MATERNAL CHILD HEALTH NURSES’ CARE OF THE OPIOID ADDICTED MOTHER AND INFANT A GROUNDED THEORY STUDY

Alice Marie Nash
This research was completed as part of the degree requirements for the Nursing Department at Molloy College.

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Molloy College
School of Nursing
PhD in Nursing Program

MATERNAL CHILD HEALTH NURSES’ CARE OF THE OPIOID ADDICTED MOTHER
AND INFANT A GROUNDED THEORY STUDY

A dissertation
by
Alice Marie Nash

Submitted in partial fulfillment of the requirements
for the degree of
Doctor of Philosophy

April, 2018
THE BARBARA H. HAGAN SCHOOL OF NURSING

The dissertation of Alice Marie Nash

Entitled: MATERNAL CHILD HEALTH NURSES CARE OF THE OPIOID ADDICTED MOTHER AND INFANT A GROUNDED THEORY STUDY in partial fulfillment of the requirements for the degree

Doctor of Philosophy

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Abstract

**Problem:** Opioid addiction in pregnancy is a public health crisis that is growing daily. This increased use of opioids during pregnancy has caused a steady rise in the number of infants born addicted to opioids. Current trends in maternal child health (MCH) settings encourage mothers and babies to be cared for together. Nurses who work in MCH settings care for the opioid addicted mother and her infant(s) as a single patient dyad. Care required for the opioid-addicted mother-infant dyad (OAMID) presents challenges to maternal-child health (MCH) nurses related to the consequences of opioid addiction.

**Purpose:** The purpose of this grounded theory study was to explore and identify how care rendered to the OAMID is perceived by the MCH nurse. Educational opportunities for both the MCH nurse and the OAMID were also identified.

**Background:** Opioid dependence has become an increasing problem in the healthcare of pregnant women. The number of opioid dependent mothers has soared within the last several years in the United States (U.S.). The forms of opioid addiction are as varied as the women who use them. The results of maternal opioid use have a direct impact on the developing fetus. This can range from premature birth, growth restriction, still birth, and neonatal abstinence syndrome (NAS). This study focused on the nurses caring for the OAMID experiencing the effects of NAS.

**Theoretical Framework:** The theoretical framework underpinning the concept of care for the OAMID by the MCH nurse is based on Jean Watson’s theory of Human Caring/Caring Science. Her ten Carative Factors are a framework depicting the tenets of caring which give nursing its own voice within the healthcare milieu (Watson, 2008).
**Research Question:** The overarching research question investigated was how do MCH nurses experience caring for the OAMID.

**Methodology:** This study utilizes the grounded theory methodology of Strauss and Corbin. Data was obtained from subject interviews and field notes with ongoing analysis utilizing the constant comparative approach. Strauss and Corbin’s method for developing a grounded theory utilizes a simultaneous process of data collection and analysis. This continual examination of data lead to the discovery of common themes that are connected. The connectedness is revealed through a process of coding the data, and the resulting theory is said to be grounded within the data.

**Findings:** The basic psychosocial problem was the inability for the MCH nurses to view the opioid addicted mother and infant as one patient dyad. The MCH nurses experienced personal difficulty caring for the opioid addicted mother, due to feelings of frustration and bias, however they readily felt empathy and concern for her infant who was going through the opioid withdrawal process. The main categories composed of sub concepts that emerged from the data were a) fear for the infant’s future, b) challenging care, c) judgmental behavior d) lack of education e) conflicted care. These five categories and their related concepts led to the development of the theory of conflicted caring.

**Significance to Nursing and Health Care:** The study highlighted a need for educational opportunities for MCH nurses in regard to providing thoughtful, compassionate and non-biased care to the opioid addicted mother and her infant. The growing prevalence of opioid addiction among pregnant women has made it necessary for healthcare providers to develop strategies that will support the MCH nurse in delivering comprehensive and culturally sensitive care to this vulnerable population.
I would like to express my deepest gratitude to all those who help to bring this dissertation to completion. I would like to recognize Dr. Vitale, my Dissertation Chairperson for her unending patience and gentle prodding that along with her expertise and knowledge for qualitative research, helped me to achieve this lofty goal. Her dedication to her student’s success is unwavering; she personifies all that Dr. Jean Watson defines in her Caritas of Caring. Also deserving of my extreme gratitude are my committee members, Dr. Victoria Siegel and Dr. Donna Driscoll. Their enthusiasm for my study topic along with their guidance and support enabled me to achieve this success. I offer deep appreciation and admiration to Dr. Veronica Feeg, for her commitment and dedication to the Molloy College Ph.D. program. I not only received an amazing foundation and appreciation for nursing research under her guidance, I grew as an individual willing to look at our world through a new lens.

I offer a tremendous thank you to all of the professors and mentors who taught, coached, and supported me in the Molloy College Ph.D. program. You have all enhanced my ability to challenge my confidence and to grow both personally and professionally. Thank you to my original cohort, and all the other doctoral students who were always available to share ideas or offer advice with kindness and support.

Mom and Dad your guidance and wisdom taught me that if I believe in myself, no goal is unattainable. I gave it that “one more day.” To my best achievements of all; Patrick and Robert thank you from the bottom of heart for never letting me quit.

Finally and most importantly to my best friend and the love of my life Bob Nash. Your unending, support and devotion is the foundation that keeps me grounded, and prepared to face
the challenges life throws me. The completion of this dissertation is as much your triumph as it is mine. I am truly blessed and extremely proud to have you by my side always, thank you.
Dedication

To Bobby with Love and Devotion,

You are The Wind Beneath My Wings.
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Chapter 1: Introduction

Opioid addiction within the United States has increased over the last decade and has become a serious public health issue. Opioid addiction has had a dramatic increase among pregnant woman as well. Opioid use by antepartum women increased from 1.19% to 5.63% per 1000 births from 2000-2009 (Patrick, Schumacher, Benneyworth, Krans, McAllister, & Davis, 2012). This increased use of opioids during pregnancy has caused a steady rise in the number of infants born addicted to opioids. These infants are accustomed to receiving the opioid in utero due to maternal-fetal circulation via the placenta. After delivery, the infant transitions to extra uterine life and is no longer dependent on the mother as a life sustaining resource. The result of that separation results in a cessation of opioid delivery to the infant. This sudden discontinuance of the opioid can develop into withdrawal symptoms in the infant. The withdrawal symptoms typically manifest as severe neurologic and gastrointestinal disturbances known as neonatal abstinence syndrome (NAS). It is estimated that in the United States, from 2009-2012 the incidence of NAS increased from 3.4% to 5.8% per 1000 births, which includes approximately 22,000 infants (Patrick, Davis, Lehman, & Cooper, 2015). Symptoms of NAS can manifest as early as 2 hours post-delivery and up to 72 hours later depending on the opioid used by the mother. The onset of withdrawal is determined by how long the drug takes to be eliminated from the infant’s system. The longer the half-life of the drug the later the onset of withdrawal (Logan, Brown, & Hayes, 2013; Oei & Lui, 2007). The symptoms of withdrawal can be very intense for the infant with neurologic and gastrointestinal involvement. Neonatal opioid withdrawal involves complex pathophysiology due to the neonate having immature neurologic development, impaired neurologic processing, and complex pharmacokinetics of the placenta (Kocherlakota,
NAS can last from several days to several weeks with 30-80% of infants with NAS often requiring treatment and prolonged hospital admission (Kassim, & Greenough, 2006).

Shaw, Lederhos, Haberman, Howell, Fleming & Roll, (2016) have studied the obstetric nurse’s perception of care to the opioid dependent pregnant woman during labor, birth, and in the postpartum period. The study revealed that these nurses felt they lacked adequate education in order to properly care for this patient dyad. They also expressed a sense of distress about the infant’s safety upon discharge to the care of the mother.

Nurses working in neonatal intensive care units (NICU) historically have had limited exposure to caring for an opioid addicted mother infant dyad (OAMID). The NICU patient population typically includes prematurity, congenital issues, or infection. However, with the recent increase in this patient population the exposure is becoming more common for the NICU nursing staff (Patrick et al., 2012). Nursing may have a decreased awareness of how to interact with the OAMID. A lack of formal training or in-service education about the OAMID, may prevent the nurse from being adequately prepared to care for this dyad. The interaction between the NICU nurse and OAMID may be complicated by the nurse’s desire to take care of the infant while having difficulty engaging in care of the mother due to ethical and moral concerns (McGuire, Webb, Passmore, & Cline, 2012). Internal barriers such as personal opinions or stigma may also complicate interactions.

Background

Opioid dependence has become an increasing problem in the healthcare of pregnant women. According to a report from the U.S. Department of Health and Human Services (2014), during the year 2012-2013, the average rate of illicit drug use among pregnant women aged 15-44 was 5.4%. Although the problem was always in our society, the numbers of opioid
dependent mothers has soared within the last several years. Pregnant women who have an opioid addiction can reside in many different populations. They reside in all socioeconomic, ethnic and religious backgrounds, throughout the world. The forms of opioid addiction may include prescription opioids, heroin, methadone, or buprenorphine. Methadone and buprenorphine are the most commonly prescribed medications for the opioid addicted mother who is in a rehabilitation program. Opioid addicted mothers who are prescribed methadone or buprenorphine through a treatment program are still at risk for having their infants develop NAS (Nanda, Brant, Reiger, & Yossuck, 2015).

NAS is a gamut of symptoms that include neurological and gastrointestinal manifestations. Throughout the withdrawal period, the infant can exhibit a combination of several symptoms at the same time. The symptoms may include all or some of the following: excessive or continuous high-pitched crying, hyperactive moro reflex, tremors while disturbed or undisturbed and increased muscle tone. In addition, the infant may exhibit an inability to remain asleep after feeding. They may develop excoriation of the extremities due to excessive rubbing against the bedding. Myoclonic jerking, convulsions, diaphoresis, fever, frequent yawning, mottling of the skin, and nasal stuffiness can also be noted. They frequently have increased respiratory rates, which can be with or without retractions. They often exhibit excessive sucking, are poor feeders with frequent regurgitation, projectile vomiting, and have loose and watery stools (Finnegan, Kron, Connaughton, & Emich, 1975; Hudak & Tan, 2012).

Research conducted with opioid addicted mothers has shown that they feel judged by NICU staff and, in addition, feel a loss of control (Cleveland & Horner, 2012). Furthermore, mothers also expressed fear of watching their baby withdraw, an inability to trust the nursing staff (Clevlend & Bonugli, 2014) and a sense of bias from health care workers (Fowler, Reid,
Minnis & Day, 2014). Maternal Child Health (MCH) nurses have expressed feelings of distress relating to concerns for the infant’s safety, abuse risk, and moral distress (McGuire, Webb, Passmore, & Cline, 2012). MCH nurses have reported an overwhelming commitment to the infant as well as personal stress, frustration, and burnout (Murphy-Oikonen, Brownlee, Montelpare & Gerlach, 2010).

Researchers have attempted to understand the issues surrounding MCH nurses care of the OAMID and have suggested that there may be a need to provide education on addiction in pregnancy and its impact on the OAMID to the MCH nurse. Opportunities may also exist to better understand the interaction between the MCH nurse and the OAMID in order to enhance the care rendered to this complex patient dyad.

**Problem Statement**

Opioid addiction in pregnant women is a public health crisis with increasing numbers of infants being born addicted. The U.S. Department of Health and Human Services (2014) reports that during the year 2012-2013, the average rate of illicit drug use among pregnant women aged 15-44 was 5.4%. It is estimated that in the United States, from 2009-2012 the increase in maternal antenatal drug use resulted in a prevalence of approximately 22,000 infants born with NAS (Patrick, Davis, Lehman, & Cooper, 2015). Care of the OAMID may present challenges to MCH nurses. These challenges may include emotional distress such as anger, frustration, sorrow or issues relating to the future care and protection of these infants. The expectation of the MCH nurse is to consider the patient to be both the mother and the infant as a single dyad. The expectation may be difficult to achieve if they are ill equipped to deliver care to the OAMID. In addition, the MCH nurse may lack the education required to care for the OAMID. The literature
search revealed a gap in information about how the MCH nurses perceive the care they provide to the OAMID, and how their care may affect the OAMID.

**Research Questions**

The research question was “How do MCH nurses experience caring for the OAMID? ” This study focused on the time period from the mother’s hospital admission, delivery of the infant and the infant’s discharge to home. Several sub-questions that helped the researcher gain an understanding of this phenomenon were as follows.

- As a nurse working in the maternal/child health arena, what is it like to render care to an OAMID?
- How does the nurse perceive the maternal-infant relationship when caring for the OAMID?
- What expectations does the nurse have of the opioid-addicted mother and her interaction with her infant?
- Are there any personal challenges that may influence the nurse when caring for the OAMID?
- What can be learned from the experience of the nurse caring for the OAMID?
- Does the interaction between the nurse and the opioid addicted mother have any influence on the mother’s ability to care for her infant?
- What educational preparation is needed in order to care for the OAMID?

**Purpose of the Study**

The purpose of this grounded theory study was to explore, identify, and learn how care rendered to the OAMID is perceived through the lens of the MCH nurse. In addition, this
researcher hoped to identify potential needs for educational opportunities for both the MCH nurse and the OAMID.

