MATERNAL HEALTH INNOVATION Podcast

Changing the way America cares for women and birthing people.

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Dr. Kristin Tully & Dr. Karen Sheffield-Abdullah

Kristin: Welcome to Maternal Health Innovation, a podcast from the Maternal Health Learning and Innovation Center, or MHLIC, where we connect around culture, measures, and best practices in maternal health. I'm Dr Kristin Tully, co-chair of the MHLIC Innovation Support Core, and I'm a researcher at UNC Chapel Hill. It's a joy to be part of a learning community, to strengthen our national policies and systems of care so that they are more commentating for birthing parents, their infants, and those who love and care for them.

In this podcast episode we get to hear from Dr. Karen Sheffield-Abdullah. Dr. Karen is faculty in the school of nursing at UNC, a midwife, a mindfulness instructor, and a very thoughtful, wonderful person.

Dr. Karen Sheffield-Abdullah: I'm a mother for first and foremost, I'm a nurse midwife of 16 years. Love all things, pregnancy, mamas, babies, and everything in between, across the lifespan for women's health and birthing individuals. And I'm also a mindfulness instructor at the core and heart of who I am. I'm also a PhD-prepared researcher, an assistant professor at UNC Chapel Hill School of Nursing, and I identify as a Black woman and really, as I think about my work and I think about what drives my work, I think about what jazzes me, all of those things together collectively have shaped who I am and who I have become.

So as I think about my research, right so if I were to put on my research hat, I'm super interested in exploring stress and anxiety in perinatal, pregnant and postpartum Black birthing individuals. And you'll hear me interchangeably use those terms throughout this podcast, so recognizing that not all people who give birth identify as a woman or as a mother. The terminology is shifting now where we use this term of birthing individual, birthing person, but you may hear me sometimes revert back to using woman, mama, mother, but recognizing that I'm respecting that distinction there.

So I'm exploring stress and anxiety and perinatal Black women, and the impact on their birth outcomes in particular preterm birth, understanding that black women have twice the rate of preterm birth compared to white women, and that has persisted despite decades of research, despite differences in socioeconomic status, maternal education, access to prenatal care. When you pair or look at a Black woman and a white woman who are pregnant, the Black woman will have their baby early at twice the rate of white women.

And that has persisted and my question is “Why?”, and what's my dissertation work really centered around, was looking at the unique experiences of stress for Black women, utilizing a particular conceptual framework called Superwoman Schema developed by Dr. Cheryl Woods Giscombe, who was my dissertation chair, advisor, mentor colleague, friend and it basically states that there are certain social, historical and cultural perspectives that have happened in this country that have caused Black women to take on certain characteristics that have shaped their experiences, and there are five different characteristics.

I don't need to list them all, but just to state that some of them are resistance to being vulnerable, determination to succeed despite limited resources, emotional suppression, caregiver role, things of that nature, and so I utilize this conceptual framework to ask the question: “Is there something unique about the stress experience for Black women that it caused us to have these health disparities in our birth outcomes that we have not looked at in the past?”

So thinking about this contextualized nuanced, unique stress experience for Black women and how that may be impacting our birth outcomes, and so I consider myself a stress researcher, but I'm also super interested in this idea of anxiety. We know that stress can lead to preterm birth. We know that anxiety can lead to preterm birth, but I don't think that we've sufficiently elucidated that within the Black community, especially talking about it with Black women.

And so I fundamentally asked the question, when I say the word stress, what comes to mind? What does stress mean for you, and surprisingly or not, they said things like anxiety, overwhelmed, got a lot going on, right. And so I was like, okay. I knew anxiety was a thing, right, and then I asked them things about Superwoman schema. Have you ever heard of the term, what does it mean? Why do you think that this has come about? Are there benefits to it? Are there detriments?

So they told me, and then I also asked them things like about mindfulness. As I mentioned, I am a mindfulness instructor and I'm really looking to ultimately develop a culturally tailored, patient centered, trauma sensitive, mindfulness-based intervention targeting stress and anxiety and Black perinatal women in the hopes of being able to improve their birth outcomes.

But if I'm being completely transparent, I'm interested in improving quality of life and wellbeing for Black women, because I'm interested in improving quality of life and wellbeing for Black women period. But when you attach it to their birth outcomes, that's when it becomes more fundable. That's when people are a little bit more interested because preterm birth and its consequences is a $26 billion cost to this country per year.

