The Trauma-Informed Doula: An Evidence-Based Guide to Providing Trauma-Informed Doula Care

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Included in this Guidebook

Introduction

Doula care requires working with clients who possess a wide range of beliefs, attitudes and life experiences that shape their journey to childbirth. The perinatal period can be a vulnerable and frightening time for any woman, but especially for those whose backgrounds include trauma. Current or previous experiences of trauma have a profound impact on pregnancy, labor, birth and becoming a parent. As a doula, it is imperative to recognize the complex histories and backgrounds that clients bring to the childbirth experience and to provide care that avoids re-traumatization and promotes safety and healing. This is what it means to be a Trauma-Informed Doula.

Trauma results from experiences that overwhelm an individual's ability to cope. A wide range of experiences can cause trauma, including assault, abuse, witnessing violence and many more. Because of its prevalence, this guidebook will focus primarily on intimate partner violence (IPV), one of the most common forms of trauma to which 1 in every 3 women in the United States fall victim. While IPV is most common among certain groups of women, anyone can be affected by this abuse of power and the negative coping mechanisms that develop in response. These experiences affect women in deep and lasting ways that influence how they experience childbirth. Doulas must recognize that every woman may have experienced some form of violence in order to provide care that is holistic and healing. Trauma-informed doula care helps ensure that every client feels safe, supported and understood during childbirth.

Experiencing violence is often the first step in a chain of negative events that includes substance addiction and incarceration. Many trauma survivors, especially those of IPV, develop substance use disorders resulting from prolonged use of alcohol and drugs to cope with overwhelming feelings of fear, pain, helplessness and hopelessness. Substance use disorders (SUDs) often lead to incarceration, which itself is another traumatizing experience. Data confirms the interconnected nature of these events: 57% of incarcerated women report experiencing trauma or abuse, 84% have histories of drug addiction and 25% report a current mental health condition.

The purpose of this guidebook is to help doulas better understand and serve clients with past or present experiences of violence, substance dependence and/or incarceration, and to examine the interrelated nature of these three occurrences. While this guidebook will have a general focus on women experiencing these conditions, providing trauma-informed doula care is best practice for all clients. Many survivors of trauma or violence avoid discussing their experiences because it is simply too painful. In order to effectively provide trauma-informed care, doulas must approach each client remembering that they do not know her full story, and that her past or present may include trauma that she has not disclosed.

This text also provides background information and data related to IPV, SUDs and incarceration. This information is merely intended to provide context and preparedness for common circumstances encountered when working with vulnerable women and should never be used to shame or make assumptions about clients. Rates, risk factors and percentages can never

encompass an individual's story. It is important to note that doulas are not qualified to provide formal evaluations or diagnoses. While this guidebook can help doulas better understand and care for clients undergoing difficult circumstances, it should not be used to make medical or psychological diagnoses.

Above all, this guidebook is meant to be used as a tool to help doulas approach every client with a mindset that promotes health, healing and safety.

The Basics of Trauma-Informed care

What is Trauma-Informed Care?
The National Center for Trauma-Informed Care defines it as "an approach to engaging with people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives". This approach recognizes that many patients have experienced or are currently experiencing violence, and that health practitioners must take this into account in order to provide holistic, effective care. Providing trauma-informed care does not require disclosure from a patient; in fact, it is very likely that victims or survivors of trauma will not disclose their experience. Trauma-informed care entails working with the mindset that each patient has the potential to have experienced violence or trauma and to provide care that takes this possibility into account by interacting in ways that promote safety and healing. Establishing safe, trusting and empowering relationships is the key providing trauma informed care.

How Can Doulas Provide Trauma-Informed Care?
Doulas interact with women at one of the most vulnerable and overwhelming stages of life. The childbirth process can bring up past experiences of trauma and violence that deeply affect a woman's experience of pregnancy, labor, delivery and becoming a parent. Pregnancy can also cause stress and vulnerability that increase a woman's risk of experiencing violence. As a doula, it is important to understand the ways that experiences of emotional, sexual and physical abuse and other forms of trauma can affect clients, and to ensure that your interactions are not unintentionally causing stress or re-traumatization.

Principles of Trauma-Informed Doula Care
Shift your mindset: The foundation of providing trauma-informed care is shifting the way we understand women and their behaviors. As a doula, this means recognizing that clients' behaviors and responses that seem ineffective or unhealthy may represent adaptive responses to traumatic experiences. Trauma overwhelms the victim's ability to control actions and feelings, often causing them to act in ways they normally would not. Therefore, survivors may appear to be angry, disengaged, or untrusting clients and may make choices that outsiders view as negative or harmful. Providing care that is trauma-informed means refraining from judgement and recognizing that each client has a complex history that impacts her choices; it means believing that each client is doing the best she can for herself and her baby. A pamphlet developed by the British Columbia Centre of Excellence for Women's Heath provides an excellent illustration of this paradigm shift:

Traditional Mindset: Trauma-Informed Mindset:

- "She doesn't care about her baby" → "She's doing the best she can for herself and her baby"
- "I just need to educate her about how bad what she's doing is for her pregnancy" → "I need to show her that I am here for her to support her and not judge her"
- "Her actions and attitudes are a problem" → "Her actions and attitudes are an attempt to cope with problems"
- "What is wrong with this woman" → "What happened to this woman?"

