would feel most comfortable and safe with, and had an incredible network of practitioners and family supporting me. Being an enneatype six with a seven wing, I felt as prepared as I could be for an experience of the unknown, which served me.

All of this undoubtedly helped me in my childbirth experience. During labor I utilized the tools that I had practiced in pregnancy, namely Mindfulness. With Mindfulness I was able to observe my thoughts and feelings as they arose in response to what was happening to my physical body. Mindfulness helped me notice the moment during transition that I started mentally saying, “NO!” to the unbearable pain of contractions. Difficult as it was, when I witnessed this happening, I

INTEGRAL CHILDBIRTH

forced myself instead to say “Yes!” aloud.

It was also with Mindfulness-based childbirth training that I was reminded to rest between contractions, not agonize over the pain of the last contraction or dreadfully anticipate the next, and allow for the blissful hormone of oxytocin to naturally flood through my body. Further, I was in an environment where I felt safe, empowered, and supported, and I had an incredibly supportive and loving partner who held me, physically and emotionally, as I birthed our baby into the world.

Overall, my labor proceeded normally, smoothly, and was relatively short for a first labor. I was not subject to any routine or unnecessary medical interventions, but received them readily when I hemorrhaged and it became medically necessary for intervention. All in all, I had as close to the ideal birth that a woman who was wanting a natural birth could hope for. That being said, it was still the most painful, surreal, and challenging experience that I have ever had in my life that required time and space for integration.

I was undoubtedly both challenged and changed by the intense experience of facing and giving birth, although it was not simply the hours of labor that changed me, instead, it was the nine months of preparation and work that lead up to that event which allowed my birth experience to be the pinnacle of my transformation. When all was said and done, I had come out on the other side of childbirth as a new, stronger, and more powerful woman, namely, a mother.

Therefore, in addition to my history and background in pregnancy, childbirth and transformational growth, it was from my own personal journey that I came to embrace an even stronger vision that the experience of pregnancy, childbirth and early parenthood, when approached in a conscious and integrated way, can not only increase the opportunity for a positive birth and postpartum experience, but that it can also act as a catalyst for increased well-being, personal growth and psychospiritual transformation for women and their families.

My intention with creating and presenting the IMPC, is to help facilitate empowering,

INTEGRAL CHILDBIRTH

positive and transformative pregnancy and birth experiences, ideally “midwifing” a healthy transformation for a woman physically, mentally, emotionally, and spiritually. I believe wholeheartedly as I have experienced it first-hand, that birth can serve this higher purpose. This pivotal shift in the perspective of childbirth and pregnancy has the ability to not only serve the individual development and well-being of the birthing mother herself, but it collectively has the potential to bring about a long-lasting global impact to the planet and its people as a whole. After all, what could be more powerful and transformative than how we relate to and approach the act of creating and birthing new physical life?

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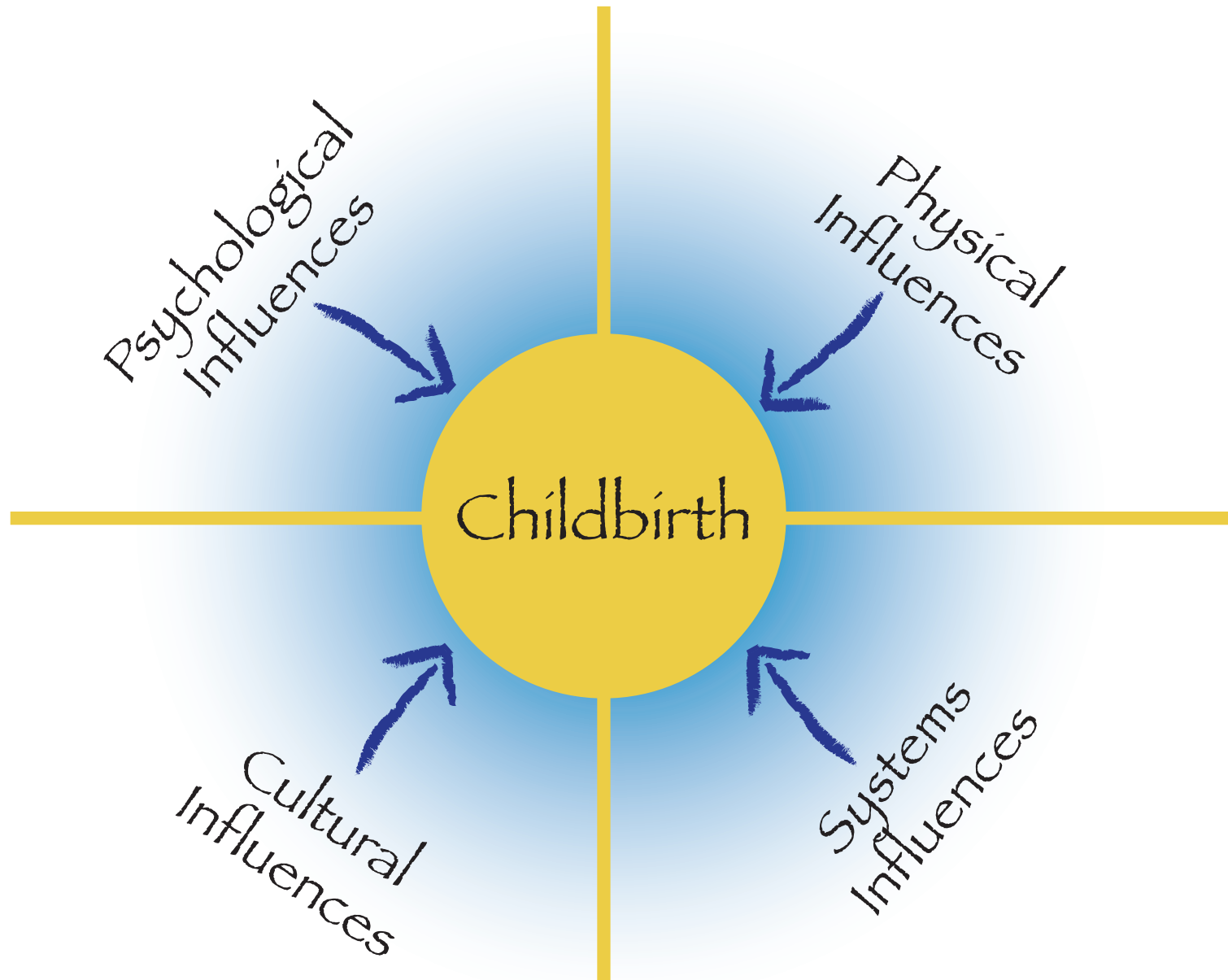
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INTERIOR

