NCPD 2.5 contact hours

By Robin McCormick and Leslie Painter

Seeing Past the Sentence:
CARING FOR PREGNANT WOMEN WHO ARE INCARCERATED

ABSTRACT: *The number of women who are incarcerated in the United States has grown significantly since 1980. Caring for pregnant women who are in the correctional system requires special knowledge and the skills of advocacy and compassion. The purpose of this article is to discuss strategies to provide compassionate, sensitive, and trauma-informed care that demonstrates the love of Christ to incarcerated pregnant women.*

KEY WORDS: *incarceration, nursing, pregnant women, prison*

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The population of women who are incarcerated continues to grow in the United States, up by 700% since 1980 (Equal Justice Initiative, 2018; The Sentencing Project, 2020). In 2019, 222,455 women were incarcerated, most being in jails or state prisons (The Sentencing Project, 2020). Women account for 7% of the current incarcerated population (Carson, 2018). Three-quarters of women who are incarcerated are of childbearing age, and an estimated 3.8% of newly incarcerated women are pregnant (Sufrin et al., 2019). Many of these women deliver babies while still in jail or prison. The purpose of this article is to provide nurses with strategies to provide informed, compassionate, Christ-like care to pregnant women who are incarcerated.

KELLY'S CASE

Kelly was lying in a bed, having been admitted from prison to the hospital for an induction of labor. She realized that in a few short hours, she would deliver her baby—a baby she would be allowed to bond with for only 24 short hours. As the nurses came in, they discussed her history among themselves. Kelly tried to tune out the nurses' words: "prisoner; drug user." Two guards sat nearby, listening to the nurses. No one acknowledged her. She felt invisible, like no one even saw her in the room. No one spoke to her, and Kelly assumed it was because she was not worthy of love. After all, she was just a prisoner, a drug addict, unworthy of compassion.

The nurse returned to the room to start an IV and begin medication to induce her labor. Kelly started crying, realizing this first step to losing her baby. As long as her daughter was inside of her, her baby girl was still hers. Kelly cried for her own mom, just wishing someone could be with her right now.

A few hours later, a physician came in to check Kelly's cervix. Kelly tried to go to another place in her head, because when the physician touched her most private places for the exam, it took her back to when she was abused as a child. Suddenly, without warning, the physician broke her water. Kelly screamed and cried. The physician looked startled and did not understand why she was upset. Kelly cried because this was one step closer to being separated from the baby she had been growing and loving for nine months.

For hours, Kelly labored alone and in pain, with only guards in the room. The guards told her to be quiet and not to scream while they talked among themselves. She watched the guards eat their lunch in front of her. As Kelly smelled their food, she wished someone would bring her a chip of ice to wet her mouth. The nurse moved in and out of the room to check the monitors quietly, adjusting the straps on her abdomen, but never making eye contact.

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Kelly called the nurse when she felt the urge to push. In her hospital room, with only the physician, nurses, and prison guards present, she delivered her daughter—her beautiful girl whom she wanted more than anything in this world. This daughter represented, to her, a new chance to change. No one was there to celebrate with her, to take pictures, to discuss hopes and dreams. There was no proud announcement of the baby's weight and length, and no questions were asked about where the baby got her beautiful curls.

With the short amount of time nurses have with these women, we can show great compassion and be the hands and feet of Christ.

The nurses took Kelly's daughter to the warmer in the room to clean and assess her. Kelly heard her baby crying and longed to hold her. She was afraid to speak up and ask for her child because she knew they did not think she deserved her baby. Finally, after a long 30 minutes, the nurse brought Kelly's newborn back to her. Kelly looked into her daughter's eyes and sobbed, realizing that after today, she would not see her daughter for a long, long time.