**Definitions of Terms**

Addiction: addiction is a primary, chronic disease of brain reward, motivation, memory, and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathological pursuing reward and/or relief by substance use and other behaviors (American Society of Addiction Medicine, 2016).

Opioids: are a class of drugs that includes the illegal drug heroin as well as powerful pain relievers available legally by prescription, such as oxycodone, hydrocodone, codeine, morphine, fentanyl, and many others (National Institute of Drug Abuse, 2016). For the purpose of this study, methadone and buprenorphine were included.

Methadone: a synthetic addictive narcotic drug used especially in the form of its hydrochloride C_{21}H_{27}NO·HCl for the relief of pain and as a substitute narcotic in the treatment of heroin addiction-also called Amidone. Retrieved from https://www.merriam-webster.com

Buprenorphine: is a semi-synthetic opioid and a partial agonist that can act as both an agonist and antagonist. It attaches to the opioid receptors but only activates them partially, enough to suppress withdrawal and cravings, but not enough to cause extreme euphoria in opioid-tolerant patients. Retrieved from https://www.naabt.org

Opioid Agonists: drugs that cause an opioid effect such as heroin, oxycodone, hydrocodone, and methadone. Retrieved from https://www.naabt.org

Opioid Antagonist: a drug that blocks and reverses the effects of agonist drugs (Naloxone). Retrieved from https://www.naabt.org
**Maternal Child Health Nurse (MCH) Nurse:** a registered nurse whose primary role is to provide health care to a pregnant or postpartum woman and her infant, from labor through to the postpartum period.

**Neonatal Abstinence Syndrome (NAS):** neonatal abstinence syndrome is a complex combination of symptoms that is exhibited in infants who have been exposed to drugs in utero and then subsequently goes through drug withdrawal after birth. NAS is caused when a woman takes opioids during pregnancy (March of Dimes, 2016).

**Mother-Infant Dyad:** a pregnant or post-partum woman and her infant(s).

**Caring:** caring is a philosophy of moral commitment toward protecting human dignity and preserving humanity (Watson, 1999). For the purpose of this study, caring encompasses any therapeutic interaction between the MCH nurse and the OAMID.

**Conflicted Caring:** providing care to an individual or individuals, based on role designation, or patient need without genuine self engagement or presence.

**Significance of the Problem**

The OAMID presents many challenges to MCH nurses ranging from emotional reactions of anger, frustration, and sorrow, to issues relating to the future care and protection of these infants. Nurses across the continuum of care in the maternal child hospital setting, from the labor and delivery, postpartum setting and nursery, are generally prepared to take care of healthy mothers and term newborns and those admitted to a NICU requiring specialized care. Mothers that have health concerns beyond expected obstetrical issues can present challenges to staff. The OAMID presents challenges because the nurse charged with the care of this dyad may not have an adequate knowledge base about addiction and its impact on the OAMID to feel confident in
providing care. The lack of confidence and knowledge may lead to care that is perfunctory in nature and according to Watson (2008) is not authentic.

**Theoretical Framework**

The theoretical framework for the study was Jean Watson’s Theory of Human Caring. Watson indicates that caring can only take place when the nurse is fully engaged with the patient in an authentic manner. A connection must take place between the two in order for a healing relationship to exist. Caring needs to happen within an environment that provides the patient the ability to be the best that they can be for the situation they are in and to provide them with a chance to optimize their potential (Watson, 2008). The OAMID comes to the MCH nurse from a background that is atypical to the patient population they expect to care for.

**Method**

A grounded theory design was used to explore the impact of the care rendered by the MCH nurses to the OAMID. A purposive sample of MCH nurses that were currently working in a hospital setting was obtained. Data was collected using one-to-one interviews between the researcher and each participant. A total of 21 voluntary participants were interviewed sequentially and the data was analyzed simultaneously, following constant comparative methodology. Interviews continued until no new information about the subject was generated within the discussions. Approval to conduct the study was obtained from the Molloy College Institutional Review Board (IRB).

**Significance of the Study and Relevance to Nursing**

Watson (2008) posits that nurses should deliver care to all patients that is authentic, loving and thoughtful regardless of the patient’s personal circumstances. MCH nurses that are engaged with the OMAID are in a better position to interact with the mother, which may enhance
her ability to care for the infant. Data obtained from this study revealed educational opportunities for both the MCH nurses and the OAMID. The educational opportunities uncovered included: a) general education on addiction, b) education on addiction in the pregnant women, c) how to score a NAS infant to deliver therapeutic interventions and d) how to deliver non-biased care to this vulnerable patient dyad. The information obtained will help to generate inquiry for developing educational resources, creating nursing interventions and best practice protocols for the care of the OAMID. MCH nurses hold a unique position for sharing much needed insight into how to best accommodate the complicated challenges associated with the OAMID.

Chapter Summary

The results of this grounded theory study provided robust information about how the MCH nurses view the care they provide to the OAMID. It revealed some of the personal barriers that the MCH nurse encounters when tasked to provide care to the OAMID. A knowledge deficit about opioid addiction in general, as well as in the pregnant population was expressed by the MCH nurses which added to their challenges. These discoveries about the delivery of care provide insight and enhance the MCH nurse’s ability to deliver authentic loving care to the OAMID, as described by Watson (2008).
Chapter 2: Literature Review

Introduction

Chapter two presents a critical evaluation of the current knowledge available about how MCH nurses perceive the care they render to the OAMID and how the care impacts the OAMID. In order to present a thorough picture of the phenomenon this literature review explored various studies regarding the effects of maternal opioid addiction. A comprehensive analysis of several qualitative studies will be presented to illustrate what is known about this topic and to provide information about the effects of opioid addiction on the mother, the infant and the MCH nurse providing the care. The literature review will provide comparative insight from the analysis of several related qualitative studies and an evaluation of how that information is relevant to this study.

Emotional Distress

Nursing care of the OAMID can present challenges for the NICU nursing staff. These challenges can have an emotional component for the nurse. In a phenomenological study conducted in the United States, McGuire, Webb, Passmore and Cline (2012), examined the lived experience of sixteen NICU nurses caring for infants with NAS. The data obtained through semi-structured interviews revealed feelings of moral distress for the nurses caring for the infant with NAS. The data revealed several common themes including caring for the infants, coping with the families and issues related to safe infant discharge. The study revealed that the NICU nurses might not be fully equipped in necessary knowledge to care for this population. The knowledge gap included having limited training in how to interact with the addicted mother, a lack of understanding about methadone treatment protocols for these mothers and an overarching concern about the infant’s discharge home. In addition, a general lack of confidence in the
mother’s ability to care for the infant in an appropriate and safe manner added to their moral
distress. The nurses expressed concerns due to the demanding care required of the infants. The
mother might not have the coping measures to handle the infant’s needs causing concerns for

In an ethnographic study on nonpharmacological interventions for care of the infant with
NAS conducted in the United States by Nelson (2016), several themes emerged. Some of the
themes were infant care needs, worry and concern for the infant’s future, and a need for maternal
education. Most nurses in the study identified a need for providing education to the mothers
about the care of their infant, but several others described the mother’s involvement as
obstructive to nursing care of the infant. However, some of the nurses in the study recognized
the positive influence their nonjudgmental attitudes may have on the success of the mother’s
education (Nelson 2016).

Shaw et al. (2016) conducted a grounded theory study in the United States examining the
obstetric nurse’s perception of care to the drug dependent pregnant woman during labor, birth,
and in the postpartum period. The results revealed similar themes of distress by the obstetrical
nurses as was reported by the NICU nurses in studies by McGuire, Webb, Passmore and Cline
(2012) and that of Nelson (2016). These themes included: a desire for increased knowledge,
feeling challenged, expressions of concern, and a lack of knowing the truth about the extent of
the drug dependence by the mother.

These studies of NICU and an obstetrical setting highlight the need to understand the
interaction between the MCH nurse and the OAMID across the continuum from delivery through
to the infant’s discharge home.
Mother’s Perspective

Cleveland and Gill (2013) conducted a secondary analysis of data obtained through semi-structured interviews of Mexican-American women who gave birth to infants while on methadone. These women shared the experience of being a mother with an infant in the NICU treated for NAS. The original study by Cleveland and Horner (2012) consisted of semi-structured interviews from 15 Mexican-American women with infants in the NICU. Five of the women selected were part of the original fifteen because they were recovering addicts on methadone and had a different description of their NICU experience then the other ten. The interviews with the five yielded four main themes in the data: a) feeling judged by the staff, b) scoring the baby, c) share with me, d) I’m the mother here.

Cleveland and Bonugli (2014) conducted a qualitative descriptive study of mothers from a southwest community in the United States, who had an infant with NAS in the NICU. The results of the interviews yielded similar themes to previous studies by Cleveland and Horner (2012), and Cleveland and Gill (2013). Themes that emerged included: a) understanding addiction for both the mother and the nurse, b) fear of watching the infant withdraw, c) feeling judged by the nurse, d) being able to trust the nurse. The significance of these studies indicates that the relationship between the NICU nurse and the opioid dependent mother may be important for positive mother-infant outcomes. These studies looked at care delivery from the mother’s perspective in contrast to the perspective of the MCH nurse.

Fowler, Reid, Minnis, and Day (2014) conducted a qualitative interpretative descriptive study using focus groups at an inner city drug health center in Sydney, Australia. The aim of the study was to explore the experience of being a mother with a history of substance dependence trying to obtain support services and help with parenting skills. The study consisted of three
focus groups each with three to six participants for thirteen mothers total. Semi-structured interview questions were used and four themes emerged from the data including: a) feelings of guilt for their substance use, b) fear of judgment by others, c) an attempt to normalize their behavior, d) a desire for support and learning to be a mother. This study involved the interaction of substance dependent mothers with a perinatal and drug health nursing team, which included nurses as well as midwives. The drug health clinic dispenses opioid substitution medications and provides healthcare services for these mothers from initial pregnancy through postpartum and into the beginning childhood years. The services offered included a mothers’ group designed to enhance the social and learning environment for the substance dependent mothers and their children. The themes identified suggested that these mothers experience feelings of bias from healthcare workers and other mothers when they attempt to access healthcare and parenting support due to their history of addiction. The feelings can become their own barrier for accessing much needed support. The study suggests that the way the mothers are treated by the healthcare personnel affects their ability to parent and their desire to seek support from healthcare professionals.

**Gaps in Nursing Education**

Murphy-Oikonen, Brownlee, Montelpare, and Gerlach (2010), captured the experience of NICU nurses caring for infants with NAS using a computer-assisted exploratory design study. The study done in Canada had a population of fourteen NICU staff nurses with more than six years of experience working in a NICU. The results of the open-ended questions revealed two main themes: a) the nurse feels a commitment to the infant and b) a contrast between technical competencies and expectant maternal care. Three additional themes were identified through an online questionnaire. These themes included: a) a disconnect between expectations of the nurses
and of the families, b) personal stress, frustration, and burnout, c) an increased awareness of drugs in the home and work life. The findings of this study suggest that NICU nurses need better education about how to care for this complicated patient dyad.

**Nurses Attitudes, Moral and Ethical Concerns**

A cross-sectional survey study by Chu and Galang (2013) looked at the attitudes of nurses toward patients that use illicit drugs at an inner city hospital in Toronto, Canada. The purpose of the study was to describe attitudes of nurses caring for patient that use illicit drugs and to identify any issues that may contribute to the development of the attitudes. The researchers looked at what they termed therapeutic attitudes, which are comprised of role commitment, role fulfillment, role support, and demographic influences. The results of the study indicated that although the nurses had neutral or ambivalent attitudes toward the patients, they identified a need for more role support in order to best care for this patient population. The authors posit that positive attitudes help foster nurse patient relationships, which can result in equitable and empathic care for this population (Chu & Galang, 2013).

A recent study by Thompson, Mastel-Smith, Duke, Haas, Vardaman, & Yarbrough, (2014) examined the lived experience of United States Military Nurses caring for the enemy. This phenomenological study looked at ten Army, Air Force, active duty and reservists’ descriptions of what it was like to care for enemy personnel during their deployment. The data suggested the nurses experienced moral and ethical concerns related to care of the insurgents. Some expressed the need to disassociate the patient from who they were in order to be able to provide unbiased care. Others described anger at using resources needed for U.S. personnel, to help the enemy. A frequent theme was feeling a conflict between the duties of being a nurse with the duty of being a solider. Although this study population is unrelated to the study of this
researcher, a similarity between the two studies is evident when comparing the type of care rendered to a patient based on of a sense of duty as was reported by the soldiers caring for enemy personnel and the majority of the MCH nurses caring for the OAMID. The similarity between nurses caring for enemy combatants, and nurses caring for the OAMID, is suggested by the internal struggle that the nurses experience, knowing they must provide care, while experiencing negative feelings for the patient. This type of perfunctory care is in contrast to care provided with presence and authenticity as described by Watson (2008) and the kind of care expected from a nurse.

