Midwifery 83 (2020) 102643

Contents lists available at ScienceDirect

Midwifery

journal homepage: www.elsevier.com/locate/midw

Review article

Evidence and guidelines for trauma-informed doula care

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ARTICLE INFO

Article history:
Received 26 August 2019
Revised 14 January 2020
Accepted 19 January 2020

Keywords:
Doula care
Trauma
PTSD
Pregnancy
Trauma-informed care

ABSTRACT

Objective: Trauma and trauma-related health conditions are common during pregnancy, but there is little evidence and guidance on how doulas (trained lay birth assistants) can provide trauma-informed care. The purpose of this narrative review is to critique and synthesize the existing evidence for trauma-informed doula care and to offer guidelines for practice.

Design: We conducted a narrative review of existing evidence in the peer-reviewed and gray literatures on trauma-informed care in maternity and perinatal settings including doula training curricula and community-based doula guidelines on trauma-informed doula care. Materials were analyzed for relevant data on trauma and pregnancy, evidence-based approaches for trauma-informed doula and perinatal care, and strengths/weaknesses of the evidence including research design, gaps in the evidence base, and populations included.

Setting: This narrative review focuses on trauma-informed doula care in the United States, although the evidence and guidelines provided are likely applicable in other settings.

Key conclusions: To be trauma-informed, doulas must first realize the scope and impact of trauma on pregnancy including possible ways to recovery; then recognize signs and symptoms of trauma during pregnancy; be ready to respond by integrating evidence and sensitivity into all doula training and practices; and always resist re-traumatization. Trauma-informed doula care also centers on these 6 principles: safety; trustworthiness and transparency; peer support with other survivors; collaboration and mutuality; resilience, empowerment, voice, and choice; and social, cultural, and historical considerations. In practice, this includes universal trauma-informed doula care offered to all clients, trauma-targeted care that can be offered specifically to clients who are identified as trauma survivors, and connection to trauma specialist services.

Introduction

Although trauma and trauma-related health conditions are increasingly common among childbearing people (Sperlich et al., 2017; Vignato et al., 2017), there is a dearth of published evidence and guidance on trauma-informed doula care. Trauma refers to an event(s) or circumstances that are experienced as physically or emotionally harmful or life threatening and that have lasting adverse effects on wellbeing (Substance Abuse and Mental Health Services Administration (SAMHSA, 2014)). This can include post-traumatic stress disorder (PTSD) and negative pregnancy-related outcomes such as substance use, prematurity, low birth weight, postpartum depression, difficulty bonding with the baby, children with PTSD, or even maternal and infant death (Sperlich et al., 2017; Kilpatrick 2017; Kendig et al., 2017). The childbearing year is a particular time of vulnerability to trauma and trauma-related health consequences (Vignato et al., 2017; Kilpatrick, 2017; Sperlich and Seng 2017). In the U.S., an estimated 9% of pregnant, birthing, and postpartum people are diagnosed with PTSD with another 18% at elevated risk, and these rates are rising (Vignato et al., 2017). Doulas can improve birth, parent, and child outcomes by providing informational, emotional, and instrumental support in the forms of prenatal birth planning, continuous labor support, and postnatal visits (Steel et al., 2015; Hodnett et al., 2013; Kozhimannil et al., 2017). To the extent that doulas can mitigate the effects of trauma on childbearing outcomes, they have the potential to interrupt intergenerational trauma—the transmission of trauma from one generation to the next—and to promote parent and child wellbeing across their life courses (SAMHSA, 2014). In recent years, there has

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https://doi.org/10.1016/j.midw.2020.102643
0266-6138/

been growing attention and demand for trauma-informed maternity care practices. Sperlich et al. (2017) have developed a useful conceptual and implementation model for trauma-informed midwifery, while community-based doulas including Fairley (2019) and Peréz (2012) are leading the way for doulas. Using this foundation as a starting point, here we describe the epidemiology of trauma and its relevance to doula work, then we conceptualize a model of trauma-informed doula care.

Trauma among childbearing people

Epidemiology of trauma

To provide trauma-informed care, doulas must shift the paradigm from "What's wrong with you?" to "What has happened to you…and how can I support?" (Sperlich et al., 2017) This requires, first, an understanding of trauma's scope and social patterning in the general U.S. population and across specific subpopulations that doulas serve. Approximately half of American women have experienced a potentially traumatizing event in their lifetime, and approximately 60% will develop post-traumatic stress symptoms including re-experiencing, avoidance, and hyperarousal (Forman-Hoffman et al., 2016). Notably, there are significant disparities in trauma exposure and health complications by race/ethnicity, socioeconomic status, sexual orientation, and gender identity with multiply marginalized individuals experiencing greatest risk (Forman-Hoffman et al., 2016; Mollard and Brage Hudson 2016; Searle et al., 2017). For example, an estimated 67% of trauma-exposed women[1] have experienced post-traumatic stress symptoms in the past year compared to 33% of trauma-exposed men (Forman-Hoffman et al., 2016), and a study in the Midwest found that Black women were 4 times as likely as White women to have PTSD during pregnancy (Seng et al., 2011).