Kelly savored this time, memorizing every detail about her newborn, taking in the baby's smell, stroking her soft hair, and enjoying every feeding and diaper change. The new mother stayed awake until her body gave in to exhaustion and she slept. The 24 hours she was allowed to spend with her daughter passed quickly, and the physician soon discharged Kelly back to her prison cell. Guards came to the room and announced it was time to leave. Kelly sobbed as she handed her baby over to the nurse.

She returned to the prison alone, her hands and body feeling empty of the baby who couldn't return to prison with her. This did not seem real. She knew her daughter would be placed in foster care, and she hoped her baby would be loved, even as she felt jealous of the person who would be allowed to love her daughter. She wondered if she would ever get to see her baby again. **

**This story does not represent a single woman, but a collection of experiences of different women who have delivered babies while incarcerated.

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CHARACTERISTICS OF WOMEN WHO ARE INCARCERATED

Women who are in the correctional system often share common traits. Many have been victims of abuse or were raised in dysfunctional homes. About 60% of women who are incarcerated have children under the age of 18 (The Sentencing Project, 2020).

There is a link between incarceration and being a member of a racial minority, being poor, and having a history of mental illnesses (Foley & Papadopoulos, 2013). The imprisonment rate for African American females is 1.7 times greater than for White females (Carson, 2018; The Sentencing Project, 2020), although the rate of incarceration for African American females has steadily declined. A history of substance abuse is seen often in women who are incarcerated. In state prisons, more females have been convicted of a drug offense, compared with males (Carson, 2018). The most common offenses by women are drug-related (26%) or property crimes (24%) (The Sentencing Project, 2020). An association also has been noted between being incarcerated in the last year and having a child earlier in life, lower levels of education, being unmarried and pregnant, and having six or more stressors reported in the last year (Pregnancy Risk Assessment Monitoring System, 2018). Women who are incarcerated also have higher levels of complications related to physical illness (Foley & Papadopoulos, 2013) and are less likely to receive proper prenatal care (Froggé, 2019). A history of childhood trauma, mental illness, substance abuse, unhealthy relationships, and disorganized family situations often are seen in incarcerated women, causing lifelong patterns of victimization (Hayes, 2015). Women in correctional facilities have unique health concerns because of their history of trauma, abuse, and high levels of stress. Healthcare providers in correctional facilities care for incarcerated women, but other nurses may be responsible for the provision of care

during the prenatal, childbirth, and postpartum periods. Thus, it is imperative that healthcare providers who care for women in correctional facilities provide compassionate, trauma-informed care while showing God's love to members of this population.

DAILY LIFE IN A CORRECTIONAL FACILITY

The theme of punishment is pervasive in the daily life of those who are incarcerated, where policies and practices strip the personhood and freedom from those in prison (Fedock, 2017). Frequently, women who are incarcerated are referred to by their assigned inmate numbers instead of by name, which can chip away an incarcerated woman's sense of personal identity. The daily routine in a correctional facility is highly structured, leaving little room for personal choice. Decisions about when to get out of bed, what to wear, what to eat, and how to spend the day are made for women who are incarcerated. Infractions are noted regarding minor rules, and these infractions may lead to a loss of privileges. For example, not making a bed could lead to a punishment such as loss of visitation. As visitation is considered a privilege, incarcerated women may not receive visits from family and friends, including their children. As contact with family is decreased, the rates of depression and self-harming behaviors increase (Fedock, 2017).

MEDICAL AND NURSING CARE GUIDELINES

The American College of Obstetricians and Gynecologists (ACOG, 2016) developed guidelines for the healthcare needs of pregnant incarcerated women during pregnancy and the postpartum period. These guidelines include assessing for pregnancy risk and testing for pregnancy at time of incarceration, and providing perinatal care following guidelines of the American Academy of Pediatrics and the ACOG. Other guidelines include assessing for substance abuse and initiating treatment, and testing for and treating human immunodeficiency virus (HIV) to prevent perinatal HIV transmission. Incarcerated women should also be screened for depression or mental stress during pregnancy and for postpartum depression after delivery, and treated as needed. Dietary supplements should be made available to incarcerated pregnant and breastfeeding women.