**Summary of Literature Review**

In the review of the literature, the research suggests that mothers addicted to opioids may experience a healthcare bias or feel judged by MCH nurses because of their addiction. Mothers who are addicted to opioids while pregnant may present an ethical challenge for the nurses. Nurses may feel committed to the infant and have concerns for the infant’s safety, which can cause feelings of stress, frustration, and burnout. Nurses who take care of the OAMID have identified a need for more education on providing care for this dyad. Missing in the literature is a more in-depth study from the perspective of the MCH nurses of their care delivery to the OAMID across the continuum from hospital admission, during labor and delivery, through the postpartum period, during the infant’s stay in the nursery or NICU, until discharge home. The grounded theory of conflicted caring generated by this study provides an in-depth view of the MCH nursing care of the OAMID through their viewpoint.
Chapter 3: Methodology

Introduction

A qualitative research design is utilized for an inquiry that requires a deeper understanding than what is obtainable through quantitative research. It forces the researcher to explore the data in rich detail, which is more abstract than a quantitative design. Qualitative research strives to get to the deepest meaning of an experience, phenomenon, or culture. This is achieved by seeking an understanding of a circumstance, phenomenon, event or culture from those who actually experience it. Qualitative design is fluid and can adjust to what is being learned from the data as it is collected and analyzed (Polit & Beck, 2017). This research study was conducted using the grounded theory methodology of Strauss and Corbin (1998). Grounded theory utilizes an inductive approach consisting of a systematic method to determine a theory based on a social phenomenon. The aim of grounded theory is to discover what social or cultural influences shape human behaviors. In grounded theory, the researcher generates a general explanation of a process, action, or interaction shaped by the views of a large number of participants (Creswell 2013). The researcher identifies the phenomenon to be studied then investigates patterns of interactions and behaviors among specific populations. In the process of investigation, it is essential for the sample population to truly experience the phenomenon or social process that is being examined. The results generated from the study are said to be grounded or imbedded in the data.

The idea for this research came from the personal experience of this researcher, as a staff nurse and then as a clinical nurse educator in the MCH division of a large community hospital. This researcher observed an increase in infants born to mothers addicted to opioids at the institution and decided to investigate how MCH nurses perceived the care they provided to these
mothers and their infants. Since this researcher has a history in the field being studied, being mindful to utilize bracketing techniques (Polit & Beck, 2017) to prevent any bias of the data as it was being collected and analyzed was essential.

The process of data collection in grounded theory is recursive: researchers collect data, categorize them, describe the emerging central phenomenon, and recycle the earlier steps (Polit & Beck, 2017). This method of building a search based on the data that has been collected and analyzed is theoretical sampling. The data guides where the search should go next. The collection and analysis of the data occurs simultaneously through a process of open coding using a constant comparative method. This process requires detailed record keeping of field notes and verbatim transcription of interviews. The researcher makes assumptions from the data that is generated by seeing similar patterns start to emerge. The patterns are compared with previous data collected in a continuous and ongoing manner. This method of data analysis allows theories to be formed, confirmed or discounted as new data is generated in the study. This theoretical sampling practice is the foundation in constant comparative methodology. Categories elicited from the data are constantly compared with data obtained earlier in collection process so that commonalities and variations can be determined (Polit & Beck, 2017). When themes or categories are identified, in the data analysis they are assigned to a specific code. All similar themes fall under the same codes and new themes that emerge get their own codes. Using a system of coding the data allows the researcher to compare the older data with the newer data and generate questions for addition inquiry throughout the study.

Problem Statement

Opioid addiction in pregnant women is a public health crisis with increasing numbers of infants being born addicted. The numbers of opioid addicted mothers has increased within the
last several years. The OAMID may present challenges to the MCH nurse ranging from emotional reactions of frustration and sorrow to ethical issues relating to the future care and protection of these infants. The MCH nurses are called upon to consider their patient to be both the mother and the infant as a single dyad. They may lack the education required to care for the OAMID. There is a lack of knowledge about how the MCH nurses perceive the care they render to the OAMID and how their care can affect the OAMID. In addition, there may be a lack of knowledge by the MCH nurse about how to render care to the OAMID.

**Purpose of the Study**

The purpose of this study was to use grounded theory methodology to explore, identify, and learn how hospital based MCH nurses provide care to the OAMID. This grounded theory approach assisted this researcher in gaining a rich understanding of the MCH nurses’ perception of their role as caregivers to the OAMID through their own voices and experiences. In addition, this researcher gained insight into the development of potential educational opportunities for the MCH nurses and their care of this patient dyad.

**Research Question**

The research question that this researcher wanted to find an answer to was “How do MCH nurses experience caring for the OAMID?” Several sub questions were asked as well to help the researcher gain an understanding of this phenomenon. The following were the sub questions used in the data collection process:

- As a nurse working in the maternal/child health arena, what is it like to render care to an OAMID?
- How does the nurse perceive the maternal-infant relationship when caring for the OAMID?
What expectations does the nurse have of the opioid-addicted mother and her interaction with her infant?

Are there any personal challenges that may influence the nurse when caring for the OAMID?

What can be learned from the experience of the nurse caring for the OAMID?

Does the interaction between the nurse and the opioid addicted mother have any influence on the mother’s ability to care for her infant?

What educational preparation is needed in order to care for the OAMID?

**Theoretical Framework**

The theoretical framework used for this study was Jean Watson’s Theory of Human Caring. Watson posits that care is facilitated to its optimum when it is provided with loving-kindness. Her theory of Human Caring is based on her Caritas Model, which consists of ten Carative Factors and Caritas Processes (Watson, 2008) (Appendix A). The Carative Factors are guidelines for the caregivers to engage in so they can provide what she terms as authentic loving care. The Carative Factors include: practicing loving kindness, being authentically present, cultivating one’s own spiritual practices, developing and maintaining a trusting relationship, and being supportive to both positive and negative feelings. The Carative Processes describe how one would experience or impart the concepts of carative factors into practice for self and others. In addition one needs to utilize self in all ways of knowing, engage in genuine teaching and learning, creating a healing environment, assist with basic human needs and being open and attending to the soul care of self and the one being cared for (Watson, 2008). Watson indicates that caring is a conscious action between people which requires trust, authenticity, presence, spirituality, openness, and love. Nurses are best situated on the healthcare continuum to be the
crusaders of Watson’s theory. This is because nurses are on the frontline encountering people who are in need of these qualities every day. The profession of nursing is a continual balance of the science of medicine and the art of caring. Watson’s theory was chosen for this study because the MCH-Nurse-OAMID relationship may be one that presents challenges to all of those involved within the relationship.

**Study Design**

This research study used the grounded theory methodology of Strauss and Corbin (1998). The data generated through this research study was analyzed using constant comparative methodology. Constant comparative methodology uses data coding as a method for gathering similar concepts, making connections within the data, and eventually formulating a theory from the data.

**Human Subject Considerations/Ethical Issues**

Approval from the Molloy College Institutional Review Board (IRB) was obtained (see appendix B) including announcement of the study (see appendix C) and a letter to participants to briefly explain the study (see appendix D). Participants were fully informed about the study by the researcher and written consent (see appendix E) was obtained. Brief demographic data was collected (see appendix F). Permission to audiotape the interview and to transcribe the data using an outside transcribing agency was obtained. Participants were assured that the information they provide will be kept confidential and no names will be used in the interview recordings or transcriptions of those recordings. In addition any field notes taken by the researcher were held in strict confidence with no identifying information. All biographic data was stored in a locked container with access available to the researcher only. Transcribed data was visible to members of the study team only as necessary with confidentiality guaranteed as
per IRB protocol. Each interview participant was assigned an identifying number that corresponded to her interview data. The researcher only knows actual names of the participants. When the data were coded, categories were created and personal responses were assigned under each corresponding category. The coded responses were identified as being from RN1, RN2, etc. Participants were told that they can resign from the study at any time and all data connected to them would be destroyed. The transcription company that was used guaranteed anonymity of the participants. The data were accessed only by transcriptionists who have been vetted through a strict security process, confidentiality agreements and a non-disclosure agreement which was obtained from the transcription service. All data were destroyed from the transcription files at the request of the researcher at the conclusion of the data collection phase of this study. No identifying information will be used in any final written documentation, or publication. All participants were invited to obtain results of the study from the researcher if they chose to do so.

**Informed consent**

Prior to participating in the research study, participants completed an informed consent approved by the Molloy College IRB (see appendix E). The consent was voluntary and the participants were notified that they were free to withdraw from the study at any time. When all questions about the study process were sufficiently clarified by the researcher, the participants gave their consent to participate which was indicated by the participant’s signature. Participant confidentiality was assured and it was maintained throughout the duration of the study during analysis of the data, and for any future written publication or documentation.

**Potential risks.** There were no anticipated risks to participate in this study. However, it was possible that while discussing personal feelings and ideas some participants might have experienced some discomfort. Any participant that did become uncomfortable at any time
during the interview process could have immediately withdrawn from the study, however no one did.

**Potential benefits.** The results of the data obtained in this grounded theory study revealed potential areas for the development of educational programs to enrich the interactions between the MCH nurse and the OAMID, and foster a more caring environment between them. The knowledge could potentially improve the care of many different types of vulnerable patient populations, who may be currently experiencing healthcare bias. It lays the foundation for establishing a more collaborative atmosphere among inter-professional healthcare teams to enhance resources for both the MCH Nurse and the OAMID which may lead to future improvements in patient care protocols and practice strategies.

**Sampling Strategies**

**Purposive sampling.** In order to develop an authentic theory of this study, it was essential to choose participants who were readily engaged with the study population. This is a purposive sampling strategy. This sampling strategy was used to ensure the data collection was current to the recent trends in the increasing population of opioid addicted mother and infants. This research began by obtaining voluntary participants who experienced the phenomenon and could contribute to the data (Creswell, 2013). To maintain the process of data collection for a grounded theory study, sampling, data collection, and data analysis was continual and simultaneous. Initial participants were obtained with the help of a recruitment letter that described the purpose of the study. This was instrumental in facilitating study participation. All subsequent participants were continually recruited as the concepts emerged from the data. Sampling continued until the information being sought was exhausted and no new information
was being generated. The potential participants were solicited through phone calls, emails, and world of mouth asking them to participate in the study.

**Theoretical sampling.** Theoretical sampling is a strategy that was used to formulate the developing grounded theory. Participants were theoretically selected based on emerging categories to help best form the theory. The goal was for the theory to be elaborated in all its intricacies illustrating an adequate representation of the theory (Creswell, 2013; Polit & Beck, 2017). Employing purposive and theoretical sampling strategies helped to insure more robust data collection.

**Sample size.** An anticipated sample size for this Grounded Theory study was 20-30 participants. However, the actual number cannot be determined until the data being obtained has been exhausted with no new data being generated through the interviews. This researcher found that no new data was being generated after interviewing 21 participants. Therefore, recruitment for this study stopped after 21.

**Inclusion criteria.** Participants selected for this study included MCH nurses with at least one year of current experience working in a maternal-child hospital setting with this patient dyad.

**Exclusion criteria.** Participants excluded from this study included nurses that did not currently work in a maternal-child hospital setting with this patient dyad or had less than one year of experience working as an MCH nurse. Nurses who never experienced caring for an OAMID were also excluded.

**Recruitment**

Participant recruitment began after Molloy College IRB consent was obtained. Recruitment was done through personal contact, phone calls, email, and word of mouth, as well
as through the distribution of a recruitment letter outlining the purpose of the study. MCH nurses were screened for eligibility and selected to participate if they were working in labor and delivery, postpartum, mother/baby, and NICU units. Potential participants were contacted by this researcher in person, by telephone, and by email. If a MCH nurse was interested in participating in the study, the study process was explained, informed consent obtained and one-to-one interviews were scheduled. At the conclusion of the interviews each participant was provided a $25.00 Visa gift card for their participation in the study.

**Data Collection Procedures**

**Demographic data.** A demographic inventory form (see Appendix F) was collected from each participant. The data included, age, gender, ethnicity, years of working as a MCH nurse, and highest level of education completed. Additional questions included marital status, number of children they had, and their exposure to opioid addiction including within family, friends, or personal experience. Participants were also asked to estimate the frequency of their experience caring for OAMIDs and if they had any negative feelings toward people who have an opioid addiction.

**Participant interviews.** Participant interviews were conducted in a confidential venue. Interviews were conducted either in a face-to-face format (10 participants) wherever possible and via telephone (11 participants) when necessary. Both the researcher and participants agreed that a second interview was not necessary. A researcher developed interview guide with probing questions was used for the interview process (see Appendix G). As the interviews progressed, additional questions that were generated from prior interviews were used as probes in the newer interviews to verify emerging themes and categories.
Field notes and writing memos. The researcher had the option to take field notes to help enhance understanding of the interview responses. This was used for data analysis as well as to enhance clarity of the data. Field notes were treated with the same confidentiality as the interview data. All of the field notes and individual transcribed interviews were kept in a locked file drawer.