Be aware of triggers: Seemingly harmless events or circumstances can "trigger" memories and feelings of traumatic experiences, causing an individual to become deeply upset or overwhelmed. Triggers can sometimes cause clients to dissociate, becoming unresponsive and removed from the present situation. As a doula, it is important to be aware that when a client has a very strong or surprising reaction to something, it is possible that painful memories and emotions experienced during a traumatic event are resurfacing. Common triggers during labor and delivery are vaginal exams, certain laboring positions and medical instruments that feel restrictive. Be sensitive to the possibility that routine aspects of labor and delivery, including but not limited to those listed above, may make a trauma survivor very uncomfortable. If the client wishes, you can help advocate on her behalf to minimize the use of procedures or interventions used by medical staff. This will not always be possible, however. In these cases, try to remain calm and reassuring; ask your client how you can best help her feel safe and supported. Triggers will be discussed in greater detail later in this guidebook.

Facilitate client choice and autonomy: The feeling of being out of control or losing autonomy can be especially difficult for trauma victims. This feeling is very common during labor and delivery, as a various medical staff regularly come in and out of the room to carry out procedures or adjustments to medication with little explanation. In these situations, you can help your client by keeping her well-informed about what is going on. Ask medical staff to explain what they are doing before they do it and encourage clients to ask questions. Make sure, either through your own explanation or by asking medical staff, that your client has clear expectations about what will happen in each check, procedure or medication adjustment. Because many aspects of childbirth in a hospital setting are out of the patient's control, provide opportunities for clients to make decisions. Ask how she would like the lights, if she would rather the door be open or closed, what type of food or drink she prefers, etc. Allowing clients to make these types of decisions can promote a sense of agency and empowerment during a time when many other aspects of care are determined by medical staff or outside factors.

Remember that your client is the expert on herself: It can be easy to assume that you know what is best for a client, especially when she is particularly vulnerable. We often slip into this way of thinking without even realizing it. Perhaps she would like a significant other present at the birth who you think is unsupportive or unhealthy. She may want an intervention or medication that you feel is unnecessary. It is important remember that your client is the expert

on her body, her emotions and her life. A doula's role is to educate and support without judgment, even if violence, addiction or other difficult circumstances cause her to make choices that you may not agree with.

The remainder of this guidebook offers more detailed information about working with clients who have experienced or are experiencing violence, substance use disorders or incarceration. It explores the cyclical nature of these three occurrences and highlights the way sociocultural factors like race, poverty, education and the criminal justice system impact this cycle. Though much of the guidebook will focus on experiences of IPV, the information and recommendations included pertain to all forms of trauma, including sexual abuse or assault not perpetrated by a partner.

Intimate Partner Violence (IPV)

Background

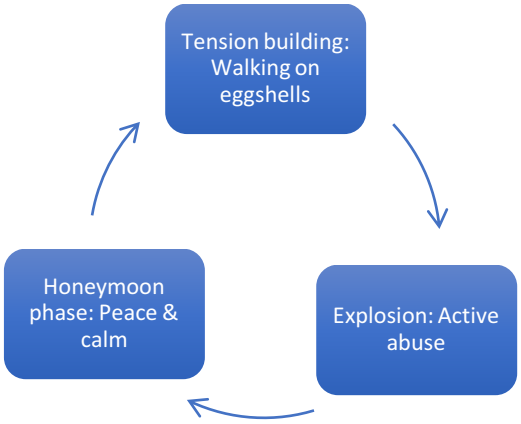
The National Coalition Against Domestic Violence defines IPV as "the willful intimidation, physical assault, battery, sexual assault, and/or other abusive behavior as part of a systematic pattern of power and control perpetrated by one intimate partner against another. It includes physical violence, sexual violence, threats and emotional or psychological abuse. Put more broadly, IPV can be conceptualized as a pattern of coercive behaviors in a relationship whereby one person uses tactics of power and control over another person. IPV is a major public health issue, as national studies indicate that 1 in 3 women in the US have been victims of some form of physical violence by an intimate partner within their lifetime, and that 1 in 5 women have been raped in their lifetime. This means that as many of 30% of doula clients have likely experienced IPV at some point.

Perinatal IPV is defined as abuse that occurs during, before or up to one year after pregnancy. A growing body of literature suggests that the risk of experiencing IPV increases during pregnancy. This is likely due to the greater physical, emotional and financial vulnerability of women during this period, as well as the stress brought on by preparing for a child. Research also indicates that the severity of IPV may increase during the perinatal period in relationships where IPV has already been occurring. It is estimated that between 3 and 17% of women in the US experience violence during the perinatal period.

Victims of violence are more likely to be affected by a host of risk factors that make them particularly vulnerable, factors which perpetrators exploit. Women who are young, unmarried, poor and less educated are more likely to experience IPV. Low social support, unplanned pregnancy and substance use are also associated with an increased risk. The majority of women in violent relationships experienced difficult childhoods that included abuse, neglect or poverty. It can be difficult for outsiders to understand why someone would remain with an abusive or coercive partner. These situations have many complex dynamics that usually include financial dependence, emotional attachment, fear and isolation. The figure below depicts the common cycle of violence in an abusive relationship. Abuse is usually followed by a "honeymoon phase" during which the abuser is exceptionally attentive and promises to change. This, combined with

the vulnerability of the victim and other contextual factors, often makes it very difficult to end the relationship.

Typical Cycle of Violence in an Abusive Relationship:



Health Outcomes & Detection

Experiencing violence can have serious adverse health outcomes for both mother and child. IPV is associated with an increased risk for placental abruption, uterine hemorrhage, preterm birth, low birth weight, stillbirth and miscarriage. It is also associated with unintended pregnancy, nutritional deficiency, adolescent pregnancy and late entry into prenatal care. For mothers, IPV is associated with a higher risk for various physical health problems that include chronic pain, frequent kidney infections, high blood pressure, frequent urinary tract infections, frequent sexually transmitted infections and poor general health. IPV is also linked with adverse psychological outcomes, including anxiety, depression, low self-esteem, negative self-image, fear of intimacy, post-traumatic stress disorder (PTSD) and the use of drugs or alcohol to self-medicate. Victims of domestic violence are at higher risk for self-harm and for developing addictions to alcohol, tobacco and drugs. IPV is often the first step of a devastating cycle that leads to substance addiction and incarceration.