Some doulas work with populations that are particularly vulnerable to trauma exposure and its mental and physical health effects including individuals who are of lower socioeconomic position, sexual/gender minority, immigrants, refugees, and/or incarcerated. Adults with annual family incomes of less than $20,000 are significantly more likely to report post-traumatic stress symptoms in their lifetime (19.5% vs. 12.4%) and in the past year (9.3% vs. 3.2%) compared to more affluent individuals (Forman-Hoffman et al., 2016). Sexual and gender minorities including lesbian, gay, bisexual, transgender, questioning, queer, and intersex individuals (LGBTQI) are significantly more likely to experience trauma during their lifetime—particularly childhood maltreatment and interpersonal violence—and to develop mental and physical health complications including PTSD (Roberts et al., 2010). For example, lesbian (27.6%) and bisexual women (30.5%) had twice the likelihood of experiencing childhood maltreatment as heterosexuals (13.1%) and three times the exposure to sexual violence (44.0% and 47.3% vs. 13.4%). Point prevalence of trauma-related mental health issues is also higher among foreign-born immigrant women in the U.S., particularly refugee and undocumented women (Bartelson and Sutherland 2018). Recent studies have documented how immigration-related stress manifests during pregnancy including miscarriage, trouble breastfeeding, fear of seeking health and social services, and "suddenly single motherhood" when male partners are deported (Lopez 2019; Lopez et al., 2017; Dreby 2012). Finally, innovative childbirth education and doula programs are being integrated into some prisons to provide much-needed support to incarcerated women, where upwards of 29–51% of female inmates meet the diagnostic criteria for PTSD (Friedman et al., 2015). Notably, there are complex relationships between trauma, incarceration, and substance abuse to which doulas must be sensitive. Substance use disorders—often secondary to trauma exposure—are very prevalent among incarcerated women with between 10–24% having alcohol use disorders and 30–60% struggling with misuse or dependence on illegal drugs (Friedman et al., 2015). The majority of women are incarcerated for nonviolent drug-related offenses, which is generally attributed to the so-called "War on Drugs" that has disproportionately affected lower income and women of color (Schroeder and Bell, 2005).

Most Common Traumas Among Childbearing People

- Sexual violence (44%)
- Domestic/intimate partner violence (36%)
- Childhood maltreatment (26%)

Trauma-related Health Risks during Childbearing

- PTSD, anxiety, and depression
- Dissociation/avoidance, re-experiencing, hyperarousal
- Suicidality
- Substance abuse
- Low birth weight and preterm birth
- Trouble with parent-child bonding
- Trouble with breastfeeding
- Infant PTSD
- Maternal and infant death

Fig. 1. Trauma among childbearing people and trauma-related health risks.

Doulas must also be aware of and compassionate toward the unique trauma exposures of childbearing people, which carry specific implications for pregnancy, labor, and childrearing (see Fig. 1). Among women and childbearing people, the most common forms of lifetime trauma exposure include sexual violence (44% in their lifetime) domestic/intimate partner violence (36%), and childhood maltreatment (26%) (Sperlich et al., 2017). Researchers have found that having a history of trauma (such as childhood maltreatment) carries a 12-fold risk for PTSD during pregnancy (Sperlich and Seng, 2017). Specific to the pregnancy and postpartum period, the most common trauma exposures are motor vehicle accidents and domestic/intimate partner violence (Mendez-Figueroa et al., 2013). Trauma during labor and childbirth—for example, loss of control and dignity, an emergency cesarean birth, or a pregnancy loss—can also serve as primary traumatization (for individuals who have never experienced trauma before) and as re-traumatization for previous survivors. Researchers have found that between 20–35% of births are traumatizing, and 2–6% of those exposed to birth trauma develop PTSD (Soet et al., 2003; Fairley 2016). Notably, more research and attention are being given to social determinants of trauma exposure including chronic and toxic stress, historical trauma, racism, and poverty, but they remain controversial (Sperlich et al., 2017; Mikhail et al., 2018).