Data Management and Data Analysis

Data transcription. All of the interviews were recorded for accuracy, uploaded to the researcher’s secured computer and sent to a transcription service where it was securely transcribed verbatim. The completed transcripts were returned via email to this researcher as a secure word document. This researcher listened to each of the recordings and verified the accuracy to the word document. The transcribed data were emailed to the participants for verification, no additional comments were offered, and no discrepancies were found. In addition, the researcher transcribed field notes during the interviews as necessary to support the data. All of the interviews were confidential and were not initiated without first obtaining a signed consent from the participant. The interview data was identifiable only by numbers RN # 1, RN # 2 etc. which was known to each individual participant and this researcher only. The data were analyzed utilizing data analysis methods as explained by Strauss and Corbin (1998). The process included open coding, axial coding and selective coding which assisted the researcher in developing a theory that was representative of the voices of the participants and grounded in the data (Strauss & Corbin1998).

NVivo computer software. Data coding was completed using the NVivo computer software program which is used in qualitative and mixed method design research for the purpose of organizing and managing qualitative data (Qualitative Research Software: QSR International,
NVivo allows the researcher to analyze unstructured data such as interviews, field notes and open ended survey responses. NVivo utilizes “nodes” to help isolate and categorize similar responses for easier data management (retrieved from https://www.qrsinternational.com, 2013). The nodes can be broken down into smaller nodes or grouped together with similar themes. In total there were 101 original nodes identified within the initial analysis of the data. Through the process of constant comparison data analysis, these 101 nodes became five categories each with four concepts that eventually became one core concept of conflicted caring.

**Constant comparison method of analysis.** Constant comparison data analysis is commonly used in grounded theory research. It is a method to help guide the research through the data search. The information provided by the participants in this study was compared in a continuous manner until repeated and specific content becomes relevant to all (Chiovitti & Piran 2003). The content was then isolated into categories or codes. The initial codes were added to the interview questions to help guide the continued inquiry. Participant responses that consistently appeared were saved in the data as pertinent to the theory development (Chiovitti & Piran 2003). The method of coding for data analysis used by Strauss and Corbin (1998) incorporates a three-step process. Open coding was used in this study. It is the initial process of data analysis; it is organized and placed into developing categories. The interrelatedness and connections among the categories were identified (Creswell, 2013). A theoretical model emerged which was then further refined and developed in the selective coding process as propositions. The propositions helped to build the story that described the interrelationships of the categories in the model (Creswell 2013).
Methods to Enhance Auditability

The ability of one researcher to follow the methods employed by another researcher from the research question through data collection, analysis and interpretation of the findings is known as auditability. Auditability is best achieved through detailed record keeping and explicitly presented results (Polit & Beck, 2017). This researcher maintained auditability by carefully recording all interviews and keeping track of additional information relevant to the inquiry via field notes and memos. Field notes are data that may contain conceptualizations about observations or interviews while memos are a more complex analysis about a concept (Strauss & Corbin, 1998). Specific criteria for selection of the participants using theoretical sampling techniques also enhanced this study’s auditability. The findings obtained at the conclusion of data analysis and interpretation were confirmed by committee member validation.

Strategies to Enhance Scientific Rigor and Trustworthiness

Scientific rigor and trustworthiness is essential in qualitative research because of its interpretive and abstract foundation. The researcher needs to incorporate methods to enhance credibility, dependability, transferability and confirmability into the study (Lincoln & Guba, 1985). Bracketing, a process of identifying and resisting any preconceived beliefs or opinions of the study topic by the researcher, was employed by this researcher to prevent bias in the data due to personal experience with the population being studied (Polit & Beck, 2017). The use of reflexive journaling helped this researcher bracket personal views and identify personal feelings, values and potential bias toward this study (Polit & Beck, 2017).

Methods To Enhance Credibility

Credibility can be enhanced having a background understanding of the social process that is being studied and performing a peripheral review of the literature prior to beginning data
collection (Strauss & Corbin, 1998). Reflexivity is another strategy used to enhance credibility in qualitative studies. This is achieved by continuous use of self-reflection about presuppositions, biases and ongoing emotions, which can be accomplished through journaling (Polit & Beck, 2017). This researcher employed the strategies of performing a literature review of the subject being studied prior to embarking on the study in order to obtain a better understanding of what is already known about the topic. In addition, journaling was done to help this researcher maintain objectivity about the data as it was being analyzed. Because this researcher was a MCH nurse for several years, bracketing was also utilized to keep the data pure and non-biased.

**Methods To Enhance Dependability**

The stability of data over time and conditions is referred to as dependability. It is indicated by the ability for the findings of a research study to be repeated if the study were replicated with the same or similar participants in the same or similar context (Polit & Beck, 2017). This was achieved in this study by keeping detailed documentation of the interviews, field notes and memos, as an audit trail for verification.

**Methods To Enhance Transferability**

Transferability is indicated by the extent that findings can be transferred to another setting or group. The researcher has a responsibility to provide enough descriptive data so that consumers can evaluate whether the data can be applied to other contexts (Polit & Beck, 2017). Detailed descriptive findings were provided in this grounded theory study of conflicted caring which has the potential to be applied to other vulnerable populations that experience disparities and biases. The educational opportunities that were discovered within this study also hold promise for other marginalized populations and the nurses that provide their care.
Methods To Enhance Confirmability

Confirmability is congruence between two or more independent people about the data’s accuracy, relevance, or meaning. It is to ensure that the findings are reflective of the information provided by the participants and that the interpretation of the information is not an invention of the researcher. It is the participants’ voice and not the bias or perspective of the researcher (Polit & Beck, 2017). This was maintained through the use of reflexive journaling and bracketing techniques (Polit & Beck, 2017). In addition, all coding that was done was verified with a qualitative research content expert in the committee chair of the researcher and through verification of the data interpretation with the participants.

Chapter Summary

The contents of this chapter explained the methodology that was used to complete the study. A description of how the data were collected, analyzed, and interpreted was succinctly outlined above. In addition, recruitment criteria and strategies, as well as IRB requirements were discussed. Finally, this chapter gives a clear description of how the ethical integrity of the study was maintained.
Chapter 4: Findings

Introduction

The purpose of this study was to explore, identify, and learn how care rendered to the OAMID is perceived through the lens of the MCH nurse. The idea for this grounded theory study came from the personal experience of this researcher, who is a clinical nurse educator in the MCH division of a large community hospital. Opioid addiction is a public health crisis that has infiltrated every aspect of society in a very short period. MCH nurses across the nation are encountering opioid addicted mother-infant dyads among their patient care assignment load in increasing numbers. MCH nurses are in a position to provide care and support to the OAMID that can be significant in helping to lay the foundation for a maternal infant connection, which may be disrupted due to the challenges brought on by an opioid addiction. However, the MCH nurse may be lacking the emotional connection, and educational tools required to render authentic care and support to this patient dyad.

Basic Psychosocial Problem

The analysis of the interview data revealed a basic psychosocial problem that was prevalent with all of the participants, which was that the opioid addicted mother and infant were two distinct entities and not one single patient dyad. The individualization of the opioid addicted mother from the opioid withdrawing infant, allowed the MCH nurses to permit themselves to feel frustration and bias toward the opioid addicted mother, and to maintain the empathy and concern they felt for the welfare of the opioid withdrawing infant intact. The recognition of the instinct to want to provide loving care to the infant and the inability to provide the same loving care led to an internal struggle for the nurses. This disconnection of the dyad was evident throughout the interviews expressed in the voices of the MCH nurses.
Categories and Concepts of the Theory of Conflicted Caring

This study identified four categories that MCH nurses expressed about caring for the OAMID. The categories identified were: a) challenging care, b) lack of education, c) fear for the infant(s) future, and d) judgmental behavior (see Table 1). The study participants identified having difficulty providing care to this patient dyad as one complete unit even though they all identified working in environments that recognized the mother and infant together. They psychologically identified the mother and the infant as two completely separate entities. The internal barriers they had formed toward the mother’s addictive behavior at times created an unrealistic need to protect the baby. An internal struggle between the expectations of their role as a nurse and their personal beliefs of how a mother should behave led to disconnected and perfunctory care of this dyad. Mothers that participated in a rehabilitation program where they were prescribed medication, such as methadone or buprenorphine to help control their addictions seemed to receive nursing care with some personal engagement by the MCH nurse. Those who continued actively using opioids without rehabilitation often experienced nursing care with less personal engagement, which was more perfunctory in nature. A common theme identified through the MCH nurses comments within the interview data was their awareness of how they should be providing care, contrasted with recognition of how they actually did provide care. The study participants all attested to providing safe, appropriate and comprehensive care to the OAMID. The care provided met their professional role as required for employment; however, they acknowledged that often care was delivered without engagement. The nurse’s lack of ability to engage with the mother due to personal opinions of what maternal behavior should be, and the affirmation of that knowledge lead to the development of a substantive theory of CONFLICTED CARING.
The chapter findings include a detailed description of each study participant, their demographic data and nursing specialty. The data analysis process will be explained in order to illustrate how the identification of the four main categories evolved and how they became the foundation for the core category of CONFLICTED CARING.

**Table 1.**

*Categories and Concepts of the Theory of Conflicted Caring*

| Category 1: Challenging care | Concept 1: OAMID care is challenging  
Concept 2: A need for support to assist the nurse with care of the OAMID  
Concept 3: Lack of collaboration with mother |
|-------------------------------|-------------------------------------------------------------------------------------|
| Category 2: Fear of the infant’s future | Concept 1: Poor support system for the OAMID after discharge  
Concept 2: Lack of trust in the mother’s ability to care for the infant  
Concept 3: Concern for the infant’s safety |
| Category 3: Judgmental behavior | Concept 1: Bias toward the opioid addicted mother  
Concept 2: Difficulty engaging with the opioid addicted mother  
Concept 3: Lack of empathy for the opioid addicted mother |
| Category 4: Lack of education | Concept 1: Understand addiction as a disease  
Concept 2: Lack of formal training on how to care for the OAMID using NAS scoring tools and pharmacologic / non-pharmacologic interventions to mitigate infant withdrawal symptoms  
Concept 3: Education for the opioid addicted mother |
| All four categories generated the core category of “CONFLICTED CARING” | |
| Category 5: Conflicted Caring | Concept 1: Experience professional disharmony  
Concept 2: Recognition of personal barriers causing judgmental behavior  
Concept 3: Division of care |

**Description of the Research Participants**

The participants in this study included 21 female MCH nurses working in healthcare facilities in New York City (3), and Long Island, New York (8), Indiana (3), New Hampshire (4), Kentucky (2), and Vancouver, Canada (1). They ranged in age from 25-60 years old. They
all had experience working with opioid addicted mothers and their infants. They identified themselves as white non-Hispanic (16), black non-Hispanic (2), Asian (1), and Hispanic (2). Their years working as a MCH nurse ranged from 3 years to greater than 20 years. Their marital status included married (16), single (3), and divorced (2). Their number of children reported included having one child (3), two children (9), three children (3), and no children (6). All maternal child health specialty areas were represented, except for pediatrics, which was excluded, NICU (2), NICU NP (1), NICU lactation consultant (1), labor and delivery (6), labor/delivery/postpartum (2), mother/baby unit (5), neonatal lactation consultant (1) and special care nursery (3). The highest level of degrees obtained included Associates degree (2), Baccalaureate degree (14), and Master’s degree (5). The five reported Master’s degrees included Education (1) Nursing (2) and Nurse Practitioner (2). Several study participants were in the process of obtaining advanced degrees including, Master’s in Nursing Education (1) Midwifery (1) and Nurse Practitioner (3). Seven participants reported having a family member expose them to opioid addiction. Three participants reported having a close friend expose them to opioid addiction. All of the participants deny ever having had an opioid addiction themselves. Several participants reported having negative feelings toward people who have an opioid addiction (7), several reported no negative feelings towards people who have an opioid addiction (13) and one was unsure. The frequency of experience caring for the OAMID was 1-3 times per month (14), 4-7 times a month (3), 8-10 times a month (1). Three participants reported having experienced care of the OAMID less frequently than monthly; they reported a frequency of once every other month (1), one to three times per year (1) and once per year (1) (see Table 2 and Table 3).
**Table 2.**

*Summary of the Demographic Data*

<table>
<thead>
<tr>
<th>Number</th>
<th>21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Range</td>
<td>25-60</td>
</tr>
<tr>
<td>Geographic Location</td>
<td>New York City, NY (3), Long Island, NY (8), Indiana (3), Vancouver, Canada (1), New Hampshire (4), Kentucky (2)</td>
</tr>
<tr>
<td>Gender</td>
<td>21 Female</td>
</tr>
<tr>
<td>Racial/ethnic group</td>
<td>White Non-Hispanic (16), Black Non-Hispanic (2), Asian (1), Hispanic (2)</td>
</tr>
<tr>
<td>Level of Education Completed</td>
<td>Associate (2), Baccalaureate (14), Master’s in Education (1), Nursing (2), Nurse Practitioner (2)</td>
</tr>
<tr>
<td>Currently pursuing a higher degree</td>
<td>Midwifery (1), Nurse Practitioner (3), Nursing Education (1)</td>
</tr>
<tr>
<td>Number of Children</td>
<td>None (6), One child (3), Two children (9), Three Children (3)</td>
</tr>
<tr>
<td>Marital Status</td>
<td>Married (16), Single (3), Divorced (2)</td>
</tr>
<tr>
<td>Years Working as an MCH nurse</td>
<td>1-3 (1), 4-10 (12), 11-15 (3), 16-20 (2), More than 20 (3)</td>
</tr>
<tr>
<td>Area of Specialty</td>
<td>Neonatal ICU (2), Neonatal ICU Nurse Practitioner (1), Neonatal NP Lactation Consultant (1), Labor and Delivery (6), Labor/Delivery/Postpartum (2), Mother/Baby (5), Lactation Consultant (1), Special Care Nursery (3)</td>
</tr>
<tr>
<td>Exposure to opioid addiction through a family member</td>
<td>Yes (7), No (14)</td>
</tr>
<tr>
<td>Exposure to opioid addiction through a close friend</td>
<td>Yes (3), No (18)</td>
</tr>
<tr>
<td>Has ever had an opioid addiction</td>
<td>No (21)</td>
</tr>
<tr>
<td>Holds negative feelings toward those with opioid addiction</td>
<td>Yes (7), No (13), Unsure (1)</td>
</tr>
<tr>
<td>Frequency of providing care to an OAMID</td>
<td>Never (0), 1-3 times a month (14), 4-7 times a month (3), 8-10 times a month (1), More than 10 times a month (0)</td>
</tr>
</tbody>
</table>

*Not a choice offered on survey - participant self-report:*
- Once every other month (1)
- Once per year (1)
- 1-3 times per year (1)
### Table 3.