Childbirth should be conducted in a licensed hospital with facilities for high-risk pregnancies when available. Postpartum contraceptive methods during incarceration should be provided. The Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) has guidelines for the care of incarcerated women (JOGNN, 2018), which include access to regular perinatal care from a clinician with obstetric expertise, adequate nutrition and exercise, a lower bunk, pregnancy clothing, accommodations for rest and work, and safe transportation to a licensed hospital for birth and postpartum care. Incarcerated women who choose to breastfeed their newborns, according to AWHONN, should receive the same education and support as nonincarcerated women, regardless of whether the mother and baby will remain together at hospital discharge.

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A key recommendation is to support maternal–infant contact by allowing women to remain in the community, having prison nurseries with adequate developmental support, placement in a correctional facility near the family, and family visiting spaces that allow women to hold and breastfeed their infants. Induction of labor or cesarean birth for incarcerated women for the convenience of healthcare providers or correctional staff should not be conducted. The AWHONN also opposes the practice of shackling women who are pregnant or who are within 8 weeks of postpartum (JOGNN, 2018). Even with these published guidelines, many correctional facilities lack comprehensive policies to address the health concerns of prenatal care, nutrition during and after pregnancy, and safe levels of physical activity (Kotlar et al., 2015), especially because there is no oversight to the care provided. Without comprehensive, evidence-based policies to guide pregnancy-related and postpartum care, gaps in care will continue to exist.

There are differences in the care received by incarcerated women and women in the "free world" (the term used by incarcerated women to refer to those not incarcerated). Women in the free world can choose their healthcare providers, the location where they receive prenatal care, the facility where they deliver, and who is able to attend the delivery. They also can decide how the baby will be fed by choosing breast milk or infant formula. Mothers in the free world are able to ensure little separation from their new infants and themselves after delivery. Additionally, mothers in the free world are often able to speak up and direct care, whereas incarcerated women may not feel they have a right to speak up due to a sense of power imbalance. Women who are incarcerated often feel they are unable to advocate for themselves, as any dissention may lead to an infraction from correctional officers. Most significantly, women in the free world are able to take their babies home with them, whereas many women who are incarcerated are unable to do so.

Incarcerated women may be transported to physicians' offices to receive prenatal care and to diagnostic facilities for ultrasounds. Although federal law prohibits pregnant women in federal prison from being shackled, no such law applies to women in state prisons and county jails. Many officials still shackle pregnant women while

they are being transported to appointments and to the hospital in labor, whereas some force women to deliver their babies while in shackles. Pregnancy may cause issues with balance while standing and walking, which can lead to shackled women falling and being injured. Shackling also prevents women from moving during labor, increasing the potential of life-threatening health risks inherent in childbirth. Nurses should know their state laws and local policies related to shackling and should advocate for safe care by encouraging the removal of shackles during prenatal visits, while in the hospital, and during postpartum follow-up visits.

By taking a trauma-informed care approach, caregivers must shift their philosophy regarding incarcerated women.

Incarcerated women are not allowed contact with their families while at medical appointments or in the hospital, resulting in many women laboring and delivering without the emotional support of family members. This does not allow for opportunities for the births to be recorded with pictures of both mothers and babies, nor a celebration time of a new birth with family members. It is often up to the nurse to serve as both a healthcare provider and emotional support person for the incarcerated woman.

ROLE OF THE DOULA

Recently, some facilities have begun allowing doula support during birth and for a short period postpartum. *Doula* is a Greek word meaning a woman who cares for another woman (Merriam Webster, n.d.). The doula may support the incarcerated woman during pregnancy, labor, and birth by providing a familiar face and emotional support. An example of this service is the Alabama Prison Birth Project, which provides doula support at Julia Tutwiler Prison for Women in Alabama.