So people's ears perk up when they think about the cost that's associated with preterm birth. And so I asked women, “When I say the word mindfulness, what comes to mind? Have you even heard of it?” Right. So we can kind of, I use this term, like as researchers, as academicians, we can often kind of pontificate from our silos about

what we think the masses need, but we need to ask the fundamental question of that community.

And so what had they heard of the word mindfulness? Because if I develop a mindfulness program, but they have no interest in it, then what's the point. So I asked them that, and I also said if I were to develop a mindfulness-based intervention, targeting stress and anxiety for you during pregnancy, would that be acceptable?

And there was a resounding 100% of them said, yes, absolutely. Then I said, furthermore, if I were to develop this program, what would you want to see in it? What would make it jazzy? What would make it novel? What would make you want to come every week? Right. And they told me, and so now I am at the next stage of taking that information and developing this intervention.

Um, and I'm even, you know, I'm very aware of language, especially in this last couple of years with concurrent pandemics. And so I even pause a bit when I say the word intervention, cause I don't really know that we need to intervene upon a particular population. So thinking about a mindfulness program that would be meeting the needs and doing it in a way where Black women would know that they are seen, that they're heard and that they are valued.

And how do we show them? We show them that by including them in the development of programming that is to meet their needs. Right. So one of the other things that I did ask very early on is, is there anything unique, least stressful about being pregnant? I'm just, I was just curious. And then I said, is there anything uniquely stressful about being Black and pregnant? And that's when it got really interesting in terms of what they told me.

Kristin: I just want to, you know, reflect back for a moment too. You've listed so many things, you know, valuing women for ourselves, not only, you know, for birth outcomes, but also for us, you know? And then you've also just outlined being with the community, you know, like the whole way.

And that is the way to do things. I think that is just the way, you know, there's, you can call it a lot of things in human centered design or participatory research, there's lots, but like this is also, you know, research justice, I think like let's have our positions, you know, collectively be in direct service and so that's just so inspiring.

Dr. Karen Sheffield-Abdullah: Yeah, I really think it's about developing programming and listening to the voices of the population of the people, of the women that I want to serve and doing that in an intentional way and being present. Right. And so I believe that's where the mindfulness piece even comes in for me.

I'm a practitioner of mindfulness. I'm a mindfulness instructor. Very simple definition of mindfulness by Jon Kabat-Zinn is paying attention in the present moment for whatever is arising and doing so without judgment. And so when I bring myself back to the present, and then really in true communication with an individual, and my mind is not off

thinking about the next thing or ruminating or worrying about what just happened, but really being able to be present.

I'm valuing that experience, and I really feel like, you know, as a midwife, I have the heart of the midwife. So I really feel like I resonate heart to heart with people. And so really valuing what it is that they're telling me what they want to see. Part of what they want to see is that they want to have the intervention, the programming be developed for us by us.

Right? So they want to have mindfulness instructors that look like them, that sound like them. They want to be in an environment that feels safe in an environment where nature is brought inside. They also talked about the importance of it really solely being for Black women, they recognize that while this may be helpful, mindfulness programming may be helpful for other populations.

They really want it to be such that those that are included are Black women, so that there is an identity that is shared across. Right. And that is not to say that Black women are a homogenous group. Right that we all come with our backgrounds, but yet there is a common thread there whereby you're not having to explain certain things.

There's an inherent understanding, and I also think that that comes back to this Superwoman Schema piece where this emotional suppression or maintaining this stoic exterior, resistance to being vulnerable because you're not sure who's in the room. When you know who's in the room, there's that, that veil, if you will, can be lifted, that burden that is carried can be lifted and you can show up authentically as you are.

And this sense of community is super important. And so I honor that, I recognize that. And so now the idea is how do I make that happen? Right. And so that's part of the reason why I decided to become a mindfulness instructor myself, right. There's not a lot of Black female mindfulness instructors out there.

And so I said, I need to start with me. And so that's what made me decide to go through Brown University's Mindfulness Center's mindfulness-based stress reduction teacher certification, which is what I'm pursuing, because I really want to understand the core precepts, the core tenets, of mindfulness that are amenable to adaptation for this population.

