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Editorial

Lactation specialists, midwives, doulas, and labor and delivery (L&D) nurses are generally drawn to this field because they want to help mothers and babies. The work can be deeply satisfying. You know you make a difference. Unfortunately, there can be a dark side to our work. One day, you observe something that is wrong and that harms mothers and babies. These experiences—and it only takes one—can haunt you for a very long time. That is the story for many of our colleagues—or perhaps even you.

People outside the field often assume that an event like a mother or baby dying, or witnessing a frightening birth complication such as eclampsia or shoulder dystocia, is the worst thing that can happen. Perhaps the mother and baby survived, but it was a near miss. That can be frightening for everyone involved: the woman, her partner or family, and the staff.

As difficult, and in some cases tragic, as these outcomes are, they are not the events that tend to haunt providers. Instead, it's events where a nurse, midwife, doula, or lactation consultant witnesses a medical provider harming or even violating a mother or baby. They may even be forced to participate and can do nothing to stop it. Beck and Gable (2012), in their qualitative study of secondary trauma in nurses, had them describe some of the traumatic births they had seen. Here is one nurse's story.

The physician violated her. A perfect delivery turned violent. I felt like an accomplice to a crime. The doctor treated her like a piece of dirt. After the birth of the baby, he proceeded to put his hand inside her practically halfway up his arm to start pulling the placenta out . . . I felt like I was watching a rape.

Another nurse described a couple of experiences that have haunted her.

Whenever I hear a patient screaming, I will flashback to a patient who had an unmedicated (not even a local) cesarean section and to the wailing of a mother when we were coding her baby in the delivery room. I feel like I will never get these sounds /images out of my head even though they occurred more than 10 years ago.

Even when providers do not work in L&D, they may be forced to go along with policies that impede breastfeeding and lead to a series of often unnecessary interventions. Conversely, sometimes trauma happens when there is poor implementation of breastfeeding policies. Heather, a NICU nurse, wrote about her experiences on the Fed Is Best site. She described some draconian hospital policies designed to keep bottle and formula use to a minimum, even when those interventions might be appropriate. It would obviously be better if the hospital practices actively supported breastfeeding rather than simply being anti-formula.

I see babies crying from being starved and dehydrated at work frequently and we aren't even Baby-Friendly . . . Because we push breastfeeding so much, even our preterm infants in the NICU end up suffering with longer hospital stays because we refuse to feed them with the appropriate bottles due to worries about nipple confusion . . . We try hard not to supplement the babies who are crying because we know our charts are being audited and if we supplement too much, we are identified and called out . . . We will sneak pacifiers to help soothe babies who are screaming and sometimes will use sweet ease to help the ones who are inconsolable.

Although most of us disagree with the message of Fed Is Best, they chronicled some problems that providers on the frontlines have experienced, especially when they feel like numbers are keeping them from providing optimal care. They described it like this:

Nurses are frustrated over the strict feeding guidelines and their inability to help hungry babies and their exhausted mothers. (Fed Is Best, n.d.)

Most of the studies describing providers' experiences are listed under the heading of secondary traumatic stress (STS), which is when someone witnesses a traumatic event and develops symptoms of posttraumatic stress disorder (PTSD). Some will even go on to meet full criteria for PTSD. The events that cause PTSD (under the current diagnostic criteria) are actual or threatened death, actual or threatened physical injury, or actual or threatened sexual violation. Unfortunately, researchers have documented all three of these types of events occurring

during births. Seeing them can be as harmful to staff as experiencing them directly.

But this doesn't quite capture all of the experiences associated with witnessing traumatic events. An emerging construct in trauma psychology may more accurately describe providers' experiences. So far, it's been used exclusively to describe the experiences of combat veterans. It's called moral injury.

Moral injury is defined as perpetrating, failing to prevent, witnessing, or learning about acts that transgress deeply held moral beliefs and expectations. It includes three types: committing harmful acts, witnessing harmful acts, and failing to stop the harmful actions of others (acts of omission). In combat, some examples of potentially morally injurious events include using violence disproportionate to the situation, engaging in atrocities, or violating rules of engagement. Emerging evidence suggests that moral-injury-based traumas differ from danger-based traumas, which primarily involve life threat for self and others (Held et al., 2019).

Although many previous studies have found acts of commission are strongly related to PTSD symptoms, Williams and Berenbaum (2019) found that acts of omission had a stronger relationship to PTSD, depression, and suicidality when controlling for combat experience. These experiences altered the soldier's worldview, which the authors suggested was more relevant to trauma symptoms than simply breaking the rules about right and wrong. A qualitative study of combat vets found that power and rank are also key to the appraisal process (Held et al., 2019), specifically, being required to do something they feel is morally wrong by someone with higher rank. This could also include failing to confront the behavior more strongly, even when they didn't participate. Rumination was another key factor. Many veterans reported thinking about the event repeatedly, wondering what they could have done differently or thinking about ways they could "undo" the event. Some used alcohol to cope with these thoughts and their subsequent emotional reactions. They also tended to withdraw from others and isolate themselves.

L&D nurses in Beck and Gable's (2012) study had strikingly similar findings. Beck and Gable performed both a qualitative and quantitative analyses on a random sample of 464 L&D nurses who were members of the Association of Women's Health, Obstetric, and Neonatal Nursing (AWHONN). An astounding 35% of L&D nurses

reported moderate-to-severe STS, with 10% having high STS and 14% having severe STS. In the qualitative portion of the study, they identified a theme that is remarkably like those identified in the moral injury literature. They refer to authority figures, acts of omission, and feeling powerless. The theme they identified is called agonizing Over What Should Have Been Done. Here are some of the statements included in this theme.

- Felt powerless because a person in authority was causing unnecessary trauma.
- Felt frustrated and angry at physician for not listening.
- Feel like I failed my patient.
- I should have tried to stop the physician.
- My patient was counting on me to protect her.

Beck and Gable (2012) noted that it is often not the unavoidable tragedies that cause the long-term problems for staff, although they may cause deep sorrow. The events that tend to haunt staff are the ones that are *avoidable*.

Traumatic deliveries are much easier to handle and cope with when they are unavoidable. What causes the anxiety and stress to nursing staff is when they feel powerless and helpless because another person in authority is causing unnecessary trauma to the patient and infant.

Even providing breastfeeding help can cause moral injury if you are asked to participate in something you believe is harmful or wrong (such as unnecessary supplementation or excessive mother/infant separation). Lactation professionals can also experience moral injury when they are unable to provide the care that they know is essential, but cannot due to bad policies, authority figures who thwart their efforts, or lack of resources, including adequate staffing.

Moral injury can co-occur with STS, but it is a separate entity that must also be addressed. Held et al.'s study found that helping veterans build a context in their understanding of the event may play a key role in the resolution of moral injury (Held et al., 2019). In many cases, veterans talked about replaying the situations and thinking about what they could have done differently if the situation had been less chaotic. Part of making meaning

was also recognizing that they would not be going back to their old selves after this experience. Encouraging them to engage in repairing behaviors, such as volunteering, may also help.

Moral injury to perinatal providers means serious consequences for our field. We are losing many competent people who decide that they need to leave the field in order to protect their mental health. For those who stay, these experiences diminish job satisfaction, which can affect patient care. I believe that there is a groundswell of discontent as providers speak out about the difficult and sometimes horrific things they observe. Providers should not be at risk because they care about mothers and babies. Perhaps the construct of moral injury can help providers give voice to their *ennui*.

Keep safe out there. You're too important to be harmed in the line of duty.

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Disclosure

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