The doula may establish a bond with a client prior to birth during weekly childbirth education classes and one-on-one prenatal meetings. The doula attends the birth from the beginning of labor until hours after the baby is born and also provides breastfeeding support if the woman would like to establish lactation (Alabama Prison Birth Project, 2020). The doula is allowed to take pictures of the mother and baby to commemorate the birth. The doula is also present when the incarcerated woman separates from the infant at hospital discharge and visits the woman back in the facility to provide continuing support during the postpartum period. Research is being conducted to demonstrate how programs like this can improve patient health (Shlafer et al., 2020) and client satisfaction.

POSTPARTUM EXPERIENCE IN PRISON

Most women who give birth while incarcerated are separated from their babies soon after delivery, limiting their ability to breastfeed, bond, and maintain parental rights. Many women who are separated from their infants shortly after birth expressed feelings of loss and abuse (Kotlar et al., 2015). Separation of mother and infant leads to higher rates of postpartum depression in this population (Froggé, 2019). Separation anxiety often is seen in both the mother and the child. Most newborns are cared for by a member of the incarcerated mother's family, whereas some infants are placed with the father or father's family. Other children are placed in foster care if a suitable family caregiver cannot be found. Even when placed with family members, visitation between incarcerated mothers and their children may be limited because of the distance to the correctional facility, lack of child-friendly visiting spaces, cost to travel, inconvenient visiting times, and visitation restrictions in place by the facility (Fedock, 2017).

Few prison nursery programs exist that allow postpartum women to be housed with their children. Programs that do exist allow women not convicted of child abuse or violent crimes to live with their children for one to three years, thereby allowing secure attachments to form between mother and child. Mother–child bonds may break cycles of generational insecure attachment which the incarcerated woman may have experienced in her own childhood (Kotlar et al., 2015). These programs have shown no harmful effects on the children and have been lauded as showing positive changes in the correctional setting (Tuxhorn, 2021).

OFFERING TRAUMA-INFORMED CARE

The Substance Abuse and Mental Health Services Administration (SAMHSA, 2014) defines trauma-informed care as an understanding of trauma and the impact it can have among populations and across various settings. By taking a trauma-informed care approach, caregivers must shift their philosophy regarding incarcerated women. A shift in the mindset from "What is wrong with you?" to "What happened to you?" will help caregivers approach these women differently. Trauma-informed care has six guiding principles: safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment and choice; and cultural, historic, and gender issues (Centers for Disease Control and Prevention, 2018). Many incarcerated women who are pregnant have experienced trauma.

Our goal as healthcare providers is to recognize this and provide compassionate, sensitive care during the birthing process of incarcerated women. Our goal as Christian nurses

should be one of support and healing during their time in the acute care setting and avoidance of retraumatizing these patients. Having the woman retell her traumatic story of being treated as an inmate and not as a laboring woman, of not having choices in her care, of not being allow to give feedback or having a chance to participate in her care contributes to previous trauma. Often, with a history of physical or sexual abuse and substance abuse, these women have suffered in silence. As they seek healthcare for the birth of a baby, the women are left in a situation in which they feel powerless. Such women are vulnerable, and hospital care delivery may trigger or exacerbate prior traumatic experiences (Tello, 2018). With a trauma-informed care approach, nurses and other staff develop a sensitivity to the vulnerability and potential prior trauma. Allowing women choices in labor, agreeing to working with a doula who has established a supportive relationship throughout the pregnancy, establishing a culture of trust and respect in the delivery room, and supporting the incarcerated woman in an effort to bond with her newborn in the brief time she is able demonstrate a trauma-informed care principle.