Trauma-related health outcomes among childbearing people

Trauma and its mental and physical health cascades can seriously affect childbearing and childrearing. Furthermore, there is a dose-response relationship so that repeated trauma exposure and subsequent mental and physical health effects are compounded over time (Sperlich et al., 2017). As trauma-informed doula Kenya Fairley explains,

> "Memories of the abuse or assault can be triggered within survivors' minds and bodies based on sights, smells, places, people, similar experiences, and a variety of other factors. These triggers may arise at times when the survivor feels particularly

[1] We acknowledge that people of all genders or who are agender can experience pregnancy and childbirth. However, the vast majority of evidence in this area comes from research with pregnant cisgender women. For that reason, our review focuses on cisgender women but we have tried to incorporate gender-inclusive language and evidence where possible.

vulnerable or unable to control what is happening, such as in labor and childbirth." (Fairley, 2016).

Experiences during the childbearing year that might cause re-triggering or "echoing" traumatic symptoms include loss of control, fetal movement, vaginal exams, passage of the baby through the pelvis and birth canal, standard positions for birth that are vulnerable and exposing, authoritative attitudes of healthcare providers, fetal monitoring and restrictive interventions such as blood pressure cuffs and IVs, small spaces or open spaces, unfamiliar people in the room, and breastfeeding sensations (Fairley, 2016; Sperlich et al., 2017; Simkin and Klaus, 2004). A meta-analysis of qualitative research with survivors of childhood maltreatment and sexual abuse showed that the six most common concerns during pregnancy are: the need for control, disclosure challenges, dissociation, hoping for healing, coping during re-experiencing, and extreme discomfort with vulnerability (Sperlich et al., 2017; Montgomery, 2013). As we've already mentioned, exposure to trauma can result in perinatal post-traumatic stress symptoms that sometimes rise to the clinical diagnostic criteria for PTSD (Forman-Hoffman et al., 2016). A formal PTSD diagnosis, according to the DSM-V, requires (A) exposure to a traumatic event, (B) re-experiencing symptoms, (C) avoidance symptoms, (D) hyperarousal symptoms, and/or (E) negative mood and cognitions such as self-blame and shame, (F) symptoms lasting for more than 1 month, and (G) that are causing significant distress or loss of functioning (Sperlich et al., 2017; Forman-Hoffman et al., 2016).

Trauma can also lead to other adverse mental health outcomes including anxiety, depression, suicidality, substance abuse, and trouble with parent-child bonding (Sperlich et al., 2017; Forman-Hoffman et al., 2016). It is important to note that substance misuse including alcohol consumption, smoking, and illegal drug use during pregnancy are often coping mechanisms employed to deal with underlying trauma and distress (Schroeder and Bell, 2005; Lopez et al., 2011). Thus, particularly in context of the opioid epidemic, doulas must approach substance abuse among their clients with understanding and compassion. Domestic/intimate partner violence, sexual violence, and childhood maltreatment along with subsequent perinatal PTSD can also increase the risk of postpartum depression and delayed or impaired parent-child bonding (Sperlich et al., 2017; Vignato et al., 2017; Garabedian et al., 2011). The concept of "ghosts in the nursery" describes how individuals who experienced childhood maltreatment might be haunted by past experiences and future fears that they are likely to repeat the parenting abuses modeled for them (Sperlich et al., 2017). Children of individuals with PTSD are, in fact, more likely to experience maltreatment and other trauma exposures, and they are more likely to develop PTSD even without being exposed to trauma themselves (Sperlich et al., 2017). Researchers suggest this intergenerational transmission of trauma, wherein children "inherit" the traumas experienced by previous generations, are driven by learned and modeled parental behaviors as well as biological processes of epigenetic changes in DNA caused by environmental stressors (Sperlich et al., 2017; SAMHSA, 2014). The evidence base surrounding doula care suggests that one way doulas influence maternal and child health outcomes is by calming stress responses during pregnancy and labor that facilitate improved birth outcomes, bonding, and maternal mental health (Hodnett et al., 2013; Gruber et al., 2013).

Trauma and its sequelae also carry important physical health consequences for birthing parents and infants including higher risk of low birthweight, preterm birth, breastfeeding challenges, and maternal and infant mortality (Sperlich et al., 2017; Kilpatrick, 2017; Kendig et al., 2017). Trauma during pregnancy seems to be involved in 1 out of 5 maternal deaths, (Kilpatrick, 2017) and this does not include trauma prior to pregnancy. Further, as postpartum depression and suicide become increasingly important factors in rising maternal mortality in the U.S., the role of trauma and its mental, physical, and behavioral health effects must be addressed. It is now estimated that 20% of postpartum parental deaths are caused by suicide, and these are considered highly preventable (Kendig et al., 2017).