Despite the serious health risks associated with IPV, it often goes undetected due to lack of proper screening. Research indicates that fewer than 10% of healthcare practitioners and fewer than 50% of obstetricians and gynecologists in the US routinely screen for IPV. For doulas, this means that the likelihood of a client's abuse being addressed by her healthcare provider is extremely limited. Part of the difficulty of detecting IPV lies in the wide range of symptoms that victims may display, many of which are common for individuals living in poverty and those with poor general health to experience. For example, listlessness, lack of energy, chronic fatigue, lack of sleep, chronic health problems, little affect in voice or expressions, disordered eating, anxiety and depression are common symptoms for those experiencing IPV.

More obvious signs of abuse include being constantly nervous, agitated, or jumpy; acting overly cheerful or subjective towards a partner; feelings of guilt or self-blame; intense isolation;

flashbacks; dissociation and suicidal ideation. Experiences of violence can also have specific symptoms during the perinatal period. It is common for victims of IPV to experience emotional numbing that prevents them addressing the pregnancy, preparing for an infant and connecting with their newborns. Victims of IPV have are at increased risk for late or no entry into prenatal care. Doulas should be aware of these signs in order to recognize them in clients and potentially address situations in which a client's safety may be threatened.

Disclosure

If you suspect that a client may be a current or previous victim of violence, it can be difficult to know whether or how to address it. It is crucial that doulas use discernment regarding when, where and how they ask clients about experiences of trauma, as well as how they respond if a client discloses. These guidelines, informed by the Futures Without Violence National Consensus Guidelines and the 2016 Neonatal Abstinence Syndrome Symposium, can help doulas talk to clients about experiences of violence or trauma:

How to Ask:

Find the right time and place. Use extreme discretion to find an appropriate time and place to speak with your client. It is imperative to find a time when you are alone with your client. Do not ask in the presence children or other individuals, including family members, friends or significant others. Doing so could threaten your client's safety, even if those present seem safe and supportive. Speak with your client in a location where she feels safe that is calm and private.

Use an appropriate tone. Make sure you speak with your client in a way that is not accusatory or assumptive. Use broad probing questions to approach the subject. Some doulas include questions about trauma in their routine intake process with clients. Use questions such as:

- "Is there anything from your past or present that may bring up challenges during your hospital stay, such as being hurt or assaulted by someone or having a bad experience with a loved one in a hospital?"
- "Is there anything that you foresee making pregnancy and childbirth especially difficult for you, such as a previous miscarriage or a difficult relationship with a partner or family member?"
- "Is there anyone in your life who makes you feel nervous or unsafe in any way?"

Ask questions. Use open-ended follow-up questions if the client is having a difficult time speaking about a situation, such as:

- "Can you tell me more about what happened?"
- "What was that experience like for you?"
- "How did your life change after that?"

Respect boundaries and confidentiality. Do not push for information if your client is reluctant or uncomfortable. If your client does not disclose, let her know that you are always available if

there is something she'd like to talk about. Remember that making your client feel safe and supported, not getting her to disclose, is the ultimate goal.

If A Client Discloses:
Mind your reaction. Be mindful of body language and reactions as your client shares her experience. Try not to overreact or underreact to what you are hearing. Sometimes shock or feeling uncomfortable can make it difficult to know how to respond. Here are some good phrases to begin with:

- "I'm so sorry that happened/is happening to you"
- "That sounds like such an awful experience, thank you for having the courage to share that with me."
- "You are not alone and what you're experiencing/have experienced is not your fault. Help is available."

Listen and Validate. Give your client space to express and process her emotions. A variety of emotions, including anger, hopelessness, love and frustration are common responses to experiencing abuse. Validate your client's emotions and assure her that her feelings are natural responses to her experience. Let her know that she is not alone, that many women experience violence and that help is available. Finally, make sure she knows that what has happened to her is not her fault.

Respond to immediate safety issues. If your client feels that she is in immediate danger, review her different options and help her make a decision about how she'd like to respond. If your client is currently experiencing violence, one of the most important responses will be connecting your client with a professional trained to assess and respond to domestic violence. Below are some action steps that you can discuss with your client:

- Help your client decide whether it is safe to return home
- Educate her about how to create an exit plan
- Offer your client immediate access to a domestic violence advocate in person or by phone through a domestic violence hotline
- If your client wants immediate police assistance, offer to help her place the call or let her use your phone
- Help her identify family, friends or local shelters that can provide assistance and/or a safe place to stay

Make referrals to community resources. Once immediate steps have been taken, your client may need help accessing a wide range of community services. It is very helpful for doulas to be aware of local community resources available in order to best support clients. Common services that clients experiencing violence may need assistance accessing include:

- Counseling or support groups
- Legal assistance

- Child care
- Transportation
- Food and clothing donations
- Substance abuse treatment

Practice self-care and maintain boundaries. In cases of abuse or violence, it is especially easy for doulas to overstep and/or become too personally involved in clients' lives. Remember that as a doula, you can help connect your client to resources, but it is beyond your scope to make evaluations or directly intervene in cases of domestic violence. Because you are not trained for these situations, the best thing you can do for your client is help her access a domestic violence advocate and/or a social worker. In addition, recognize the toll that being a doula in this situation takes on you and make time for self-care. It can be helpful to talk with a trusted friend or mentor about the situation (while maintaining client confidentiality) to process your reactions and feelings. Give yourself time and space to deal with the emotional impact the situation is having on you. You cannot successfully care for a client's needs unless you are caring for your own.