Description of the Research Participants

<table>
<thead>
<tr>
<th>#</th>
<th>Pseudonym</th>
<th>Area of Specialty</th>
<th>Description</th>
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<tbody>
<tr>
<td>1</td>
<td>RN #1</td>
<td>NICU</td>
<td>RN #1 is a 35 years old white non-Hispanic female who is married with three children. She has a baccalaureate degree in nursing and is in the process of completing a master’s degree in nursing education. She has worked in a NICU in Suffolk County, New York for more than 4 years but less than 10 years. She acknowledges feelings of frustration towards a mother who denies drug use, but is actually using drugs, she has a close friend who has a history of drug addiction, brought on by opioid pain medication use. She reports caring for the OAMID at least once every two months.</td>
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<tr>
<td>2</td>
<td>RN#2</td>
<td>Lactation Consultant</td>
<td>RN #2 is a 60-year-old white non-Hispanic female who is divorced with three children. She has an associate’s degree in nursing and she has been a lactation consultant for over 20 years in Suffolk County, NY. She reports no negative feelings toward people who have an opioid addiction. She states she has two siblings that died from opioid use: one sister and one brother, and has a close friend who is currently addicted to opioids. She reports caring for the OAMID 1-3 times per month.</td>
</tr>
<tr>
<td>3</td>
<td>RN#3</td>
<td>Mother/Baby</td>
<td>RN#3 is a 34-year-old white non-Hispanic single female with no children. She has a baccalaureate degree in nursing. She has been working in the mother/baby unit for more than 4 years but less than 10 years in Nassau County, NY. She reports having a sister who was addicted to opioids but is in recovery; she acknowledges ambiguity about her feelings toward people who have an opioid addiction. She reports caring for the OAMID about once per year.</td>
</tr>
<tr>
<td>4</td>
<td>RN#4</td>
<td>Labor &amp; Delivery</td>
<td>RN#4 is a 25-year-old white non-Hispanic single female with no children. She has a baccalaureate degree in nursing. She has been working in a mother/baby unit for more than 4 years but less than 10 years in Nassau County, NY. She acknowledges negative feelings toward mothers</td>
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who use opioids during pregnancy. She reports caring for the OAMID 1-3 times per year.

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<tbody>
<tr>
<td>5</td>
<td>RN#5</td>
<td>Labor &amp; Delivery</td>
</tr>
<tr>
<td></td>
<td>RN#5 is a 57-year-old black non-Hispanic female who is divorced female with one child. She has two baccalaureate degrees, one in nursing, one in business and she is currently pursuing a graduate degree as a nurse practitioner. She has been working for over 15 years in labor &amp; delivery in Suffolk County, NY. She acknowledges she has negative feelings toward people who have opioid addiction. She reports caring for the OAMID 1-3 times per month.</td>
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</table>

| 6 | RN#6 | Labor & Delivery |
|   | RN #6 is a 33-year-old Asian female who is married with two children. She has a baccalaureate degree in nursing. She has been working in labor and delivery for more than 4 years but less than ten years in Queens, NY. She reports that she has no negative feelings for people who have opioid addictions. She reports caring for the OAMID 1-3 times per month. |

| 7 | RN#7 | Mother/Baby |
|   | RN#7 is a 37-year-old white non-Hispanic female who is married with three children. She has a baccalaureate degree in nursing and has been working in mother/baby for over 16 years in Kentucky. She acknowledges having negative feelings toward people who have opioid addictions. She reports caring for the OAMID 4-7 times per month. |

| 8 | RN#8 | Labor & Delivery |
|   | RN #8 is a 28-year-old white non-Hispanic female married with no children. She has a baccalaureate degree in nursing and has been working as a labor and delivery nurse for 6 years in Nassau County, NY. She reports that she has no negative feelings toward people who have opioid addictions and reports caring for the OAMID 1-3 times per month. |

<p>| 9 | RN#9 | Mother/Baby |
|   | RN#9 is a 42-year-old Hispanic female who is married with one child. She has a baccalaureate degree in nursing and is currently pursuing a graduate degree as a nurse practitioner. She has been working in mother/baby for 15 years in Nassau County, NY. She reports that she has no negative feelings toward people who have opioid addictions and reports caring for the OAMID 1-3 times per month. |</p>
<table>
<thead>
<tr>
<th></th>
<th>RN#</th>
<th>Department</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>RN#10</td>
<td>Labor/Delivery/Postpartum</td>
<td>RN#10 is a 29-year-old white non-Hispanic female who is married with two children. She has a baccalaureate in nursing and has been working in labor, delivery and postpartum for 6 years in Indiana. She reports having a cousin with an opioid addiction and acknowledges negative feelings toward people with opioid addictions. She reports caring for the OAMID 1-3 times per month.</td>
</tr>
<tr>
<td>11</td>
<td>RN#11</td>
<td>NICU NP &amp; Lactation Consultant</td>
<td>RN#11 is a 28-year-old white non-Hispanic single female with no children. She has a master’s degree and is a nurse practitioner. She has worked in the NICU for 6 years in NYC, NY, and she is a lactation consultant. She reports having no negative feelings toward people with opioid addictions, and reports caring for the OAMID 1-3 times a month.</td>
</tr>
<tr>
<td>12</td>
<td>RN#12</td>
<td>Labor &amp; Delivery</td>
<td>RN#12 is a 29-year-old black non-Hispanic female who is married with one child. She has a baccalaureate degree in nursing and is currently pursuing a master’s degree as a nurse practitioner. She has been a labor and delivery nurse for 7 years in Brooklyn, NY. She reports having a family member and a close friend who have opioid addictions. She reports no negative feelings toward people with opioid addictions, and reports caring for the OAMID 1-3 times a month.</td>
</tr>
<tr>
<td>13</td>
<td>RN#13</td>
<td>NICU NP</td>
<td>RN#13 is a 32-year-old white non-Hispanic female she is married with two children. She has a master’s as a nurse practitioner. She has been working in the NICU for 10 years in Nassau County, NY. She Reports that she has no negative feelings toward people with opioid addictions, and reports caring for the OAMID 1-3 times per month.</td>
</tr>
<tr>
<td>14</td>
<td>RN#14</td>
<td>Special Care Nursery</td>
<td>RN#14 is a 49-year-old white non-Hispanic female who is married and has two children. She has a baccalaureate degree in nursing and has worked in the special care nursery for over 20 years in New Hampshire. She reports that she has no negative feelings toward people with opioid addictions and reports caring for the OAMID 4-7 times per month.</td>
</tr>
<tr>
<td>15</td>
<td>RN#15</td>
<td>Labor &amp; Delivery</td>
<td>RN#15 is a 28-year-old Hispanic female who is married with no children. She has a</td>
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<tr>
<td>16</td>
<td>RN#16</td>
<td>Special Care Nursery</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>RN#17</td>
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<td></td>
</tr>
<tr>
<td>18</td>
<td>RN#18</td>
<td>Mother/Baby</td>
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</tr>
<tr>
<td>19</td>
<td>RN#19</td>
<td>NICU</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>RN#20</td>
<td>Mother/Baby</td>
<td></td>
</tr>
</tbody>
</table>

**Midwifery student**

baccalaureate degree in nursing and is currently pursuing a graduate degree in midwifery. She has been a labor and delivery nurse for 6 years in Kentucky. She reports that she has no negative feelings toward people with opioid addictions, and reports caring for the OAMID 8-10 times a month.

RN#16 is a 54-year-old white non-Hispanic female who is married with two children. She has a baccalaureate degree in nursing and has worked in a special care nursery for over 20 years in New Hampshire. She reports that she has no negative feeling toward people with opioid addictions and reports caring for the OAMID 1-3 times a month.

RN#17 is a 34-year-old white non-Hispanic female who is married with two children. She has a master’s in nursing and has worked for three years in a special care nursery in New Hampshire. She acknowledges that she has a family member who has an opioid addiction, and she states she has no negative feelings toward people with opioid addictions. She reports caring for the OAMID 4-7 times per month.

RN#18 is a 39-year-old white non-Hispanic female who is married with two children. She has an associate’s degree in nursing and has been a mother/baby nurse for 15 years in Indiana. She reports having had a niece who was addicted to opioids who died from the disease and a nephew who was also addicted but has been in recovery for three years. She acknowledges having negative feelings toward people who have an addiction to opioids and reports caring for the OAMID 1-3 times a month.

RN#19 is a 31-year-old white non-Hispanic female who is married with two children. She has a master’s degree in nursing education and has been working in the NICU for 9 years in Vancouver, Canada. She reports that she has no negative feelings toward people with opioid addictions and reports caring for the OAMID 1-3 times a month.

RN#20 is a 29-year-old white non-Hispanic female who is married with no children. She has a baccalaureate degree in nursing and has been
Category 1: Challenging Care

The participants in the study frequently used the terms challenging, demanding or difficult to describe caring for the OAMID. A palpable sense of frustration and discouragement could be felt as the participants, described their lack of ability to meet the needs of the OAMID to their own satisfaction or standards. Personal values, beliefs, and opinions sometimes impeded the nurse-OAMID interaction. Other issues that influenced their interactions and were outside of their control included organizational and legal boundaries. The scope of the interaction as described by the participants is explained by the three concepts that make up category 1 (see Figure 1), which includes:

1. OAMID care is challenging
2. A need for support to assist the nurse with care of the OAMID
3. Lack of collaboration with the opioid addicted mother
Figure 1.

Category 1: Challenging Care

Concept 1: OAMID care is challenging. The participants frequently described taking care of the OAMID in terms of being a challenging experience. Although the term challenging can have a negative connotation, in these instances it depicted the complex nature of the care and the interactions between the MCH nurse and OAMID. RN #13 is a nurse practitioner with 10 years’ experience working in a neonatal intensive care unit (NICU) caring for the OAMID. She described trying to meet the needs of the infant who is going through withdrawal and difficult to console. She expressed concern about being unsure of the types of medication the mother may have been using or what her personal circumstances are. RN #13 described the challenges she has regarding her inability to help the infant through the withdrawal process. The challenges
specific to the mother she described as being related to the mother condition in relation to her opioid addiction. RN #13 depicted the opioid addicted mother and her infant as two independent entities rather than a single dyad. She stated:

It can be challenging. It can be challenging because the baby needs a lot of care and it might be very uncomfortable and might need a lot of swinging and swaddling and that kind of thing. Sometimes it’s challenging because you don’t know exactly what medications the mom was taking…there could be other factors related to the opiates, you just don’t know. I think the baby is more challenging because obviously, if the baby is crying all the time and they are uncomfortable, then you feel bad for them, you want to help them, and you might feel like you can’t. I think it’s also challenging for the needs of the mom because the mom could be in a variety of different situations, like, the mom could be in a program or trying to be in a program, or she could just not care and that can be frustrating also.

Building a caregiving relationship between the OAMID and the MCH nurse was described as requiring cooperation and communication. RN # 6 is a labor and delivery nurse with over 4 years’ experience taking care of the OAMID. She shared the example that caring for one addicted mother who is uncooperative provides more of a burden than caring for two patients who do not have an addiction. She described a mother with an addiction as manifesting poor behavior and being uncooperative. The description depicts a need for negotiation or persuasion in order to obtain a collaborative relationship. She stated:

I’m thinking something is challenging when you have to put in more effort to accomplish it. More effort than the normal way you do. You can take care of two patients who are normal, no addiction, nothing, you know a well-behaved patient. It is much harder to
take care of one patient who has an addiction and they are not properly behaving, they are not cooperating. It is much harder than taking care of two patients. Lack of cooperation and a way to communicate with them, and a way to make that relationship special, all that's challenging. You have to really put more initiative in to take care of this patient than you do for another patient because it’s really like convincing them for every single thing it’s a little tougher than the normal.