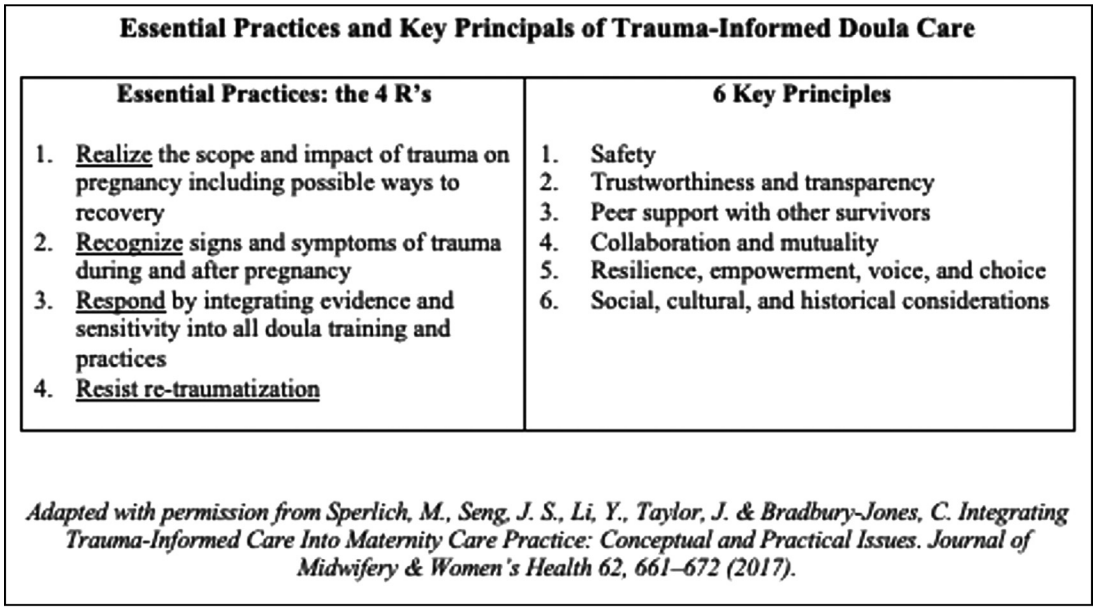
Resilience and empowerment

By describing the most common negative health impacts of trauma for childbearing people, we do not intend to apply a deterministic or fatalistic lens. Rather, we celebrate the agency, resilience, and empowerment that are intrinsic to trauma-affected individuals and to which doulas are well-acquainted. It is essential to remember that birth can be a "time of positive transformation and breaking the chains of past trauma experiences." (Fairley, 2016).

The concepts of empowerment and resilience are often overlapping and indistinct, but both play an important role in maternal and child health, particularly in the context of trauma. Brodsky and Cattaneo (2013) have developed a Transconceptual Model of Empowerment and Resilience, which emphasizes that these are two iterative and interconnected processes. They explain that resilience is typically inward-focused while empowerment is more outward-focused. Resilience refers to a process of (1) self-awareness, (2) intention, (3) action, (4) reflection, and (5) maintenance that allows individuals to adapt, withstand, and resist stressors and risks in their environment. Childbearing people who have been exposed to childhood maltreatment and other traumas demonstrate resilience when they break the intergenerational cycles of violence through behavior change, and when they adopt protective instead of harmful coping mechanisms. Empowerment, on the other hand, can be defined as "a meaningful shift in the experience of power attained through interaction in the (external) social world" where power is "one's influence in social relations at any level of human interaction, from dyadic interactions to the interactions between a person and a system" (Brodsky and Cattaneo,2013). Trauma-affected childbearing people demonstrate empowerment when they access perinatal social support including doulas, when they advocate for trauma-informed and patient-centered healthcare, or when they engage in policy- and systems-level change through collective action. Studies on doula care have shown improvements in maternal empowerment as measured by perceived control of medical decision-making during birth and by questions asked by the patient about their healthcare (Gruber et al., 2013). Notably, empowerment is a key principle of trauma-informed care as we discuss below.