Labor and Delivery: Triggers

Violence and trauma can have a profound impact on women during labor and delivery, as certain aspects of the childbirth process often bring up painful memories, sensations and emotions experienced during trauma. These are called triggers: seemingly harmless events that bring up memories and emotions related to traumatic events, causing extreme distress. Doulas can support victims of violence during labor and delivery by being aware of common triggers and being prepared to respond appropriately. A client's triggers depend on her specific experiences, so do not assume that every client who has experienced trauma will react to the same things in the same ways. However, it is important that doulas understand the triggering effect that routine aspects of childbirth can have on victims of violence and how to best respond. Common triggers related to childbirth include:

Loss of control over body. For those who have experienced violence, loss of control and autonomy over their bodies can be extremely frightening. It is common for these feelings to be especially intense during the active phase of labor as the baby moves down the birth canal and emerges. Feeling exposed or lacking privacy can also make survivors feel vulnerable and out of control.

Medical equipment and procedures. Fetal monitors, IVs, blood pressure cuffs and other medical instruments may trigger memories of being restrained during abuse or violence. Closed doors and tight spaces can have a similar effect. Vaginal exams and the insertion of an epidural can bring up memories of having to remain still during sexual abuse.

Certain labor positions. The most common laboring position promoted in a traditional hospital setting—on back with legs spread wide—can be extremely uncomfortable for victims of violence, especially those who have experienced sexual abuse. Hands and knees may bring up similar feelings. Small spaces, such as the bathroom or shower, trigger painful memories of

being trapped or confined. Being touched from behind, for instance for a double hip squeeze or lower back massage, may also make IPV victims feel uneasy.

Language. Common phrases used to coach women through labor may have unintended consequences, reminding survivors of language used by their abusers. Try to avoid using phrases like these:

- During contractions: "Relax and it won't hurt as much", "Surrender to the pain"
- During the placement of an epidural or a vaginal exam: "Be still and it will be over", "The less you move, the quicker it will be done"

Breastfeeding. Breastfeeding can be especially difficult for victims of IPV, particularly if abuse was sexual in nature. Attention to the breasts or having to expose the breasts may bring up flashbacks of abuse. A victim's sense of control over her body may feel jeopardized by a newborn's regular demand to nurse. In situations where abuse is currently taking place, a victim's partner may exhibit jealousy when she breastfeeds. A controlling or abusive partner may demand that she stop breastfeeding or increase the occurrence or severity of abuse.

Trauma-Informed Doula Tips for Victims of Violence

The following recommendations can help doulas prevent re-traumatization while providing care to victims of violence. Remember that these practices are best practice for all clients regardless of disclosure status.

Emphasize control. Facilitating a sense of understanding and control over what is happening at each stage of labor and delivery is especially important for victims of violence. Ask medical staff to verbally explain each procedure before they begin and describe each step as it is being implemented. If the medical staff is not willing to describe their actions step-by-step, offer to describe what is happening at each step yourself. However, use discretion in these situations. You may want to suggest stopping if providing a detailed description during a procedure seems to be making the client more fearful or anxious. Unless there is an emergency, make sure that your client has a chance to ask any questions about each procedure or intervention before it begins. If unknown staff is in the room, help build rapport by asking them questions and encouraging your client to ask questions. Advocate for the removal of unnecessary monitors or for minimizing the number of vaginal exams if the client desires.

Be sensitive to touch. Be aware that IPV victims may be uncomfortable with physical touch. Always ask before touching a client, and begin with a touch that is gentle and visible, such as placing a hand on her arm. Make sure to ask permission and fully explain any labor positions before implementing them. Do not be surprised or offended if a client has a strong aversion to a particular labor position. Do not try to push particular positions if your client seems uncomfortable with them.

Promote privacy. Protecting your client's privacy is a way to contribute to her sense of control and safety. This is especially important for violence survivors, as feeling exposed can be

extremely triggering. Ask clients if they are comfortable with extra personnel in the room, such as students or interns. Offer extra sheets and gowns for coverage during vaginal exams. Ask whether she would like extra friends, family or staff in the room to step out during vaginal exams or other procedures.

Support feeding choices. Because of the complex responses that breastfeeding may bring up, avoid judging a client's feeding decisions and offer support to meet her needs. You may be able to help your client find ways to provide breastmilk that feel safe and comfortable, such as nursing in private, pumping and bottle feeding or using donated breastmilk from a milk bank. Be open to the possibility that you may also need to help your client give herself permission not to breastfeed in order to preserve her personal mental health and wellbeing.

Provide validation. Whatever the situation, make sure that your client feels heard. Look her in the eyes and answer her questions in plain language. Assure her that her concerns are legitimate, important and normal. If your client is upset or confused about something, assure her that you will help her find a solution.

The table below is an excerpt from the book, "When Survivors Give Birth," an excellent resource for more information about how doulas can care for victims of sexual abuse. The table provides specific triggers that may arise during childbirth, possible psychological causes and techniques for support.