Several of the participants expressed a need for the opioid addicted mother to be transparent about her addiction. A lack of transparency was viewed as a deterrent to forming a collaborative relationship. Providing full disclosure opens up opportunities for timely intervention such as obtaining a urine toxicology screen on the mother that can help determine what substances she used. In addition, a dialogue between the MCH nurse and the opioid addicted mother helps with identifying what types of social service support in needed. She stated that parents that do not admit to their addictions pose difficulties for her in terms of gaining her respect. She stated:

Challenging, some give full disclosure those I respect more, you know what you are getting. We have had parents in the past that deny using and that can be challenging.

Social work gets involved anytime toxicology is positive but we don’t screen everyone. If they deny use we can’t offer support. They see the baby arching, and crying, we try to explain why it happening and they deny. It’s challenging.

Some participants expressed having a sense of skepticism while interacting with opioid addicted mothers who may have already gone through the social system and have a preconceived notion of how their hospital experience should go. The MCH nurses expressed a sense of apprehension in being able to trust the mother. In addition, the behavior of the opioid addicted
mother was described as sometimes being the result of the staff’s interpretation based on experience with this patient population. The preconceived expectations of the staff could also be a reflection of the culture of the unit where they work. Personal experience with this patient population and personal values about addiction can also be a factor. Issues that involved any communication difficulties between the OAMID and the MCH nurses were attributed to the stability of the mother’s behavior, and her treatment of the nurse. RN #8 is a labor and delivery nurse with over 4 years’ experience caring for the OAMID. She shared her feelings about the difficulty she has experienced obtaining clear communication with the addicted mother and the need to obtain assistance from social work to insure that the communication is consistent. She stated:

I feel like their personalities are challenging ...difficult to deal with, like I feel like they can flip back and forth. You get to be aware if they're trying to like catch you on certain things. Like, you need to be very careful with your words sometimes. I think when you get a patient like that, you get social work involved. I feel like the patient will take any little word from those people and try to turn it around and be like, ‘well this one told me this.’ You kind of have to make sure everyone’s on the same page when you give a patient information like that. To make sure that they don’t turn around and say. ‘Oh well I was informed this way’. When they are on that, and they won’t let it go.

As a nurse working in a mother/baby unit for 15 years, RN # 9 described the challenge as being a combination of the unpredictable nature of the opioid addicted mother’s personality and the nurse’s approach to her care. RN # 12 has been a labor and delivery nurse for 7 years, and in addition to having experience caring for the OAMID, she reported having a family member and a close friend with opioid addictions. She stated that she has no negative feelings toward people
with opioid addictions. However, she described the opioid addicted mother as presenting with her own agenda, and a desire to be in control of her own care. She expressed that this type of behavior can lead to difficulties with the OAMID and the staff, which she concedes might be also be due to the culture of the individual unit. They said:

RN #9 said sometimes they are not very predictable. Sometimes, these kind of patients may be a little harsh in the way they act towards the nurses or be demanding. So I try to get along with them, and for the most part, I get along well and I never have had an issue with them, but it’s just the way you talk to them and how you approach them to get their needs met.

RN#12 said they are the ones who already come in with a rubric, like they already have an agenda. They already have it set out; their plan, and they want you to work within their scope. These patients are always considered problematic which is the culture maybe of the unit.

RN #19 was a NICU nurse with 19 years’ experience working in a NICU in Vancouver, Canada. The perspective she shared about caring for the OAMID, was in relation to one’s own personal values and beliefs about opioid addiction in general. She believes a person’s point of view on addiction and their experience with this population can affect how care is rendered. It was interesting to note that she only referred to the infant as the patient. She stated:

It's really challenging because it's like the patient and the mom are complex as it is, and depending on what your experiences are, and what your beliefs are with those who you know use substances, it can be really hard to just walk into that. My first time, I think I was like looking to blame the mom almost and looking for how do you do this to your child. My personal and ethical beliefs were really challenged.
The complex nature of the challenges could also include situations when a caring relationship was established between the OAMID and the nurse. RN # 15, a labor and delivery nurse with over 6 years’ experience, described becoming attached to an OAMID that she took care of for several months. This opioid addicted mother achieved a period of sobriety, which was hopeful for the staff, but she was unable to maintain it. This change in sobriety resulted in the nurse’s sense of disappointment. RN #17 has worked in a special care nursery for three years. She reported having a family member with an opioid addiction and that she has no negative feelings toward people with an addiction to opioids. However, she expressed a sense of frustration and some difficulty caring for opioid addicted mothers who do not seek a program for recovery. She acknowledged that addiction is a disease which requires empathy for the OAMID, and in spite of the challenges she experienced with this patient population, she also felt a sense of reward. Their statements were:

RN#15: “But with the moms you know it's hard because sometimes they're in withdrawal, they may or may not want to be there, they may or may not have support, so I think it just is varying degrees of difficulty with the moms. You can get really attached to these women. You really root for them and it can be disappointing when things don't necessarily go the way you'd like it to. I've had some women we've treated for three months, and they're sober and they're doing great, and then we set them up to go to these rehab houses, and they come back and they're addicted again, or relapsed. So it can be really disappointing, but really encouraging when they do really well, and you get to follow them and see all the progress they've made. So, it's a little bit of both.”

RN# 17: “It's difficult when they are still using street drugs and not wanting, or seeking, or any of that to try to get help. It's a little bit more frustrating and difficult but,
understanding that it's an addiction and all that, it still gives me some, you know, empathy for the situation. But overall, for the most part it's a pretty rewarding experience.

**Concept 2: Need for support to assist the nurse with care of the OAMID.**

A need for support to properly care for the OAMID, was a concept that was expressed by the participants. The participants expressed frustrations and concerns involving difficulty with their patient care assignment ratios, administrative requirements such as documentation, and issues with social support resources. RN #11 is a nurse practitioner in the NICU and a lactation consultant with 6 years’ of experience working with the OAMID. She expressed frustration in caring for the OAMID which she identified as having more unique needs than those of her other patient assignments. One of the needs she described was documentation of the NAS scoring criteria, which she indicated takes time away from her ability to care for the infant. RN #19 expressed a similar concern with an emphasis on feeling pressure to complete her care and stress related to an inability to spend more time with the OAMID. They stated:

RN # 11: “The baby is withdrawing, and now the baby is in pain because they're excoriated, and they won't go to sleep, and they're tremulous, and when making assignments you sometimes forget that those can be the most time consuming babies. I feel like it can sometimes add more stress to your day, if you have three or four babies as an assignment and you have a baby screaming, it gets really frustrating, because you can't do anything. Every second I feel like this. If I have a four or three baby assignment, with a withdrawing baby who is severely withdrawing, sometimes I will have three moms at the same time asking me questions. And I'll have a screaming baby, and you can have other people in the room that are hearing a screaming baby and thinking, ‘why aren't the
nurses taking care of them?’ Then they will tell you, ‘Oh isn't somebody going to calm the baby down?’ I feel like we get jaded by seeing it so often. You are like, ‘Ugh, again, I have to do this?’ And you have to score, and that adds more charting, and you have to do your care plan, so it's like this big ripple effect. If we could just take care of the baby like we wanted to, like nurses are supposed to, I think that this would all be alleviated.” RN #19: “Managing an NAS baby and then a premature baby in the same day, like sometimes there's a lot of time pressure and conflict because if the NAS baby and mom are high need and then you have multiple assignments that you got to do, and that's a super challenge too. So then if you only have a few minutes and you are feeling stressed because of the patient assignments, then it's even worse. I think you're limited in how much you can do and spend time with these moms.”

The challenges expressed by some of the nurses extends beyond what occurs within their health care organizations. RN #17 is a resident of New Hampshire who described her frustration at the social support provided to this patient population on the state level. This type of frustration may cause difficulty for health care workers to come to terms with due to the enormity of the problem and the difficulties involved in trying to make changes in legislation in general. She stated:

I think there's lots of difficulties. I think for us, particularly, in the state of New Hampshire, the social system is not very helpful, and so a lot of our frustrations stem from the fact that we send some babies home to homes and parents that we know are going to be unsafe, and we don't get support from the state system. You know, they say that as long as the family has a plan for who's going to take the baby when they use heroin then they can still take the baby home. It happens a lot, and so that part of it's frustrating.
RN # 3 is a mother-baby nurse with over four years’ experience taking care of the OAMID. She reports having a sister who was addicted to opioids but is currently sober. She expressed concern about the lack of social services provided to the OAMID after discharge home. She stated: “you can be sending the baby home and you feel like it’s not the safest environment, but social services says that it’s ok, but how do you know, who follows up once they leave here? It’s a big concern.”

**Concept 3: Lack of collaboration with the mother.**

Several participants expressed a challenge relating to what they viewed as a lack of collaboration between the nurse and the opioid addicted mother. This lack of collaboration was viewed by the nurses as the opioid addicted mother being uncooperative with her own care needs and the needs of her infant. Teamwork was considered an essential component toward gaining and understanding of how to best accommodate the unique health needs of the OAMID. RN #11 described her expectation of the mother’s behavior as one that is not concerned with the needs of the infant or the nurse’s advice. She referred to the mother as “mom of the year,” Her description illustrating the term is suggestive of a negative connotation, toward the behavior of the opioid addicted mother. She implied that others on the healthcare team are familiar with the use of this descriptor when describing the interaction of the opioid addicted mother and her infant. She said:

I mean I will expect them to just kind of do that “mom-of-the-year” scenario. She will just come in, and wake a sleeping baby up. I'll be like, ‘Mom, please, don't bother the baby now, don't wake up the baby because I finally got the baby to sleep.’ I feel like she will just pretend I didn't say that and just do whatever she wants to do, then take out the baby and hold the baby. Then she will keep saying, ‘oh, the baby's hungry, the baby's
hungry.' because they think that is the only way they can console the baby. It’s just that the mom-of-the-year thing is the running thought that we all have.

RN #16 has been a special care nursery nurse for over 20 years in New Hampshire, and also referred to the opioid addicted mother as “mother of the year”, with the same negative connotation as RN # 11. However, she acknowledged the difficulty these mothers experience due to their opioid addiction and the expectation set for them within the organization where she works. She described a form of contractual collaboration between the MCH nurse and the opioid addicted mother. The collaboration in reality is an expectation for the opioid addicted mother to participate in. She stated:

I feel like you get the moms who once their babies are born try to be mother of the year, you know that type who, over exaggerate talking to their baby and tell you stuff that they think you want to hear. Someone who definitely over exaggerates and gives a narrative of everything she's doing. Almost like she wants acknowledgement. Which I'm sure these women don't get any feedback or acknowledgement because most of these substance using moms come from horrible backgrounds. But they're prepared, they know what to expect, they know how they need to care for their baby to ease that baby's symptoms especially in our environment here where we have the moms take care of their babies. We expect them to be here 24-7, and they should be doing all the baby's care.

RN#18 has been a mother/baby nurse for fifteen years. She openly admitted to having negative feelings toward people who have an addiction to opioids. She has a family member who died due to an addiction, and another who is in recovery from an opioid addition. In spite of this she acknowledges a need for collaboration between the mother who has an opioid addiction and the nurse. She describes the need to include the mother in the process of scoring
the infant during withdrawal, and to take advantage of the opportunity to teach her the process of how to score so she can understand why it is being done. She said:

I'm watching the baby because she's breathing too fast or whatever and I start talking to the mom and say this is what I'm looking at. This is why I'm looking at it. And, you know, it's ... if I see that she's receptive, well then, I'll take it to the next step and collect, you know, the NAS score and start going over all of those different categories and explain to her what may be coming down the pike. I can't say that I would do that for everyone. It depends on where they are and if they seem receptive and able. You know, in a position where they're able to learn.

RN #18 expressed a sense of frustration if she perceived that the opioid addicted mother was not willing to follow any of the instruction the MCH nurse gives her regarding how to care for her infant in a safe manner. She perceives the opioid addicted mother as not showing any respect if she does not follow the instructions she was provided with. She explains the level of engagement the opioid addicted mother is capable of is dependent on sobriety. The description provided suggests the nurses hold the authority over the opioid addicted mother rather than a mutual collaboration between the two. She stated:

I feel like when I try to educate, they listen to me, they have some respect. And then the opposite, you know? I walk in a room that's just kind of a way of life, addiction is a way of life. You know? People being arrested and things like that, that's just kind of normal. That's their norm. They don't really care what happens, they don't care about anything. That can get pretty frustrating because, you know, I can say, ‘Oh, well you know your baby is on this formula, or you need to make sure your baby's sitting up, to prevent reflux because that's going to further increase your baby's NAS score.’ And you know… I'll
walk in and they got the bottle propped up. On this baby that's five days old and they've got the baby laying down on the bed and somebody's playing on the phone, or whatever. They're not as attentive sometimes. But it really does depend on the individual. I don't think it's a one size fits all. Not every addict acts the same way. I think it depends on where they are in their addiction. If they're working on sobriety, if that matters to them, if they're in a program or if they are still in the midst of their addiction and they're going to withdraw if they don't get something.