What is it within MBSR that I think would work really well? Right. And what might not work as well? Or how do I culturally tailor that? So it's, it sounds like a bunch of fancy words, but when we break that down, the culturally tailored piece is centering the lived experience of the Black woman. And what their values are, what they're saying is important and tailoring the intervention to incorporate those voices. Right?

Kristin: Yeah. And you can only do that when you have real relationships with them. Tell us about what it means to be safe and brave.

Dr. Karen Sheffield-Abdullah: Yeah. Yeah. So in this past year, as I said, I've been in the past year or two, I've really become a little bit more aware of language and how we use language. And as I think about cultivating a safe space, I had some hesitancy and how I was using that word, just because when we're in a group setting topics may come up that don't feel safe for an individual.

It doesn't feel safe to share, or it may be activating for that person because of their individual experience, perhaps with trauma, right. And so can we ever say that a space is truly safe because you never know what may be said, may not feel safe for an individual. And so I have thought about this idea of creating a brave space where people can show up authentically as who they are and share courageously.

And so often when I'm in groups or in, in settings or in spaces, I will say, I don't know that we can create a safe space, but what I am wanting to be able to do is create a brave space. And out of that was born this company that I've developed called BRAVE Company, and BRAVE is an acronym that stands for Boldly Resilient, Authentically Valued and Expecting, and this idea of expecting as a bit of a play on word, it can mean a couple of things. Expecting for the birthing individual would mean expecting the child, but for non-pregnant individuals expecting really is about what are you expecting in life?

Kristin: And I think that transparency and that recognition, and like, to me, that proactive acknowledgement to build decision-making around how we want to engage. And like, if we know what we say is protected and if it's valued and it's for something, you know, like we have a purpose, like in, in all of our activities, like in, with research participants and with each other, and then in our, you know, our dissemination efforts or programs at work, like knowing that, and I think reaffirming it all the time, like matters, I think is incredibly helpful.

Dr. Karen Sheffield-Abdullah: Yeah. And as I think about, you know, perinatal health care, right, and, and what is needed, I think it looks like fostering an environment where they can show up in brave ways and being honest about their experiences, and being in an environment where being vulnerable is okay, and where they know that they are being seen, heard, and valued by their healthcare providers.

Right. So that's, as I'm thinking about, you know, particular projects that you and I are working on together and thinking about how we move the needle, shift the paradigm, I don't think it needs to be that complicated, Kristin. I think there are some very basic core principles values that we can bring to the table collectively to think about how systematic change can happen within healthcare systems and trickling, if you will, to the healthcare providers on so many different levels, such that when we walk in the room, with someone who has just given birth or perhaps somebody who is even laboring, right.

Thinking about prenatal care and postnatal care. I think if we show up in ways where they know that they're being seen, and you take a moment, that that carries so much weight in terms of trust, that that an individual now says, okay, something's different about the care I'm receiving.

Kristin: And what do you think about our health care team member friends, and, you know, the community as a whole with nursing and with the providers, you know, what are your thoughts about how people can be equipped with providing the care that they would like to in these very, very hard times?

Dr. Karen Sheffield-Abdullah: It is hard times. And as a clinician, right? As a nurse midwife, a clinician of 16 years, I recognize there's a lot, right, that's happening right now. But just inherently within the profession, we're busy, right? We're constantly moving from room to room or, you know, from space to space. And how do we prioritize the person that we're with in that moment?

I think there's multiple ways we can think about doing that. As a midwife, I think inherently within the education that I received at Yale, it was modeled for me. It was demonstrated for me how you can show up and be present with a birthing individual and letting them know that you are my priority.

Yes. It may be the fact that there are all types of things happening outside of this room that need my attention. But in this moment, I'm here with you and it may be something as simple as sitting down. Not standing up and writing or at the, you know, at the computer charting or whatever, something just as simple as that and listening, not interrupting and then shared decision-making informed consent.

Here are your choices, but you ultimately are the one that's making the decision. Right. But, and, and, and not only that, but. Shared decision making and informed consent in language that makes sense to the individual, right? We talk about language concordance, right, so that can even be for non-English speaking patients, but also talking in a way in which folks can understand what are the, the decisions that they're making, right.

What am I consenting to here? Right. You know, whether it's about a procedure or contraception or what their needs are for their transition home. Right? Thinking about how we can just, if I were to, you know, introduce the mindfulness principles here, take a pause, take a breath, be present. And maybe you do that prior to walking in the room.