Penny Simkin and Phyllis Klaus 1994: Strategies for specific Triggers of Anxiety during Childbirth

Trigger/Challenge	Possible Psychological Causes	Techniques
Resistance to or inability to tolerate vaginal exams, blood draws, IVs, catheters, etc.	• Invasion of body boundaries triggers abuse • Fear of having genitals exposed	• Advocate for as few interventions as possible • Have medical staff ask permission before each procedure • Ask medical providers to work slowly and explain each step as they go • Respect privacy as much as possible

Strong preference for one care provider or for gender of care providers (doctor, nurse, anesthesiologist, etc)	• Distrust of gender of perpetrator • Distrust of unknown people	• Validate her need and try very hard to honor it • Ask for a person of mom's desired gender, especially for invasive procedures
Struggling during administration of epidural, even though she requested it	• Someone doing unknown things to her body from behind triggers abuse • Having to lie still during painful contractions brings up memories of abuse	• Have anesthesiologist explain the procedure face-to-face before starting • Doula stays facing mom and provides reassurance
Becomes very upset during active labor (more than is common) and labor stalls	• Labor pain is reaching a point where mom feels "out of control." Deep fear of pain behaviors (screaming, thrashing, panicking) associated with being helpless and out of control during abuse	• Use rhythm and ritual to cope with pain • Pain medications or epidural may be especially appropriate in this case
Holding back during second stage leading to failure in descent	• Reluctance to become a parent • Deep fear of pain, stretching, possible tearing	• Reassurance—recount all the ways she has been a good mother already • Apply hot compress to vagina and perineum

Lack of interest in newborn; resists staff attempts to give baby to mother	• Dissociation as a coping mechanism • Dissociation during birth may delay bonding • Traumatic birth experience may override thoughts of baby	• Allow mom to express how she feels • Don't push contact on her—give mom time to recognize that labor is over and "come back" • Model how to hold/interact with baby • Point out ways the baby positively reacts to her (reaches out to her, stops crying, etc.)
Reluctance or inability to breastfeed (extreme pain, disgust)	• Attention to breasts brings on flashbacks to abuse • Exposing breasts triggers memories of abuse	• Refrain from touching or getting close to a woman's breasts • Teach latch techniques without making mom expose her breast • Give her privacy to try techniques • Facilitate pumping and bottle-feeding if desired • Recognize that mom may not be able to or want to breastfeed and support her choice

Substance Use Disorders (SUDs)

Background

It is common for trauma victims to use drugs and alcohol to cope with the pain, fear and hopelessness they experience, and prolonged use can result in the development of a substance use disorder (SUD). It can be challenging for doulas to remain nonjudgmental when working with clients who have SUDs, as doulas have an extensive understanding of the effects drugs and alcohol have on fetal development. However, it is critical for doulas to recognize the complex experiences that shape women's choices and the context in which those choices are made. The

information provided in this section is not meant to shame women who use drugs and alcohol during pregnancy but instead to help doulas understand and have empathy for these clients. Women with SUDs generally have complex histories and life experiences that shape their choices. Individuals with SUDS are more likely to have sustained adverse childhood experiences (ACEs), such as abuse, neglect, household violence, substance abuse within the household, mental illness within the household and the incarceration of a household member. Many women with experiences of trauma or violence use alcohol or drugs as a way to cope with or appease an abusive partner. Most women in substance abuse treatment have a history of trauma or abuse and 25% have been diagnosed with PTSD. Women who report substance use during pregnancy are more likely to have major depressive disorder, generalized anxiety disorder and panic disorder. This guidebook will focus primarily on opioid use during pregnancy, as this is a growing public health concern nationwide.

Opioids are a highly addictive class of drugs that include prescription painkillers and the illegal drug heroin. Common prescription opioids include oxycodone (brand name OxyContin), hydrocodone (brand name Vicodin), codeine, morphine and fentanyl. Opioids are the most commonly used class of illicit drugs nationwide after marijuana. Addiction to prescription painkillers often leads heroin use because it is cheaper and easier to obtain. Both the abuse of prescription opioids and the use of heroin are increasing rapidly in the United States, leading to an unprecedented number of deaths due to drug overdose. Rates of death are highest in the Northeast and Southern regions of the country. National statistics indicate that 5.4% of all pregnant women and 14.6% of all pregnant teens ages 15-17 report current illicit drug use. Among women who reported illicit drug use in the last 30 days, 27% reported using heroin or prescription pain killers. It is estimated that 57,000 pregnancies are exposed to opioid abuse each year in the United States.

Health Outcomes & Risk Factors

Opioid use and withdrawal has serious adverse effects on maternal and child health. Opioid abuse during pregnancy is associated with an increased risk for intrauterine growth restriction, placental abruption, preeclampsia, postpartum hemorrhage, sepsis, premature rupture of membranes, intrauterine passage of meconium, preterm birth, low Apgar scores at birth and miscarriage. Women with SUDs are more likely to have gestational diabetes, poor mental health, frequent urinary tract infections, HIV, Hepatitis B, Hepatitis C and other STI's, which compound poor perinatal outcomes. Common signs that a client may have a SUD include late entry into prenatal care, poor weight gain, malnutrition, erratic behavior, poor attendance of medical appointments, track marks and being in a violent relationship. While being aware of these comorbidities is important, doulas must remember not to make assumptions about clients and their substance use. The presentation of these symptoms alone is not definitive evidence that a client has a SUD, and doulas are not trained or qualified to make these diagnoses.

Opioid withdrawal can also have serious health effects on mother and baby. Abrupt discontinuation of opioid use among pregnant women with opioid addictions leads to withdrawal, which can cause insomnia, vomiting, tremors, increased blood pressure and heart

rate, anxiety, depression and a high risk of relapse. Opiate withdrawal during pregnancy is also associated with an increased risk for fetal respiratory depression, intrauterine growth restriction, preterm birth and miscarriage. Because of these risks, opioid maintenance therapy (OMT) is the gold standard of treatment for opioid addiction among pregnant women. It is helpful for doulas working with clients who have opioid addictions to have a basic understanding of OMT.