Trauma-informed doula care

Adapting the National Center for Trauma-Informed Care (NCTIC) (Substance Abuse and Mental Health Services Administration, 2014) definition for the doula and pregnancy support context, we define trauma-informed doula care as: a doula-related program or service that realizes the scope and impact of trauma including possible ways to recovery, recognizes signs and symptoms of trauma, responds by integrating evidence and sensitivity into all training and practices, and resists re-traumatization (see Fig. 2). These are the essential practices of trauma-informed care and are commonly called the "4 R's." Trauma-informed doula care also follows the 6 key principles of any trauma-informed program or service. These are: (1) physical and psychological safety in the environment and interpersonal interactions; (2) trustworthiness and transparency that build trust and confidence between the client and doula; (3) peer support with other survivors; (4) collaboration and mutuality between doula, client, and healthcare team that promote



Essential Practices and Key Principals of Trauma-Informed Doula Care

Essential Practices: the 4 R's	6 Key Principles
1. Realize the scope and impact of trauma on pregnancy including possible ways to recovery 2. Recognize signs and symptoms of trauma during and after pregnancy 3. Respond by integrating evidence and sensitivity into all doula training and practices 4. Resist re-traumatization	1. Safety 2. Trustworthiness and transparency 3. Peer support with other survivors 4. Collaboration and mutuality 5. Resilience, empowerment, voice, and choice 6. Social, cultural, and historical considerations

Adapted with permission from Sperlich, M., Seng, J. S., Li, Y., Taylor, J. & Bradbury-Jones, C. Integrating Trauma-Informed Care Into Maternity Care Practice: Conceptual and Practical Issues. Journal of Midwifery & Women's Health 62, 661–672 (2017).

Fig. 2. Essential practices and key principals of trauma-informed doula care.

healing through relationship-building and leveling of power differences; (5) promoting client resilience, empowerment, voice, and choice; and (6) being responsive to cultural, social, and historical considerations including gender, racial, ethnic, socioeconomic, and sexuality differences and inequalities. Trauma-informed care uses a tiered model including universal, trauma-targeted/specific, and trauma specialty services. First, trauma-informed doula care is universally offered to all clients at baseline (as though assuming anyone could have a trauma history). Then trauma-targeted or trauma-specific services are made available for those doula clients who are identified as survivors of trauma. Finally, some doula clients will need support from a trauma specialist, who is a trained mental healthcare provider. In these cases, doulas can serve as patient advocates, provide emotional support, and help connect clients to the specialized care they need.

Universal trauma-informed doula practices

Based on the awareness of trauma and its impacts, doulas must offer trauma-informed care universally at baseline, which is actually beneficial for all clients regardless of trauma history (Sperlich et al., 2017; Substance Abuse and Mental Health Services Administration, 2014; Fairley, 2016). This involves the consideration of trauma during doula training, when screening new clients, and in all practices during pregnancy, labor, and the postpartum period (see Fig. 3).

Training

Many training resources on trauma-informed care are available to doulas, but it is unclear how consistently doulas are being exposed to these materials. Doula training and accreditation institutions including DONA (Doulas of North America) International and CAPPA (Childbirth and Postpartum Professional Association) are a critical first step where doulas can receive basic instruction in trauma-informed care. Currently, most doula training programs offer brief overviews on the subject and point to required readings that go deeper (CAPPA, 2019) We have compiled these and additional resources and readings (see Fig. 4) that might be helpful to trauma-informed doulas and their clients, focusing on the main causes of trauma in childbearing people: sexual violence, domestic/intimate partner violence, and childhood maltreatment. Individual doulas and doula programs could augment this basic introduction by holding journal club discussions about those required readings, about technical assistance materials from the NCTIC, and about challenging cases they encounter. Some institutions also offer trauma-informed care trainings that doulas can attend: for example, a student-led organization at the Emory University School of Medicine hosts an annual Trauma-informed Care Training Day. Topics covered during the training include: how to interact with patients using trauma-informed techniques, asking about sensitive information, community resiliency model and self-regulatory skills, trauma-informed care in health care settings, re-traumatization and how to avoid it, trauma-informed parenting techniques, and the role of race/racism in trauma and resilience.

Prenatal doula practices and screening

The prenatal period is an ideal time for doulas to build trusting and mutually respectful relationships with their clients, which is the foundation of trauma-informed care. Additionally, doulas are also able to provide basic yet empowering childbirth education to clients, which can minimize stress for everyone and especially those affected by trauma. By creating a birth plan with each client, doulas can reduce anxiety and give everyone autonomy over their body and choices.

Doulas might feel they do not know the trauma exposure status of their clients, and need support for screening during intake and other opportunities. First, doulas can *observe* their clients and the dynamics between their clients and intimate partners, family members, and others. Doulas can also include standard trauma exposure questions during *intake* of new clients after a trusting relationship has been established (Substance Abuse and Mental Health Services Administration, 2014; Fairley, 2016). Intake screening must occur in private and should include both experiences of trauma and access to resources for resiliency, particularly social support. Doulas should only ask such questions if they are prepared and trained to provide appropriate follow-up when trauma is disclosed, for example, by providing known resources for referral and services like those presented in Fig. 4. We have adapted questions by