Maybe that's educating healthcare providers, healthcare systems, healthcare teams. About mindfulness principles, practices. Taking that breath before you enter the room so that you can be fully present with that individual, and I guarantee you that when you take the time to sit and listen, what they will say, what you can learn.

There's some, there's some literature out there I know about how quickly healthcare providers interrupt the patient when we ask them a question and they start to answer and then we're like, yeah, so, you know, and we don't actually give them the space or the time to answer the question. Yeah.

Kristin: And I think, you know, there's so much needed attention to implicit bias and training, and a huge part of that story to me is like keeping you like keeping mindfulness, like keeping that pause and like that intentionality that you've been outlining throughout communication so it is actually meaningful. And so that when

someone asks a question about, I'm not sure my baby's feeding enough, or, you know, is it okay if I take his pills or whatever like that, we recognize that it's a bigger question.

Like that there's an opportunity there to think about what is driving, what they're saying and how we can help with that bigger picture, you know, in addition to whatever specifics and not only respond with the solution that we, in an effort to be helpful like that we think that they should do or that they want, you know?

And because then that can be something that maybe they would have navigated too, but it's not fair or appropriate. And that's, I think, how we see a lot of the disparities and outcomes, because that process can be strengthened.

Dr. Karen Sheffield-Abdullah: Right? Absolutely. I think it's about contextualizing, right? Like really understanding that this person, it's not just about the pregnancy or the birth, but looking at them more holistic with their lives, right. Their lives and what is potentially influencing, impacting who they are and how they're showing up and taking a moment to perhaps just go a little deeper with that, you know, and, asking additional questions and really getting a fuller picture.

Oftentimes within healthcare professions, we talk about taking the history is 80% of figuring out what the, you know, 80 or 90% of figuring out what the, what the problem is. But what I would say is perhaps putting less focus on the problem and spending a little bit more time, doing a deeper dive into what is here and how can we best address it.

And it may not be the easy answer, but being willing to do the work. And I think that's part of what we're wanting to do. And the projects that I'm working with you on is doing this deeper dive and really thinking about how can we elevate the lived experience of this individual. And how might we help them in the way that they would find most helpful, right. Not what we think, given our limitations.

Kristin: And what you said about, like, how they show up. I think that's been really important for me and I think our broader team to learn about how some behaviors are for self-preservation, you know, and like, when we share and however, we respond, it's like help seeking or avoidance. And this again, I think it's incredibly powerful to try to get at the reality of what's occurring so that then together we can have a transformation, you know, and I'm here for the revolution and like, you know, and when you said about interventions, like, yeah, we need to not be doing more things or have this be like, but like we need to change this standard.

And I think, you know, the culture of health is what drives like, well, and our, you know, societal views too, like it's in a healthcare system as a part of that, but like how we think about this journey, you know, and the pieces of it, then that drives everything. You know, what we think to ask and who is right, and who we don't.

Dr. Karen Sheffield-Abdullah: Right, and I think that's how we ultimately get to achieving health equity. Right, and thinking about this, this idea surrounding health equity, where every individual, every person, regardless of background, race, ethnicity,

socioeconomic status, payer status, you know, insurance status, regardless of all of that, have an equal, fair, and just opportunity to achieve their optimal health.

That's what it's about. You know what I mean? And I think that this is where we're wanting to go and I - and perhaps in my broader vision - think it is achievable, you know, or I wouldn't be wanting to do this work. Right. I recognize that it's not necessarily an easy task. There's a lot of inherent barriers to achieving that, but I think we're doing the real work of wanting to figure out how we can achieve equitable health for all individuals.

I'm struck in the past couple of years, just thinking about racial injustice, social injustice, and how that has impacted communities, fundamentally bringing back these simple ideas surrounding kindness, compassion, authenticity, being seen. That hit that, that hits home for me as a Black woman, I want to be seen, I want to be heard.

And I want my words to be valued inherently. Not because somebody else may value it may, may somehow come and then adds their own two, you know, 2 cents that then adds some credibility to what I said no, when I say it, believe it, this is my lived experience. And so, we can talk on and on and on about George Floyd and Ahmaud Arbery and Brianna Taylor and you know, and all that has happened, that things seem to have quieted down a bit, which worries me a bit to be perfectly honest, because I don't know that anything has truly changed.