Opioid Maintenance Therapy (OMT)

OMT refers to the regular medical provision of low doses of methadone or other medications to individuals with opiate addictions in order to prevent withdrawal, relapse and neonatal abstinence syndrome (NAS). The evidence base for OMT is well-established and is linked to increased utilization of prenatal care, decreased neonatal morbidity and mortality and increased birth weight. OMT for pregnant opiate-addicted women is considered best practice by ACOG, the World Health Organization and the CDC. Though methadone is the most common drug used for OMT, emerging evidence suggests that buprenorphine (brand name Suboxone) is an alternative and possibly more effective option. Compared to methadone, buprenorphine has a lower risk of overdose, fewer drug interactions and can be distributed on an outpatient basis, eliminating the need for daily visits to the hospital. Buprenorphine is also associated with a reduction in the severity of neonatal abstinence syndrome symptoms. Neonates whose mothers received buprenorphine during pregnancy required less morphine, had a shorter hospital stay and required less medical intervention than neonates whose mothers were treated with methadone. However, there is a lack of evidence regarding the long-term effects of buprenorphine treatment on infants and children. Whether methadone or buprenorphine is used, it is important for doulas to be aware of the benefits of OMT for clients with SUDs.

Pain Management and OMT

Pain management during labor and delivery can be especially difficult for women with an opioid dependency. Chronic opioid use heightens the body's response to painful stimuli, making labor exceptionally painful. OMT medications can also dull the effect of opiate pain relievers, thus requiring higher levels of medicine to control pain. The small dose of opioids that women on OMT receive does not control the pain of labor, therefore medical guidelines advise that laboring women on OMT should receive pain relief as if they were not taking opioids. Women on OMT can safely receive epidurals, but IV narcotics are not recommended because drug interaction with OMT medications can lead to withdrawal symptoms.

Doulas can support clients on OMT by educating them about pain management challenges and options and advocating for the pain management option chosen by the client. Some women with SUDs resist requesting more pain medication during labor because they worry that this will lead to judgment from medical staff. Doulas can help these clients give themselves permission to ask for what they need by educating them about the real effects that OMT has on the body's response to pain. Reassure these mothers that the pain they are feeling is real, and that it is okay if their bodies require more medication to manage it. Non-pharmacologic pain management techniques, such as a strong emphasis on ritual and rhythm, can also help clients manage the pain of labor and delivery. It is especially important that doulas talk with clients

who have SUDs about pain management prior to labor, as these clients often have heightened anxiety about issues related to pain medication.

Neonatal Abstinence Syndrome (NAS)
NAS is a cluster of symptoms commonly present in newborns exposed to opioids while in the womb. The increasing rate of opioid abuse in the US correlates with a rise in the rate of NAS from 1.3 cases per 1,000 lives births in 2000 to 6.1 cases per 1,000 live births in 2012. Symptoms of NAS include seizures, tremors, overactive reflexes, poor feeding, diarrhea, poor weight gain, extreme irritability and fussiness, high pitched crying, fast breathing, poor sleeping, botchy skin and vomiting. Not all infants with NAS display all of these symptoms; the range, onset and severity of symptoms depends on the type of opioid used and the dose and timing of exposure.

NAS is diagnosed through a scoring system similar to an Apgar test that measures the presence and severity of symptoms. An infant's level of opioid exposure is determined through urine or meconium testing, though not all infants with opioid exposure will experience symptoms of withdrawal. Signs of NAS usually appear within 72 hours of birth, and treatment varies according to the severity of symptoms. NAS complications can last for up to 6 months after birth, but most infants recover within one month. Common treatment methods include delivering IV fluids to prevent or treat dehydration, supplementing breast milk with high calorie formula to prevent or treat malnutrition and administering small doses of an opioid (most commonly morphine) to the infant. No medical interventions may be necessary depending on the severity of symptoms, but the American Academy of Pediatrics guidelines recommend that all opioid-exposed infants remain in the hospital for 3 to 7 days to monitor progress. Doulas can help clients watch for NAS symptoms at home so that they can identify and address NAS if it emerges after hospital discharge.

Doulas play an important role in supporting mothers whose infants have NAS. One of the most crucial functions will be helping your client soothe her fussy baby. Show your client how to swaddle her newborn and encourage as much skin-to-skin time as possible. Suggest keeping the lights dim and room quiet, as infants with NAS are highly sensitive to stimuli. Evidence shows that rooming in and breastfeeding can greatly reduce the symptoms and severity of NAS, so doulas should advocate for these when appropriate. Because NAS can make it difficult for infants to suck and swallow, mothers will likely need extra assistance with breastfeeding. Help ensure that these clients quickly get assistance from lactation consultants. However, be sure to respect your client's feeding choices and remember that experiences of IPV may impact her ability to breastfeed. Doulas will likely need to address maternal guilt, as many women experience extreme feelings of guilt when infants with NAS exhibit distress. Doulas can help these clients by providing reassurance and reminding them of the ways they have already been good mothers.

Alcohol & Tobacco Use
Many women with opioid dependencies also suffer from addiction to alcohol and tobacco. National data shows that 92% of opioid dependent individuals also have a nicotine addiction.