The MCH nurses viewed trust as important towards a creating a collaborative relationship with the opioid addicted mother. Several participants described having minimal to no trust in the opioid addicted mother, which they felt affected how they rendered care. The nurses viewed having a trusting relationship with the opioid addicted mother as helping to enhance the nurse’s ability to give care and helping to enhance the mother’s ability to accept care. RN#17 described the unease both the mother and the nurse may feel about each other prior to gaining each other’s trust. She stated:

I think that they need to trust that we're not going to walk out and write a report on what they said or what they did, and I also think that we need to trust that they're not going to close the curtain and shoot up in the room. So I think it's a two way street, and I think as much honesty as you can portray from the beginning, you know, I always like to make sure that these families know that we are required to report this to the state, and to children’s services, and that they will be interviewed, and investigated and all that and that the behavior that they exhibit while they're here can be kept in their record and be part of that. I like to be forthcoming with that.
RN#6 explained that trust between the opioid addicted mother and the MCH nurse is beneficial towards successfully providing education and delivering care. She stated:

Patients who are addicted, are not going to trust you, so you should have a trusting relationship. In the beginning, you should try to have that trusting relationship so you can actually educate them much better. I have experienced patients that if they are not comfortable with the nurse, they will give you trouble all the time and they won't listen to you, they always complain, and all that. But if they really like you, they will call you by your name, whatever you tell them, they will really listen. So I think that you have to have that trusting relationship from the beginning. Once you meet the patient, if you can try to get that relationship, it's really going to help you for education, the care and everything.

RN# 8 described how a trusting relationship can yield positive outcomes for the OAMID and provide support and encouragement to them in spite of their circumstances. Her description of a positive experience that an OAMID she previously cared for had a trusting relationship that was formed between the two of them. It came back to her as a lesson in encouragement. She stated:

I think I've learned a lot taking care of them. (OAMID) I think trust with patients is something we take for granted because it is not like you get a patient like this every day, so you need to build that relationship with that patient that may have such a difficult personality due to the addiction or whatever has happened in their life. Really it can impact their whole care and their whole stay with you and their whole experience. You know, you get patients that come back and say: ‘Oh, I remember my nurse . She did this, this, and this.’ And I'm like, ‘I don't remember your name.’ You know, but they
remember everything that you did, so I just think that the trust that you develop with your patients is so important. With these patients, it is just so hard sometimes. But I think you just can't give up, and I think that they look for that too, because maybe they're used to people giving up on them.

RN#19 felt that without a trusting relationship between the OAMID and the nurse setting mutual goals for success, care is difficult. She stated:

It makes a difference when you're trying to talk to a mom and make a plan for the infant and she's saying one thing but doing another. Then, right away the trust is broken and I think that if a mom is forthright with it right away, whether she's intending to care for the baby or not, it's just easier. If honesty is there, you can work with somebody when they're being honest. If they're denying the drug use, it's obvious when there's a baby withdrawing, it's very difficult to hide. I think that sets everybody up for failure because if you can't really talk to mom about the root cause of everything, and even talk to the mom about not just the drug use but what caused the drug use and trying to get to a place where the mom can be vulnerable then I don't know why, everyone's closed to talking and closed to working and moving forward, I don't know how we can move forward together and be successful and meaningful then creating goals and setting goals if, if trust doesn't exist there.

**Category 2: Fear For the Infant’s Future**

The participants in the interviews were very concerned about the vulnerability of the infant and expressed concern for the infant's welfare after discharge from the hospital environment. This was very interesting to this researcher, because the infant was
formally described as being separate from the mother, and not part of the dyad. However, the infant was viewed as being part of the OAMID, when addressing the behavior of the opioid addicted mother and her effect on the infant. In contrast, there appeared to be little to no concern for the mother’s future from the nurses. The scope of the concern as described by the participants is explained by the three concepts that make up Category 2 (see Figure 2) which include:

1. Poor support system for the OAMID after discharge
2. Lack of trust in the mother’s ability to care for the infant
3. Concern for the infant’s safety

**Figure 2.**

*Category 2: Fear for the infant’s future*
Concept 1: Poor support system for the OAMID after discharge.

The participants expressed their personal concern for the lack of an adequate support system for the OAMID after discharge. This included concern for the mother’s ability to sustain her sobriety, her ability to care for herself and provide for a safe living environment for the infant. The lack of a support system included having someone available to care for them and give them the confidence they need to care for themselves and their infants as well as having access to appropriate social service support to meet their basic living needs. RN #8 stated:

Some of them are so naïve. They've lived a completely different life from me, so I can't judge them, they lived a life and hey didn't have support in their life, and they didn't have anyone take care of them, so I think that they don't think that they can take care of their baby. Or they don't know how to take care of the baby, because they've never been cared for. I mean, I want to have faith in like the system and stuff like that, but I think with how many people that are on the streets, that are homeless, and have kids, and the shelters are too full, so I think it's hard to believe in that system sometimes. So, I think it's hard, I think we're always like, what's gonna happen? I mean, you never know. You never find out, and that something's gonna happen with like the parents and the baby. Is the dad gonna take the baby away from the mom? Then maybe she was in rehab, and now she's gonna spiral back down, and go back to her addiction and stuff like that. I mean these patients sometimes aren't mentally ready or prepared, or ever ready--to take care of another person, because they can't take care of themselves.

RN #18 describes a situation that occurred to an OAMID after discharge, in spite of the involvement of the grandmother and social services. The mother had both drug and mental health histories and the staff worked within the identified support system to
insure a safe discharge for the OAMID but there was an unfortunate outcome, that caused the staff to feel a loss of control for the situation. She stated:

Well, I mean we had a situation several years ago. It's probably been six our eight years ago now. We had a mom with a known drug history and a known mental health history who was having a baby. The paternal grandmother was very concerned that the baby would be abused and wanted CPS (child protective service) involvement. She contacted CPS herself and didn't really get anywhere. She expressed her concern to the nursing staff we expressed our concern to the physician. We were watching that baby for a couple extra days to watch her for withdrawal and didn't get any. Nothing that the doctor wanted to see as a withdrawal symptom, you know they are irritable and fussy, and things like that. It could have been from drug withdrawal, it could have been, you know, just fussy baby. But, more than likely it was drugs. That baby went home and ultimately died at the hand of his mother. At eighteen days of life. So that was a big deal. What was worse is that grandmother worked with us and she knew what was going to happen. She, was so upset and mad at the doctors. She was probably mad at some of us too, for not pushing harder and trying harder to make sure that the baby was safe. I think there are a lot of situations where we feel out of control. Like, you know we involve social services, they are crossing their T’s, and dotting their I’s but it really doesn't help. You know, it doesn't fix the situation we send baby's home with people and we think, "We might see them on the news.

RN # 17 shared a similar concern about how the MCH nurses feel a sense of concern for the safety of the infant after discharge if social service resources are not available to support the opioid addicted mother. She stated:
I said, so definitely for those babies that are particularly difficult for us to deal with, as nurses, I think we have a lot of concern for those family members, especially for them, those who don't have other people to help them, so it's just mom and dad no support system, because, you know, we, I always try to tell families, you know, put the baby down and walk out of the house if they're crying, they won't be harmed from crying for a period of time, you know, but they would be harmed if you didn't do that, and so it's hard for me to feel good about saying that if they don't have someone that they could call or if they felt like they couldn't call. So that part of it is definitely a little nerve racking.

**Concept 2: Lack of trust in the mother’s ability to care for the infant.**

A concept identified within the scope of the interviews, was the nurses had a lack of confidence or trust in the opioid addicted mother’s ability to care for the infant after they were discharged from the safety of the hospital environment. It was evident that the nurses felt their care of the infant was superior to the care that the mother could provide her own infant. This lack of trust contributed to the nurse’s fear of discharge for the infant, by augmenting their lack of control for the unknown. RN # 1 and RN # 6 stated:

RN # 1: Those that deny send up a red flag so we get concerned about the baby and sometimes it is like we can’t sleep at night thinking about that. We are a close knit group mothers and grandmothers we enjoy being with the babies we have a lot of good outcomes but things like this can keep us up at night because we get troubled by it. We can worry about the baby’s future, the mother’s ability to care for the baby.

RN # 6: When the baby is born, of course, the mother is really like the same, like other mothers, that's how I see it. They're really cuddly with their baby, they really want to breastfeed the baby. I don't see any differences like with the other mother, but after they
get the discharge how are they going to be? I always think it in my mind- our minds, so of course, we will refer them to the social worker because we think that if the mother has the addiction, if she turns back to the drugs, if she has a relapse then it is going to really affect the mother-baby bonding. They can have a care deficit for the baby. That's always in our minds.

RN #4 is a labor and delivery nurse with over 6 years of experience working with the OAMID. She reports having negative feelings toward mothers who use opioids during pregnancy. She expressed concern that the opioid addicted mother may be neglectful in proper care of her infant. She stated:

If a mother is, or soon to be mother, is using drugs while she's pregnant, how is she going to care for this child outside of her body? We think a lot as far as neglect and then social work gets involved. CPS can become involved when we think of the wellbeing of this infant. Sometimes there is a light at the end of the tunnel, if you know the mother gets help. Once the baby's born, basically all the infant's vital needs as far as nutrition, eating, hygiene, they may have a soiled diaper for X amount of hours. They may not eat for X amount of hours that’s neglect, or hygiene for the baby, infection, whatever is going to stem from their safety. At the same time, you don’t know if the father of the baby or if there are friends or any other family that's involved with drug use, and that just may influence the, the negative behavior that's going on.

RN #20 has seven years ‘experience working as a mother-baby nurse in Indiana. She reported having several cousins who have opioid addictions, and acknowledged that she has negative feelings toward people who have addiction to opioids. She explained her feelings as, “it is very hard to have sympathy for the mothers who are not trying to better themselves; care less
about their infants going through withdrawal. Her point of view about discharging the infant includes a brief stay in the foster system, while the opioid addicted mother gets the help she needs, instead of a direct discharge into the mothers care. She stated:

I think the toughest thing for me is when we send the kiddos home with the parents or with the mom or whomever. Without any justification as to why it's okay for them to go home, rather than just, putting them in, as state, you know, into foster care, just for a while, until mom proves herself that she is going to get better. Because then what's going to end up happening to the kiddo whenever it gets to go home finally, and mom is still doing everything that she was doing.

RN # 19 expressed her opinion that if the MCH nurse does not partner with the opioid addicted mother to empower her to feel that she can successfully care for her infant, the mother will not be able to be successful. She stated:

I think you have the power, and I don't like to think of it as a hierarchy in how the relationship works, but when these moms are vulnerable, and they're walking into the hospital, and feeling nothing but judgment or feeling like the nurse is the power holder or like the nurse thinks that she knows best, that is so terrible. I don't think there can be a successful relationships. How can you empower these moms to care for their infants if people don't actually think they're able to do so?

Concept 3: Concern for the infant’s safety.

Several participants expressed a sense of fear for what will happen to the infant after discharge from their care in the hospital. There was a sense of responsibility felt due to the discharge which led to some nurses expressing personal distress, which they identified as causing them to lose sleep or become burnt out. Knowledge that the infant was discharged to a safe
environment and did well because of the care they rendered, was seen as important to the nurses, and provided them a sense of satisfaction. RN#2 was a lactation consultant with over twenty years of experience working with the OAMID. She reported having two siblings who died from an opioid addiction and she currently has a close friend who has an opioid addiction. She reported that she has no negative feelings for people who have an addiction to opioids. She stated:

Unfortunately some of them can't really beat the addiction so it's really hard. And one of our concerns is when they go home with the baby that, maybe they'll fall asleep if they're taking the opioids, and, are they going to really care for their baby. So for us as a healthcare professional we're concerned about the safety of the baby and the mother.

RN#11 describes her frustration in sending the infant home to another family member while the opioid addicted mother is living in the residence as well. She does not get a sense of security for the infant, even though social services has been involved, because the opioid addicted mother is has access to the infant. She points out that she is not passing judgement on whether this mother should have an infant or not, but that the environment is not optimal for the infant’s safety. In addition, she describes feeling a sense of responsibility for the discharge and anything that might happen to the baby afterward. The uncertainty of the situation is disconcerting and stressful to her. She stated:

I’m discharging the baby to this grandmother, while the mom's there, and the mom lives at the house. And the mom is going to be with the baby all the time even though CPS says, ‘Mom's not allowed alone with the baby.’ So I feel like it makes me very frustrated to discharge the baby. Because I'm discharging the baby, quote-unquote
obviously not to the mom, legally, but by all purposes I just feel like it's what's most upsetting, when there's been illicit drug use while you're pregnant, you choose not to seek help and recover, and then I'm discharging the baby still in your life. Not that she doesn't deserve a baby, but I don't think it's safe, and I don't think it is right, and then I feel like I'm responsible because my name is all over the discharge. So I think in that respect, it's hardest when the baby is being discharged to a relative. Yeah, like no follow-up? Because we don't actually know what happens to these babies and moms and stuff. Because we really don't know ... how any of our babies do, unless they come to visit. If you could see like ... good things come out of it, I feel like that would make you less ... burnt out as a nurse. If we knew what really happened, like, six months or a year later I think it adds to, like, you feel like everything you may have done and all the hard blood, sweat, and tears you put into it maybe didn't make a difference. It maybe went- not unnotice, you just have to be grateful in your heart, I think. But I feel like if you knew what happened you could be like, "Oh, thank god I spent so much time helping her eat and grow, because now she's thriving so well.