Table 1. Strategies for Communicating with and Caring for the Incarcerated Pregnant Woman

• Listen to her story.
• Use eye contact.
• Ask questions as appropriate about her feelings about the pregnancy.
• Realize that she may have many mixed emotions about the pregnancy and motherhood.
• Realize that she may have been a victim of abuse or rape.
• Avoid judgment.
• Remember that God created and loves this woman and her child.
• Affirm her worth as a person.
• Understand that the examination, labor, and delivery process may bring up past trauma.
• Offer kindness and reassurance.
• Apply trauma-informed care.
• Encourage breastfeeding when possible.
• Remind yourself that the newborn child is also a patient who has no control over these circumstances, but may face lifelong physical, cognitive, and emotional problems due to behaviors of the parents.
• Show interest in the new mother's dreams and hopes.
• Provide education that is free of medical jargon and in understandable terms.
• Be present with support and comfort during physical exams, labor, and delivery.
• Foster initial bonding between mother and baby.
• Facilitate engagement in a prison nursery program where possible.

DEMONSTRATING GOD'S LOVE

Compassionate care of all patients is the hallmark of nursing. The incarcerated pregnant woman is in an environment that is cold, regimented, and unforgiving. When she comes into the correctional system pregnant or becomes pregnant while incarcerated, the incarcerated woman cannot share her feelings with her family and support systems nor work through the emotions of pregnancy outwardly.

When these women enter a healthcare facility, nurses should provide compassionate, nonjudgmental care and support to these mothers. (See Table 1: Strategies for Communicating with and Caring for the Incarcerated Pregnant Woman.) An environment of trust and therapeutic relationships should be established, and the women should be given as many choices about their care as possible (Gokhale et al., 2020). In this, we are acting in response to God's directive to care for others as if we were caring for him. "Truly I tell you, whatever you did for one of the least of these brothers and sisters of mine, you did for me" (Matthew 25:40, NIV).

In the short amount of time nurses have with these women, we can show great compassion and be the hands and feet of Christ (Holwick, 2018; Mertens & Mertens, 2021). A Christian nurse can take these opportunities to evaluate the patient's spiritual well-being, as described in Matthew 25:36: "I needed clothes and you clothed me, I was sick and you looked after me, I was in prison and you came to visit me" (NIV). Laboring women and new mothers are vulnerable and often seek to do the best for their newborns. The compassion and empathy we share as Christian nurses can break through the tough exterior these women maintain while incarcerated. Sharing the love of Christ and the hope we have in him can provide something to look forward to and an incentive to work on when the women return to jail or prison to complete their sentences. We can let incarcerated women know that God hears their prayers: "The Lord hears the needy and does not despise his captive people" (Psalm 69:33, NIV). Nothing can separate them from the love of God (Romans 8:38-39).

KELLY'S CASE REVISITED

Kelly was lying in a hospital bed, having been admitted for an induction of labor. She realized that in a few short hours, she would deliver her baby. After a few minutes, her doula joined her in the room, having been called by the correctional facility when her client was on the way to the hospital. Her doula went directly to Kelly's bedside and checked on her comfort. Kelly felt relieved to see a familiar face because she had met regularly with the doula throughout her pregnancy.

As the nursing staff came in, they greeted Kelly by name and discussed her pregnancy history with her. The nurses asked if she had any care

Web Resources

- **Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN)** https://www.awhonn.org/
- **Catholic Prison Ministries Coalition** https://www.catholicprisonministries.org/
- **Kairos Prison Ministry** https://www.kairosprisonministry.org/
- **New Horizons Ministry** https://newhorizonsministries.com/
- **Prison Fellowship** https://www.prisonfellowship.org/
- **The Sentencing Project** https://www.sentencingproject.org/wp-content/uploads/2016/02/Incarcerated-Women-and-Girls.pdf

preferences. Kelly stated she was planning to breastfeed and wanted the baby placed directly on her bare chest after birth to provide skin-to-skin care. Two guards sat nearby, talking quietly among themselves. Kelly felt love and compassion from her nurse; she felt safe. She felt like the nurse was part of her care team and Kelly was relieved that no one seemed to be judging her. The nurse returned to the room to start her IV and begin medication to induce labor. The doula held Kelly's hand and distracted her as the nurse proceeded. Kelly started crying, realizing this first step toward delivering her baby. The doula wiped away her tears and stayed beside her. Kelly stated to the doula, "As long as my daughter is inside of me, she is still safe. The world can be such a scary place."