Doula Practices for Universal and Trauma-targeted Care

Universal Care	Trauma-targeted Care
• All doulas trained on scope and effects of trauma • All doulas trained in trauma-informed care • Client is monitored for verbal and non-verbal signs of trauma and related symptoms	• Care is tailored to the specific circumstances and needs of the client • Giving client power and control is the primary objective • Referral to trauma specialists as needed
Pregnancy • Birth planning (location, provider, lighting) • All clients screened for trauma exposure and health complications • Social support (and potential dangers) are identified	Pregnancy • Specific birth planning to avoid re-triggering and re-traumatization • Communication with clinical care team about trauma history and birth preferences • Enrollment in trauma-targeted services
Labor • Distraction during early labor • Ritual and rhythm: breathing, position changes, bathroom breaks, affirmations, repetitive or mindful movements, visualizations, dim lighting, quiet/music • Consent is obtained before touching • All client preferences and choices are respected and advocated for • Clients are encouraged to ask questions and speak their needs	Labor • Coping mechanisms during post-traumatic symptoms • Respect and advocate for birth preferences (i.e., minimal vaginal exams, epidural, minimal visitors) • Monitor who is in the room to ensure safety • Grounding exercises during dissociation and re-experiencing • Extra support during transition, which can be particularly difficult for survivors
Postpartum • Support for bonding with infant including skin-to-skin and sleeping in the room • Support for breastfeeding or any infant feeding of the parent's choosing • Modesty protected during breastfeeding, changing, etc. • Processing the birth if client agrees	Postpartum • Address "trauma echoes" (especially with breastfeeding) with sensitivity and discontinue as needed • Closely monitor parent-child attachment • Deeper processing of the birth with reframing as needed to emphasize strength

Fig. 3. Doula practices for universal, trauma-targeted, and trauma specialty care.

Fairley (2016) and the American College of Obstetricians and Gynecologists (Chamberlain and Levenson, 2013):

- Are there any experiences now or in your past that were traumatic that could affect your pregnancy, birthing, or parenting experience?
- In the past, have you spent any time in the hospital that would cause anxiety for you being in the hospital during childbirth?
- It is helpful for people to stay mentally focused on their labor: have you had any troubling or frightening experiences in the past that may get in the way of your mental focus during labor?
- Who in your life can support you during this pregnancy?
- Does your partner support your decisions about if or when you want to be pregnant and have children?
- Has your current partner ever threatened you or made you feel afraid?

If a client discloses trauma exposure, Fairley suggests that doulas can ask the following questions then proceed with trauma-targeted doula care as described below:

- If you feel comfortable, can you share more about what you experienced?
- When these issues resurface, what do you do to cope?
- How do you think those past experiences will affect your birth experience now?
- What helped you the most in healing from your experience?
- Who in your life has supported you to heal from this experience?
- How can I best support you?

Universal practices during labor and postpartum

Their consistent and constant presence for the duration of labor and childbirth is likely the most powerful health-promoting service a doula can offer to any client, including clients affected by trauma. Similarly, doulas' primary roles as patient advocates for birthing clients perfectly positions them to identify, support, and amplify a given client's priorities, preferences, and needs (Fairley, 2016). This is essential for survivors of trauma for whom a primary symptom is the loss of power and control.

Resources and Readings for Trauma-Informed Doulas and their Clients

Websites and Training

- Futures Without Violence
  www.futureswithoutviolence.org
- National Resources for Sexual Assault Survivors
  https://www.rainn.org/national-resources-sexual-assault-survivors-and-their-loved-ones
- National Coalition Against Domestic Violence
  www.ncadv.org
- National Resource Center on Domestic Violence
  www.nrcdv.org
- Office on Violence Against Women
  (U.S. Department of Justice)
  https://www.justice.gov/ovw

Readings on Trauma-Informed Care

- Kenya Fairley
  With Harp and Sword: A Doula's Guide to Providing Trauma-Informed Birth Support
  https://www.kenyathedoula.com
- Miriam Pérez
  The Radical Doula Guide
  https://radicaldoula.com/the-radical-doula-guide
- Penny Simkin and Phyllis Klaus
  When Survivors Give Birth
  https://whensurvivorsgivebirth.net
  *trainings available
- Substance Abuse and Mental Health Services Administration.
  Concept of Trauma and Guidance for a Trauma-Informed Approach
  https://store.samhsa.gov/system/files/sma14-4884.pdf