And I think that needs to be continued to be highlighted in ways that recognize these are stress oars. And I am anxious to see birth outcomes as a function of this time, right. Has there been an uptick at all in adverse outcomes? And also the lived experience of black birthing individuals and how they navigated all of that.

Right. I think we're seeing some of that in the work that we've done together and evaluating the impact of COVID and racial unrest and injustice that has happened during that time. But imagine what women told me was uniquely stressful about being Black and pregnant for an example, are the judgements and assumptions that are made about them, right?

Negative.

Yeah, absolutely. If they aren't wearing their wedding ring that their providers are saying, oh, is the father of the baby not involved. And this participant, this individual said, my husband is at work and couldn't make it today. But there was an assumption. Yeah, well, she wasn't wearing her wedding ring because she has gained weight during the pregnancy and, and not for nothing. But she doesn't want to wear a wedding ring. That's perfectly within her right.

Another individual said when I found out I was having a son, the stress of what that meant the conversations that would have to be navigated, when do they go from being cute, to being a threat? The stress that comes with that is real. And so how do we address that? How do we shift the society? How do we shift the culture? How do we shift the paradigm by which we are living in this very real pressure cooker, if you will,

how you navigate those relationships, those conversations, that stress, how do we navigate that stress for Black women?

Kristin: What else do you want to bring up?

Dr. Karen Sheffield-Abdullah: You know, if I don't get anything else across, just how important it is I feel that we're seen, heard and valued. And I've said that so many times, but it really is inherently so important to me. And if I could just share a story with you really quickly. So I attended a five-day mindfulness workshop in New York and had the opportunity to co-facilitate.

And I was asked to co-facilitate this because they wanted to bring in this aspect of stress and the unique type of stressors that can be present for certain populations. And knowing that I'm a stress researcher, they really valued my perspective. And so I was brought in to help co-facilitate and navigate some conversations that perhaps may be a little bit uncomfortable, however, as a nurse midwife, I am perfectly comfortable in uncomfortable situations, right?

So birth can be, you know, there's all types of things that happen during birth. I'm completely comfortable holding space for birthing individuals and whatever ways that I need to do that. And so getting back to this experience where I showed up, and showed up in such authentic ways to share this content, this mindfulness content with this group of individuals.

And it was the day to talk about stress, right? And so I was talking about stress and stress reactivity and mindfulness mediated stress response, and talking to them about the Lazarus and Folkman model, a transactional model of stress. Really gave them real world examples of the unique stressors that can be present for Black women.

And, but really bridged it back to how do we show up authentically with our individual identities and the intersectionality of those identities? For me, it is Black woman. Right. But it could also be Black woman, mother. Mindfulness instructor, whatever those intersections of how we identify. But I shared with them a bit about the unique experiences of stress for black women.

And we talked about stressors and I piled up cushions of like, okay, just name stressors for me. What are some things that are stressors in life? Right. And people said, finances, job, work, family, you know, and I started piling up cushions, right. So that they could see all these different stressors and how that can represent kind of cumulative stress, right?

Or also what we call Allostatic Load, that's something that Bruce McEwen talks about. And so I did this demonstration and we talked about stress and people had questions. And apparently, I kept saying, “I see you. I see you,” as the hands were going up. I may not have been able to answer the question in the moment, but I was acknowledging, I see you had no idea that I was doing that.

And so afterwards, you know, we had a break and then we came back after the break and it was brought to my attention during the break that some individuals were having a really hard time holding space for the content that was delivered. Like, it was really hard for them to hear about these unique stressors that exist for Black women.

And so I came back and I kind of circled back to this, you know, I, I want to, I wanted to address it and I wanted to be able to have people open up even more about what was, what's difficult about hearing, about different lived experiences, right? And one individual spoke up and she said, you know, I noticed during the morning session that Karen kept saying, I see you.

And that is steeped in this African tradition of being seen and being heard. And she said, Karen, I just want to let you know that in all that you shared with us this morning, I see you. And it was a moment for me where I felt this is, this is what I'm talking about. Right. And that this white woman and I in full transparency was the only Black woman in this entire group.

And she said, Karen, I want to let you know that I see, and the flip side to that is I am here. And this is steeped in this African tradition, which is when a person greets you, they say, I see you and the person then responds with and I am here. And then that person says, I see you. And then you in turn would say, and I am.