The doula replied, "Although things have been tough for you, here is a new life who does not have to go through the life you have had. She has you as a mom, and this is a new start for you." Kelly was so glad she was not alone. A few hours later, the physician checked her cervix. The guards stepped behind a curtain to help maintain privacy. Knowing about Kelly's history of abuse, prior to touching her the physician verbalized each movement to be performed. The physician asked permission to break her water. Kelly agreed as the doula remained present, holding her hand and helping her breathe through the discomfort.

For hours, Kelly labored with her doula supporting her. The doula worked with her using relaxation exercises and helped her reposition for comfort. The guards were still in the back room, sitting quietly and relieving each other for breaks, each of them eating lunch downstairs in the cafeteria so the smells would not bother the laboring mother. Kelly's doula provided ice chips to wet Kelly's mouth.

The nurse returned periodically to check the monitors, adjusting the straps on Kelly's abdomen, making eye contact, and asking her if she needed anything. Kelly was grateful for her nurse in whom she sensed a calm and warm spirit. When Kelly felt the urge to push, she called the nurse. She was excited, and she and her doula celebrated how close she was to meeting her daughter.

There are differences in the care received by incarcerated women and women in the "free world."

In her hospital room, with her doula, physician, and nurses, Kelly delivered her daughter. The prison guards, knowing that this was a sacred moment, stepped outside the room to allow privacy. Kelly's beautiful daughter, whom she wanted more than anything in this world, represented a chance to change. Her doula, nurses, and physician were there to celebrate with her, to take pictures, and to discuss hopes and dreams. The nurses proudly announced the baby's weight and length. The physician asked about where the baby got her beautiful curls and commented on how much the baby looked like her mom.

The nurse placed the infant directly on Kelly's chest and the baby immediately calmed. The doula helped ensure both mother and baby were in comfortable positions. Knowing Kelly was thirsty, the doula offered a soda and held the straw to Kelly's lips. Kelly looked into her daughter's eyes and fell in love. She cried, realizing this new life had been created inside her, and she could have a new start. She asked God to give her strength to be a good mom. Her doula reminded Kelly to remain in the moment and savor her time with her new baby. The infant took that moment to latch on and began her first feeding. Kelly memorized every detail about her baby, taking in the smell, stroking her newborn's soft hair, and enjoying every feeding and diaper change. She stayed awake until her body gave in to exhaustion and she fell asleep. The doula slipped out, planning to return the next morning.

The 48 hours Kelly spent in the hospital with her daughter passed quickly, and she was discharged. Her doula had spent the morning with her, taking pictures and celebrating her daughter with her. Kelly was grateful the nurses allowed her to keep her baby in the room as they performed the assessments. She felt confident in her ability to be a mom, especially because the nurses and doula helped her with breastfeeding. Kelly reflected on her stay and was thankful for the love and empathy she received from the nursing staff. She had been afraid that they would judge her, but instead they made her feel worthy. The guards came to the room and told her it was time to leave. They brought in a pink car seat, looking like proud uncles as they watched the new mom strap her baby into the seat. Kelly sobbed tears of joy, so grateful the prison had a nursery program and that she had been accepted for it. She knew this discharge could have been so different.

Kelly was grateful of the love and support she would be given as she cared for her daughter until she was able to be released from incarceration in three months.

CONCLUSION

Women in prison face unique healthcare concerns that may cause gaps in care. Those who are pregnant face even more issues. To provide compassionate healthcare, the healthcare provider should implement biblical principles while providing competent trauma-informed care. Opportunities to share God's compassion with these women who feel unloved is paramount to the success of the family unit and the mothers' perceived self-worth. Validating their experiences and fears of their future and the importance of the babies they are bringing into the world is a way we can extend the hand of Christian love to incarcerated pregnant women.

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