Hotlines and Live Chats

- National Center on Domestic Violence, Trauma & Mental Health
  312-726-7020
  www.nationalcenterdvtraumamh.org
  *includes service provider database
- National Domestic Violence Hotline
  1-800-799-7233 (SAFE)
  www.thehotline.org/what-is-live-chat
- Childhelp National Child Abuse Hotline
  1-800-422-4453
  http://www.childhelp.org/hotline.
- National Sexual Assault Hotline
  1-800-656-4673 (HOPE)
  Live chat:
  https://ohl.rainn.org/online
- National Suicide Prevention Lifeline
  1-800-273-8255
  https://suicidepreventionlifeline.org
- Loveisrespect
  Teen Dating Violence Hotline
  1-866-331-9474 or
  Text 'loveis' to 22522
  www.loveisrespect.org
- National Organization for Victims Assistance
  1-800-879-6682 (TRY-NOVA)
  http://www.trynova.org
  *includes training for advocates

Fig. 4. Resources and readings for trauma-informed doulas and their clients.

A primary aim of trauma-informed doula care is to restore that control.

Many doula strategies and services during labor and the postpartum period can universally support all clients, while being particularly sensitive to the experiences of trauma survivors. One foundational tenet of universal trauma-informed care that all doulas must heed is consensual touch. Further, trauma-informed doulas will respect all client preferences and choices, and will encourage all clients to advocate for themselves by asking questions and speaking their needs. Distraction during early labor (for example, walking or watching movies) is especially useful for keeping trauma-affected individuals calm and in their comfortable and safe environment. The classic doula technique of ritual and rhythm is a powerful coping technique during active labor and can help all clients ground and find inner power and calm. This might include breathing, position changes, going to the restroom and sitting on the toilet, yoga or other mindful movement, repetitive movements, and affirmations. Dimming the lights and setting a calm mood with music (if the client prefers) can provide a calmer birth experience. After birth, all clients should be supported to bond with their newborn through skin-to-skin contact and sleeping in the same room. Similarly, all clients should be supported in the infant feeding method of their choice without judgment. Finally, if the client is comfortable a ready, doulas can provide a very powerful space for processing the birth.

Trauma-targeted doula care

Clients who have been identified as trauma survivors can be further and more specifically supported through trauma-targeted doula care. The first step is to identify the client's priorities (Fairley, 2016; Simkin and Klaus, 2004). This can include making a trauma-informed birth plan that avoids common and client-specific triggers (i.e., vaginal exams, strangers in the room, breastfeeding). Doulas can also encourage clients to communicate with their clinical care team about the trauma history and their needs for accommodation during reproductive health care. This includes selecting the birthing location, identifying a trauma-sensitive and mutually respectful clinical provider, and articulating preferences regarding induction and augmentation, pain management, and other common interventions (Sperlich et al., 2017; Fairley 2016; Simkin and Klaus, 2004). All trauma-targeted care should be tailored to the specific circumstances, needs, and priorities of the client. The primary objective, again, is to restore power and control.

Trauma-targeted programs and specifically vulnerable populations

Ideally, all trauma-affected childbearing individuals would be referred to trauma-targeted programs tailored to their specific circumstances and needs. While doulas might not have the power to refer and enroll their clients directly, doulas should at least be aware of trauma-targeted programs that are evidence-based and effective. Some of these programs are in early stages of development, while others are being implemented more widely. Doulas can ask about these and similar programs available in the health systems where their clients receive care.

The most common program that uses the trauma-informed approach of peer support is Centering Pregnancy, wherein pregnant people share their healthcare appointments with other pregnant people of similar gestation and circumstance (Gerber, 2019). These groups can be tailored so trauma survivors are able to interact with and receive support from fellow survivors who are likely experiencing their same challenges. The Survivor Mom's Companion (Sperlich and Seng, 2017) is a psychoeducational and self-paced intervention where pregnant individuals with a history of childhood maltreatment move through a workbook while receiving ongoing support from a counselor, nurse, or outreach worker in-person or via telephone. Radical and queer doulas are also developing programs that are trauma-informed and tailored to the unique needs of pregnant LGBTQI individuals and racial and ethnic minorities that have experienced long-term chronic stress and traumatization due to racism and ethnocentrism. A leading voice in this arena has been Pérez (2012) who created the Radical Doula Guide. Finally, doula programs are also being developed to serve the needs of incarcerated populations and their trauma-related needs including Motherhood Beyond Bars (2019) in Atlanta, Georgia; the Minnesota Prison Doula Initiative (2019) in Minneapolis; and the Michigan Prison Doula Initiative (2019) in Washtenaw County among others. Their websites provide additional materials and resources.