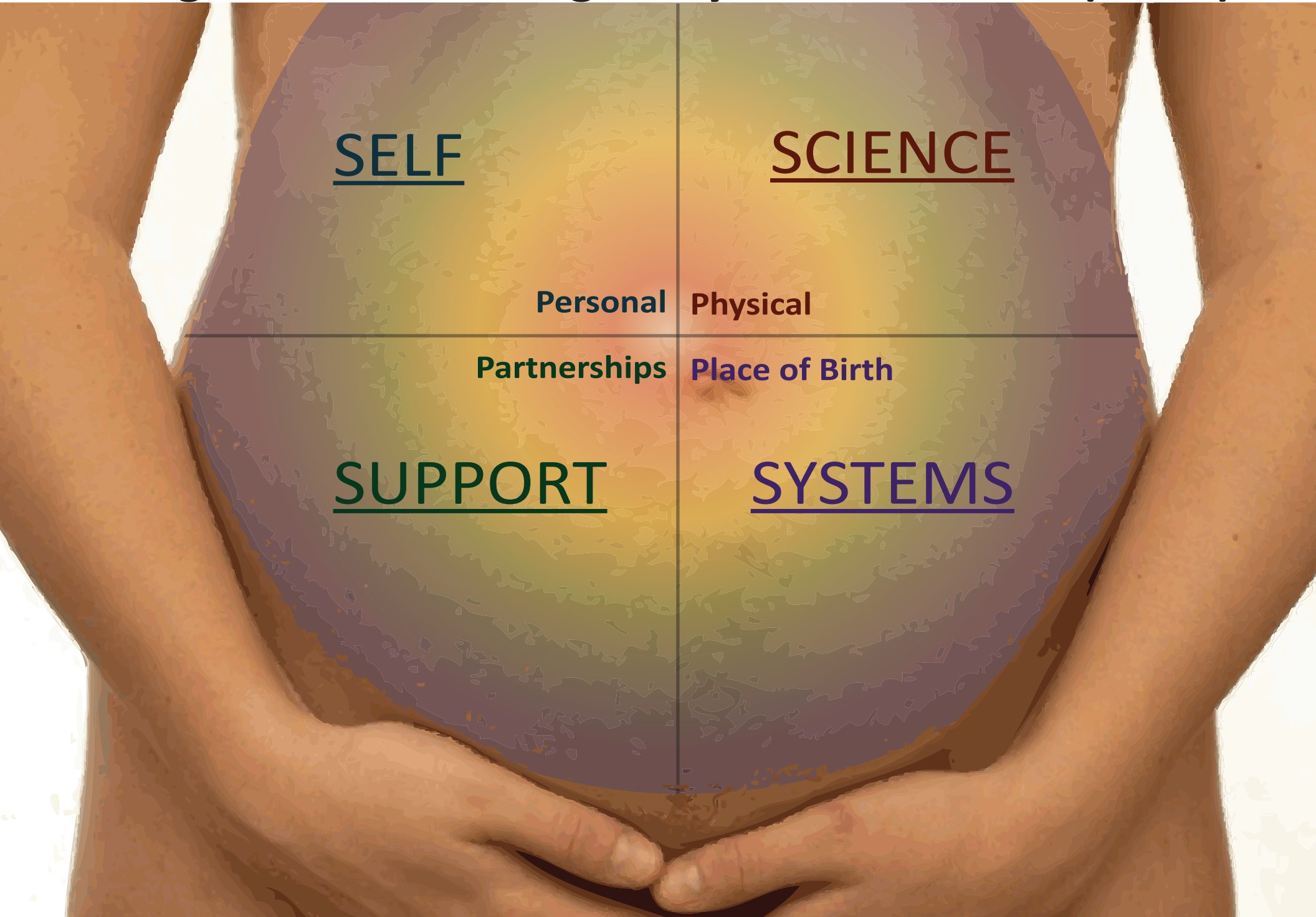
EXTERIOR

INDIVIDUAL

COLLECTIVE



Integral Model of Pregnancy and Childbirth (IMPC)



Integral Approach to Childbirth