Right. And so recognizing that kind of call and response, right of ICU and I am here and I have, I mean, there was so much there for me in recognizing that I actually think that's some of the programming that I'd be developing, a mindfulness program called “I See You” and I am here because that is at the essence of what I believe is needed.

If as a community we could truly stand and look at another individual that is not like us and say with authenticity. I see you. And for that person to then be able to respond and I am here. How that's a shift, Kristin, that's a shift. If we could do that for one another, whether it's in the healthcare space, not just healthcare provider to patient, healthcare provider to healthcare provider, thinking about that interaction and how we would be providing better care to our patients.

If we are seeing one another, taking a moment to truly see one another, not what has been politicized or, you know, aggrandized within society, where we're all getting hijacked by, you know, whatever is the newest thing that we're doom scrolling through. Instagram or whatever our social media may be. But honestly, as I think over the last couple of years just being seen and being here.

Kristin: Yeah. I mean, I think that's what power is then, you know, like, Showing up for each other. And first of all, being willing to do that and being open to what that means, I think that's sure something to work towards.

Dr. Karen Sheffield-Abdullah: Yes, yes. And having, you know, being humble, you know, Joia Crear-Perry. I heard her talk about that, this idea of being culturally competent, but being culturally humble.

Right. Can I ever say that I'm competent in another one's culture? I don't know. Right. But can I say I'm humble enough to want to learn about that culture.

Kristin: Yeah. And this, this I learned this morning, this concept of confident humility, or maybe it's the reverse humble confidence, like, you know, I'm here and I'm trying, and I know that like, this is a journey, you know, and, and this is something too that I don't know what I don't know.

And I, but I'm here and I want to, and I, I know not only do we have good intent, but we are intentional with our actions to try to. You know, to show up and to try to listen and to reflect on what not only is shared, but then what that means and recognizing that takes a lot, I think, and over time. And so I think that I am totally in alignment with you about humility and how that should, I think, be embedded to us in our journeys and becoming better humans and therefore, you know, being helpful in our spaces.

Dr. Karen Sheffield-Abdullah: And although one would think that this is not something that is innovative, in fact, I think it is innovative. I think coming to a particular, if you will, public health issue or public health problem, and being willing to take a moment to kind of do this deeper dive in steep into these concepts and these ideas.

In a way that isn't like, we don't have time to really be thinking about, you know, seeing and hearing and, you know, being humble and all that. Like, we need to figure out how to reduce, you know, readmission to the hospital. You know what I mean? And from postnatal care, this is the innovative piece it's thinking outside of.

In mindfulness we have this exercise called The Nine Dots. I don't know if you've heard of that, but it's nine dots, three dots across and three dots down, right, in this square. And we asked people to just take a moment to think about how you can connect all nine dots with four lines, never lifting your pen from the page.

Right. And we send them home that night too, to just think. When some people come back the next day and they're just like, oh my God, I don't know how to figure this out. Well, my goodness. And they're stressed about it. And so we give them opportunities to come up and show how they try to solve the issue. And I, you know, and then I go up and I show them how it can be done, but the idea is you have to go outside of the nine dots.

Right? You have to think outside of that block of nine, that's interesting to have to bring the line up and out and then bring it back in. And that's the innovative piece that I think is important for us as we work together, thinking outside of our habitual conditional way, conditioned way of thinking about approaching a problem. The innovative piece is thinking outside of those nine, literally outside them, literally outside of the box.

Kristin: In this world of, you know, subject matter experts and technical assistance and coaching, and that, I think that to me, what's innovative is recognizing the wisdom that we all have. That we are all experts in these things in different ways, and that integration is the power.

Dr. Karen Sheffield-Abdullah: Absolutely. I believe that the community has the answers. We just need to ask them.

Kristin: Right. Thank you, Dr. Karen.

Dr. Karen Sheffield-Abdullah: Thank you. Always a pleasure. I'm so excited that we got to see each other.

Kristin: Thank you for listening to Maternal Health Innovation, a podcast from the MHLIC. You can find this and other resources maternalhealthlearning.org. We also have accounts on Twitter and MHLIC_org and Facebook. Search for Maternal Health Learning and Innovation Center. This episode was edited and produced by Earfluence.