During labor, trauma-targeted doula care involves controlling the environment, providing coping strategies, and respecting the survivor's autonomy (Sperlich et al., 2017; Substance Abuse and Mental Health Services Administration, 2014; Fairley, 2016). First, the environment must remain safe and secure as a "sanctuary" (Sperlich et al., 2017), which requires monitoring of who is in the room. Clients can be encouraged to advocate for minimal visitors in the room, and the healthcare team can be alerted to specific individuals who should not be allowed into the space. If or when post-traumatic symptoms arise during labor, doulas can support their clients to rely on the coping mechanisms they identified during birth planning and intake. This might include grounding exercises to minimize flashbacks and dissociation, breathing rituals, visualizations, or other strategies. These strategies, along with verbal and emotional support from doulas, will be vital during the transition phase of labor, which can be especially challenging for trauma survivors.

After birth, doulas can support parent-child bonding and help their clients address trauma "echoes" with sensitivity and empathy (Fairley, 2016). Trauma survivors are at increased risk of postpartum depression and challenges with attachment, so might require more visits from postpartum doulas over a longer period of time. Survivors would also benefit from deeper processing of the birth experience, if that feels safe, with an emphasis on reframing as needed to emphasize the client's strength and resilience.

Referral to trauma specialists

At times, trauma survivors will need to be referred to specialists who use evidence-based interventions (for example, eye movement desensitization and reprocessing) and are sensitive to perinatal triggers (Sperlich et al., 2017). This includes behavioral health specialists such as counselors and/or psychiatric specialists when medical interventions (for example, anti-depressants) are indicated. The Sidran Institute is an excellent resource for finding trauma-educated providers and programs in your area (Sidran Institute, 2019). Medical care including any medical recommendations are outside the scope of doula work, but doulas can empathically support clients as they connect to specialty care, as they weigh their options, and as they navigate behavioral and medical changes during pregnancy and the postpartum period.

Trauma stewardship for doulas

Providing trauma-informed doula care can be incredibly taxing, and it requires ongoing attention to self-care and sustainability to ward off burnout (Sperlich et al., 2017; Fairley 2016). Directly serving trauma-affected clients can also be re-triggering for doulas who are, themselves, survivors of trauma. Traumatizing birth circumstances can also result in trauma-related symptoms that, if not properly addressed through counseling or other interventions, lead to long-term mental and physical distress. Researchers use the term "trauma stewardship" to describe the practice of effectively caring for oneself in order to provide care to trauma survivors without lasting negative effects (van Denoot Lipsky et al., 2009). Secondary exposure to trauma might be inevitable when doula clients are disclosing or actively experiencing trauma and its symptoms, but vicarious trauma and trauma-related symptoms can be avoided. Fairley (2016) suggests some of the following activities for doula self-care and trauma stewardship:

- Know your emotional, physical, and mental limits.
- Pursue ongoing education, training, and professional development.
- Maintain knowledge of community resources (and access as needed).
- Engage your back-up doula colleagues and your social support network.
- Practice grounding and cleansing rituals when returning home from a birth/visit.
- Process and debrief with other maternity care professionals.
- Develop a long-term self-care plan with protective health behaviors that promote wellbeing (ex: physical activity, nutritious diet, mindfulness, creativity, sleep, and connection to others).

On an organizational level, doula programs must devote resources to supporting and retaining doulas. This includes adequate training in trauma-informed care, support systems for debriefing trauma-related cases, protocols for ensuring doula safety, and back-up systems for when doulas need rest.

Conclusion

Trauma exposure and health-related outcomes are very common among childbearing people, but to-date there has been a lack of evidence and guidance for front-line doulas who provide critical informational, emotional, and physical support during pregnancy, labor, and the postpartum period. By increasing doulas' capacity to realize the scope and consequences of trauma, to recognize trauma symptoms, to respond to trauma, and to resist re-traumatization, it is possible to deliver trauma-informed doula care. This has the potential to mitigate the short- and long-term parental and child health effects of trauma and to interrupt the intergenerational cycle of trauma passed down from parent to child. Here we have described the epidemiology and etiology of trauma among childbearing people, and we have proposed an evidence-based model of trauma-informed doula care that is grounded in the key principles of safety; trustworthiness; peer support; mutuality; resilience and empowerment; and considerations of social, cultural, and historical contexts. The tiered approach to trauma-informed doula care includes universal trauma-sensitive approaches, trauma-targeted services for clients who are survivors of trauma, and linkages to trauma specialists as needed. Finally, we have linked to resources, readings, and evidence-based programs. This narrative review is useful to both doulas and scholars of reproductive health care, and serves as a foundation for future research, training, and programming on trauma-informed doula care.

Ethical approval

None.

Declaration of Competing Interest

None.

Acknowledgements

The authors would also like to thank Drs. Seng, Sperlich, and colleagues and Ms. Kenya Fairley for their foundational work in trauma-informed maternity and doula care.

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