Among women who reported using illicit drugs during pregnancy in 2011, 32% also reported using alcohol and cigarettes. Again, it is important for doulas to avoid judgement and recognize the context of clients with alcohol and tobacco dependencies. Women who use alcohol and tobacco during pregnancy are more likely to be experiencing poverty, violence, poor social support, mental illness and stressful life events. Alcohol and tobacco use can have serious perinatal health effects. Tobacco use during pregnancy reduces the amount of oxygen delivered to the fetus through the placenta, leading to an increased risk for fetal stress and placental abruption. It is also associated with an increased risk for low birth weight, intrauterine growth restriction, preterm birth and birth defects such as cleft lip and cleft palate. Heavy alcohol use during pregnancy can result in fetal alcohol spectrum disorders, a wide range of health problems that include developmental and intellectual disabilities. Alcohol consumption during pregnancy also increases the risk of premature birth, birth defects, low birth weight, miscarriage and stillbirth. In some cases, women with nicotine dependencies can use nicotine patches or the prescription drug bupropion (common brand names Wellbutrin and Zyban) during pregnancy to foster tobacco cessation or treat nicotine withdrawal, but the research on these practices is not well-established. It is helpful for doulas to be aware of community resources available for clients seeking cessation treatment or support.

Breastfeeding Guidelines and SUDs

It is critical that doulas understand the breastfeeding guidelines for clients with SUDs in order to appropriately support and advocate for them. Breastfeeding is still recommended in most cases, although doulas should defer to the decisions made by medical professionals. Clinical guidelines indicate that mothers on a stable regimen of OMT who are determined to have a low risk of relapse should be encouraged to breastfeed unless the risks clearly outweigh the benefits. However, breastfeeding can be especially difficult for infants with NAS due to poor suck and swallow coordination, extreme irritability, vomiting, nasal stuffiness and long periods of being separated from the mother for medical procedures. Therefore, clients whose infants have NAS that want to breastfeed will likely need extra support and assistance. Early initiation of breastfeeding is especially important for infants with NAS. Symptoms usually do not begin immediately after birth, so it is critical to establish breastfeeding during the window between birth and the onset of symptoms that may make feeding more difficult. Doulas can support mothers of infants with NAS who want to breastfeed by promoting feeding soon after birth, encouraging pumping if the infant has to be separated from the mother for medical treatment and advocating for these clients to receive support from lactation consultants. Regardless of the feeding method your client chooses, skin-to-skin contact should be encouraged as much as possible.

Similar to mothers on OMT, guidelines developed by the CDC and La Leche League International still encourage breastfeeding for women who smoke cigarettes if cessation is not possible. However, heavy smoking, defined as more than 20 cigarettes per day, can complicate breastfeeding by inhibiting the let-down reflex and reducing a woman's milk supply. Heavy smoking can also cause infants to have nausea, stomach cramps, vomiting and diarrhea. Current smokers who wish to breastfeed will likely need extra help and support from doulas

and lactation consultants. La Leche League International offers helpful guidelines regarding cigarette use for breastfeeding mothers:

- Never smoke during feedings
- Smoke right after nursing to allow nicotine levels to drop before the next feeding
- Smoke as few cigarettes as possible
- Smoke away from the baby, outdoors, or in separate room that is well ventilated

Trauma-Informed Doula Tips for clients with SUDs

Be prepared for complications. Unfortunately, SUDs increase the risk of complications for both mother and baby. Although this will not always be the case, be prepared for the possibility of problems arising and the need to help clients stay calm.

Provide reassurance. Many mothers with SUDs experience extreme guilt if complications occur during labor or postpartum. Women with SUDs are also more likely to have many stressors in their lives that compound these feelings of guilt, making it difficult to cope. Reassure clients that they are doing the best they can for their babies, and point out the ways they have been good mothers already during pregnancy and labor. Many clients with SUDs have a heightened sensitivity to feeling judged. Help clients ask for what they need from medical staff, and prepare them for the possibility that their bodies may require a higher dose of medication than is typical to manage pain.

Routinely check your attitude. Even the most experienced doulas struggle with avoiding judgement at times. This can be especially challenging when witnessing a client or her baby's health being negatively affected by substance use. However, your role as your client's advocate and supporter is especially important for women with SUDs, as these clients often have little social support and are especially weary of judgement in a medical setting. Check in with yourself periodically to assess your attitude. Remind yourself:

- My client is doing the best she can for herself and her baby.
- Her actions and attitudes are an attempt to cope with problems in her life.
- I do not know her full story or what she has been through.

Incarceration

Background

Experiencing violence often puts women on a trajectory that leads to substance dependence and eventual incarceration. The connection between these events is clear: 57% of incarcerated women report experiencing trauma or abuse, 84% have histories of drug addiction and 25% report a current mental health condition. The majority of imprisoned women are sentenced for nonviolent drug-related crimes, largely as a result of the mandatory drug sentencing laws established in the 1980's as part of the nation's War on Drugs. This social justice issue is of particular concern to doulas because women of child-bearing age are the fastest growing incarcerated population. Sixty-one percent of incarcerated women are mothers and 4% of were

pregnant at the time of admission. Approximately 40,000 pregnant women are incarcerated each year. It is especially important for doulas working with incarcerated women to provide trauma-informed care, as pregnant women who are incarcerated have a much higher likelihood of previous and current violent experiences than non-incarcerated pregnant women. Incarceration disproportionately affects minority women, as 70% of imprisoned women are African American or Latina. African American women are 18 times as likely and Hispanic women are 4 times as likely to be incarcerated as white women. Similar to women at risk for IPV and substance abuse disorders, women who are incarcerated are more likely to be poor, have low educational attainment and have adverse childhood experiences. All of these factors, including imprisonment itself, increase the risk of poor perinatal outcomes.

Health Outcomes & Conditions in Prison

Women who are incarcerated have a higher risk of poor perinatal outcomes, especially preterm birth and having infants that are small for gestational age. This is likely due to a complex combination of factors that include race, health risk factors prior to incarceration and conditions in prison. It is well established that African American women, who make up the majority of the population of imprisoned women, are more likely to experience poor perinatal outcomes, including congenital abnormalities, preterm birth, fetal growth restriction, fetal death and maternal morbidity and mortality. Imprisoned women of all races are more likely to experience chronic medical conditions, stress, depression, STIs, poor nutrition, limited access to reproductive care, substance abuse and violence, all of which are correlated with poor perinatal outcomes.

It is likely that sub-optimal conditions and services for pregnant inmates also contribute to poor perinatal health outcomes. Most prison healthcare systems function independently with little oversight regarding the type or quality of services provided. Prisons are not mandated to provide physical or mental health services for inmates, allowing for the health needs of pregnant women and their babies to be overlooked. The Rebecca Project for Human Rights conducted a review of state prisons in 2010 that highlighted the alarming lack of policy in place to protect pregnant inmates. The review found that 43 states do not require medical exams as a component of prenatal care, 41 states do not require providing adequate nutrition to pregnant inmates, 38 states do not require screening and treatment for high risk pregnancies and 48 states do not offer pregnant women screening for HIV.

This lack of protective policy has profound implications on the health and wellness of pregnant inmates. A national survey found that only 54% of pregnant inmates were receiving some kind of prenatal care. Another study revealed that pregnant inmates reported feeling physically unsafe and constantly hungry. Many studies confirm that most prisons fail to meet the nutritional recommendations for pregnant women. In addition to violating basic human rights to health, these conditions compound the sociodemographic risk factors that lead to poor perinatal outcomes for pregnant women in prison.

Prison Policies for Labor & Delivery

It is important for doulas to understand prison policies and procedures for women giving birth in order to optimally care for incarcerated clients. Below are some common prison policies that doulas should be aware of in order to prepare for client needs:

Transportation to hospital: An Incarcerated client will usually be meeting her medical providers for the first time when she is brought to the hospital for labor. If incarcerated women are provided with prenatal care, it is rare for this to take place at the hospital where they will give birth or with a consistent provider. Oftentimes inmates will not be permitted to be transported to the hospital until active labor has begun. If an induction or cesarean section has been scheduled, the mother is often not informed until the day before the procedure. These factors can make it very difficult for incarcerated women to feel comfortable with their medical providers or prepared for the birthing process.

Shackles/Restraints: Pregnant inmates often arrive at the hospital in leg irons and handcuffs. The Rebecca Project for Human Rights found that 22 states either do not have policy addressing when restrains may or may not be used on pregnant women, or have a policy which allows for the use of waist chains or leg irons for pregnant women. Women are often required to be bound to the bed with restraints during labor and shortly after delivery.

Visitors: Prison policy varies regarding whether inmates are permitted to have visitors during labor and delivery. It is possible that the doula could be the only extra person allowed to provide emotional support.

Security: Two correctional officers accompany pregnant inmates to the hospital and stay in the hospital room with the mother at all times, although male officers can be asked to step out during vaginal exams.

Postpartum: Inmates are forcibly separated from their newborns at the time of discharge, which sometimes occurs as soon as 24 hours after birth. In some cases, the newborn will be placed in the care a family member or other guardian. If not, the infant will usually be placed in the state foster care system.

Trauma-Informed Doula Tips for Incarcerated Clients

Normalize the birth experience. This will be an important part of the doula's job when working with incarcerated clients. Unknown medical staff and 24-hour surveillance by correctional officers make labor and delivery especially difficult for pregnant inmates. Doulas can help by doing everything possible to normalize the experience. Build rapport with medical staff by asking questions and encouraging your client to do the same. Ask if the client would like male correctional officers to leave the room during vaginal exams and other procedures. Reflect on what a salient event childbirth is in the client's life and what an amazing job she is doing.

Be a strong advocate. Incarcerated women are often used to having very little say in their day-to-day lives, so the doula's role as an advocate is especially important for these clients. Help

clients ask for what they need and allow them to make decisions whenever possible. Speak with the medical staff to advocate for the removal of shackles and restraints and permission for the client to walk around the hospital floor. Be prepared to mitigate any differential treatment if necessary.

Facilitate bonding. Another important role of the doula will be providing emotional support after delivery and when the client is forced to be separated from her baby. Facilitate skin to skin contact and breastfeeding as much as possible. If appropriate, help the client record the birth experience and time with her baby by taking pictures, reflecting on the baby's features and recounting the amazing job she did during labor and delivery. However, take your cues on how to act from your client, relating to the baby in a way that recognizes and supports the complex emotions she is likely to experience. Be prepared for your client to exhibit a wide range of emotions, including anger, grief and numbness.

Closing

The cycle that exists between violence, substance use and incarceration is a social justice issue that affects millions of women and demands attention. Doulas can respond to this problem by implementing trauma-informed care in order to ensure that all clients receive care that is appropriate and supportive. The foundation of trauma-informed care is a paradigm shift in the way doulas approach clients which recognizes that every woman has a unique story that could include violence and/or trauma and that negative behaviors or choices are often attempts to cope with difficult life experiences. By implementing this mindset and the recommendations included in this guidebook, doulas can avoid unknowingly re-traumatizing clients and instead provide care that is holistic and healing. The resources below provide further information that may be helpful to doulas regarding trauma-informed care, domestic violence, substance abuse and incarceration.

Helpful Resources:

http://www.nassymposium.com/site/Documents/Trauma-Informed_Prenatal_Care_and_Delivery.pdf

http://theprisonbirthproject.org

www.rebeccaprojectjustice.org

https://pregnantsurvivors.org

ncadv.org

http://www.coalescing-vc.org/index.htm

http://www.nationalcenterdvtraumamh.org/about/

http://www.llli.org

https://www.cdc.gov/violenceprevention/pdf/intimatepartnerviolence.pdf

http://www.futureswithoutviolence.org/userfiles/file/Consensus.pdf

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