RN #10 expressed similar concerns about the OAMID living environment. She stated

“If I have patients that are on any kind of drugs, I think about okay, well, what's it going to be like in five years or two years or six months being little kids living in these kind of environments? So I think I'm affected a lot by that.”

RN#14 was a special care nursery nurse with over twenty years of experience working with the OAMID in New Hampshire, and she reported having no negative feelings for people who are addicted to opioids. She described that the MCH nurses do have concerns about the infant’s
safety, but it is out of their control. Her description is one suggestive of being resigned to a situation that is difficult to change and seems inevitable to her. She stated:

I mean we talk about, a little bit of comments, I think that's everywhere, you just have to kind of go like whatever, we can't fix them. New Hampshire is not very proactive over removing babies from custody and there have been ones that we've been like yup, we're gonna read about that one in the paper. And sure enough we do. There are some we fear, that we feel should not go home and we will say that very strongly to the CPS worker and they're like well they're going home with the parent. All right, see you in the paper! I've been doing it 27 years so I'm pretty good at compartmentalizing. I think it’s hard on the younger nurses, I’ve heard these CPS workers say to the parent, what's your safety plan when you use heroin, who's gonna watch the baby?

**Category 3: Judgmental Behavior**

The study participants frequently recognized the use of judgmental behaviors toward the OAMID during their nursing care (see Figure 3). These behaviors were identified as stigma or bias toward the OAMID and were identified through self-disclosure, witnessing the behavior of a colleague or as expressed by the opioid addicted mother. Some of the participants self-disclosed having negative feelings for people who have opioid addictions but recognized that translating that negative vibe to the OAMID was not appropriate for providing care. Several participants described some colleagues who demonstrated judgmental behaviors by referring to the mother as being to blame for the infant’s withdrawal, or by refusing to care for the OAMID altogether. It was also acknowledged by several participants that the mothers expressed feelings of being marginalized by a lack of engagement by the nurses. The three concepts that make up category 3 include:
1. Bias toward the opioid addicted mother
2. Difficulty engaging with the opioid addicted mother
3. Lack of empathy for the opioid addicted mother

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**Figure 3.**

*Category 3: Judgmental behavior*

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**Concept one: Bias toward the opioid addicted mother.**

Several of the participants described experiencing bias toward the opioid addicted mother either themselves or witnessing it by a colleague. Recognizing bias or judgmental behavior is difficult because it involves looking at our own selves and seeing a flaw that we may have difficulty accepting. Individuals may have a natural tendency to look at the behavior of others, formulate opinions or make judgement calls. Even with acknowledgement of the
judgmental behavior they may still find it difficult to not do. RN # 11 described how her fear of the opioid addicted mother taking her infant from the institution caused her to make a judgment even though she knew it may not be valid. She stated:

I get along with everybody usually, and I'm just very patient with the moms. I understand that there's a reason for everything, so I do try my best to never ever judge. Every once in a while it can be extremely difficult. But for the most part, um, I do interact with them a lot, and I keep an extra eye on them in the sense that sometimes, especially when they're not gonna get custody, I'm afraid they may just take the baby. There has been an issue in the past where it seemed like that may happen, so I keep that in the back of my head. So then, in that case, I guess there is maybe a little bit of judgment.

RN#18 described how some nurses have preconceived notions of what the opioid addicted mother looks like, instead of waiting to meet her as an individual. She equated the care required for the OAMID as being the reason for a colleague to transfer to a medical surgical floor to work because she was becoming “jaded and biased” by the experience. She stated:

I think prior to even meeting the mom, I think that a lot of nurses will kind of have that preconceived notion that they're not going to be attentive. They are going to smell, they're going to be dirty, things like that. That’s not always the case you know? You can have a drug addict that's married to an attorney, we've had that too. I think, some people are more aware of it than others. I recently worked with a nurse who recently just quit doing this to go do surgery because she thinks the patients will be asleep there because she acknowledged she was getting a little bit jaded and was feeling biased. And
she's like, “I shouldn't be doing this anymore. I'm feeling like this.” And it kind of stemmed from taking care of an opiate-addicted mom.

RN #9 felt that nurses can help the OAMID if they learn to recognize their judgments and treat addiction solely for the illness that it is. She stated:

I think we, as nurses, think we have that ability to change people, like I think the way we approach them and not being judgmental, maybe not drastically, but we can plant that seed in that person because nobody wants to be an addict, and I really, really feel sorry for these people, you know. I treat addiction as a sickness.

RN#14 related a story of an opioid addicted mother telling her that she can sense when she is being judged by the nurses. In the following description, one can almost feel a sense of poignancy as the mother explained how bias that is in one’s heart is difficult to disguise and more difficult to change. She stated:

I've had some say they feel like they're judged by the nurses. Some will tell me because I talk to them for a long time and they're pretty honest with me. Some will say it's not anything they say, sometimes I'm just like well tell me, how do I teach them? How do you teach somebody? And I thought she was going to give me all this wisdom and she's like you can't teach it, it's in their heart so it comes out. She said they could say the right thing, they could read a transcript of what they said and it would be exactly the right thing, but we can tell. She said in her own words users can tell who's judging them and who's not.

RN#10 explained that as a mother herself she found it hard to not be critical of the opioid addicted mother who she felt showed no regard for the infant who was undergoing withdrawal. She stated:
I know for me personally as a nurse because I happen to be a mother of two small children. It's a little bit more critical just for the fact that those mothers tend to not show a lot of sympathy towards their infant in regards to the effects of the drugs on the babies and the withdrawal process.

RN#2 felt that the MCH nurses get angry with the opioid addicted mother and form judgements toward their behavior because the infant withdrawal process that they witness. She explained how judgmental behavior by the MCH nurse does not go unnoticed by the opioid addicted mother. She stated:

But what happened to some of the nurses, you know, they can't deal with it because we have these babies that are really irritable, crying, they have diarrhea they get rashes from the diarrhea, and the nurses become like a little angry at the mother. But we, you know, as healthcare professionals we really are not allowed to judge. They open up to me because I think they're not stupid people. They know people that care about them and people that are not judging them. I'm one of those people that does not judge them.

RN # 21 explained that MCH nurses can treat the OAMID with bias and stigma based not only on their addiction but on what their personal status is such as being what she termed a “stable married couple” or not, which is not the case with other mothers. She stated:

There's definitely a stigma for these moms and babies and I think the stigma is in that these moms, once they're discharged, have little to no care for their babies. You know that is the case with some women, but I don't think by far its the general consensus. But, I think there is a stigma, that they're not there to support their baby through that withdrawal process, you know, doing skin to skin, and holding, and soothing, things that can help them with those withdrawal symptoms. I've seen that with the nurses on my floor that
there's a misconception of these women and how they will be as mothers. I think that it's almost that they aren't as empathetic, or as compassionate. The nurses really struggle with this population, if it's not a healthy woman and husband married, stable population, if they have anything outside of that, it definitely changes the way that they care and treat their patients.

RN # 4 explained how she viewed some of the opioid addicted mothers having no concern for the infant they are carrying or that they portray a very concerned parent in spite of being directly responsible for harming her own infant. Her prejudice toward this patient dyad is evident to the researcher but unclear to her. She stated:

I mean, there's been patients who, you know, are users and sometimes if it's an unplanned pregnancy they don't really think there's another person that's being affected. I've seen patients like that put the kid up for adoption. Then there's others who are so overprotective of their baby even though they're harming them themselves. It's very difficult. You see this patient who is very dependent and very obsessed with the fact of, you know being addicted to all these drugs, then from our side, it's hard to see that, and while they're pregnant. So also it's difficult to kind of not judge, because you're trying to help these people to withdraw. But then also they're pretty much harming their infant. I think there's a barrier as far as developing a good rapport with this patient. I feel, like pretty much off the bat, getting report on this patient before even introducing myself to them, there's already this judgment. Not from a nursing standpoint, but for ourselves, I think before even knowing the patient and who she is we already get this preconceived judgment of her and it's going to be off the bat most likely negative.
RN# 5 was a labor and delivery nurse with over fifteen years of experience taking care of the OAMID. She acknowledged having negative feelings toward people who have an opioid addiction. In the following excerpt from her interview, she described the opioid addicted mother as one who is solely concerned about herself and not her infant, and how it is difficult for the nurse to feel empathy for her. She equated the issue to the social circumstances the mother may have been in at one time during her life which has led to opioid addiction. She described a difference between the opioid addicted mother who may have been abused as a child with one that used opioids in high school. The nurse made a comparison of the two. She allowed for empathy for the abused mother but had clear contempt for the mother who may have picked up the opioid addiction as a recreational trial in high school. Her description was almost of disgust but, she did admit to having a biased viewpoint. She stated:

I feel like the most challenging part is that they are so narcissistic, where they only are concerned about themselves, that even if you wanted any empathy for them, it's very difficult to bring out. ... You know you hear a story and you just feel bad for some of them, it's hard to really judge because you don't know their social dynamics. Some of these people have been molested from the time that they were children. So, if that's documented and you see that, I mean, you have your whole mindset changed towards these patients. I know it's not fair, it's like you're stereotyping. However, you do it because then you can see why maybe this person is in this predicament. You know, they had no one to reach out to for guidance, and honestly, they just came from a pit hole. You have some people who were in foster care system and the rules weren't as stringent as they are now. It was a day in their life for them to be abused, and they have no self-worth. If you don't have any self-worth, you are not going to care about yourself, you're
not gonna care about your baby and anybody else that's surrounding you. I don't really care what sort of intervention that we try to give to you because you have to love yourself and most of these people, they do not love themselves. They don't even care about themselves. They don't care, you know? You have social dynamics where you just had someone who when they were in high school they just picked up drugs. That's different. The whole the whole thing with the heroin addiction ... It doesn't matter whether it's recreational or social. They do not have self-worth. They are liars. Okay, are manipulators and they play on every sympathy button and they are very aggressive and they get very mean and they try to, um ... Pass over the blame on you like you are the mean one. You're being mean to them. It's like you- It's your fault, like the blame game, you know…it's word for it is transference.

RN#1 described how the simple description of an opioid addicted mother as “a heroin user” can change the way the nurse perceives that mother before even meeting her. This type of hand off from one nurse to another can lead to a biased view of the mother. She justified the bias by it being “human nature” to feel that way. She stated:

In report sometimes you hear ‘mom is a heroin user,’ you can tell the nurses demeanor changes, they get upset about that, its human nature the nurse wants to protect the baby. The baby is innocent. It’s difficult to see any differently until they get to know the mother. There is a little prejudice before they come in and meet the mother, it’s almost human nature like ‘how can you do that to your baby?’ It’s challenging to put biases aside.
Concept 2: Difficulty engaging with the opioid addicted mother.

Several of the participants described knowing that they themselves or their colleagues did not fully engage with the OAMID. They were available to provide the necessary care, but it was more perfunctory and what they were required to do as a professional. But it lacked presence or genuine concern. RN #11 described an encounter between an opioid addicted mother and the MCH nurse providing her care as one that was lacking the interactions that she saw other mothers receiving. The sense of her description of the opioid addicted mother being ignored and insignificant is almost palpable. She stated:

The mother had mentioned that she felt like she wasn't getting ... I'm trying to think of how she explained it, it was more like, the nurse wasn't as ... I guess wasn't visiting the bedside as often as she had seen that same nurse with other parents and interacting with other people, it wasn't the same interaction and she could feel that vibe because again, it's a big room with fifteen or sixteen babies. And you know, we'll sit maybe in the middle or something, so she could sense, and she felt like, she was being judged. But it was never a ... no one was ever rude, no one was unfriendly, no one didn't introduce themselves as the baby's nurse and answer questions, it was more like just a vibe, that she felt like, nurses were spending more time with other babies and parents while she was there.

RN #1 described how opioid addicted mothers are given basic care until the nurses can determine if they are going to be transparent about their opioid use. She indicated that those that do admit to opioid use are then treated in a nurturing manner, but those that deny usage, only receive the care that is necessary, as if they are insignificant. She stated:

When that baby is admitted the nurses are not overly warm and fuzzy to them. When the parent has been there awhile and they learn the mother’s history they turn toward
understanding and nurturing—those that don’t fess up and deny all are not given any special treatment. They still do their job but the tone is cut and dry I mean, what do we have to talk about with them?

RN #17 described how taking time out to have a conversation with the opioid addicted mother instead of just coming in to do a quick assessment, allows for more in-depth caring and provides the mother the comfort level to seek help and ask questions. She noticed a difference in the way some nurses take a lot their time with the OAMID. She stated:

I think that the nurses who kind of just come in, do their assessments, hand the baby to the mother, give her the bottle, or with nursing or whatever, and just leaves, then comes back in a little bit to see how things are going, and don't really make an effort to sit down and chit-chat, make small talk. It's a big difference. I sometimes think that sitting there for the first five minute of them feeding their child, you really gain a lot of insight into the situation, and, the parents are more willing to chit-chat with you than others-But I think just that action of sitting down in the room is really a big thing for us. It just tells the family that we're not above them, we're kind of willing to be at the same level and, I think that definitely makes a big difference, whereas, you know, nurses that kind of come in, come out, do their thing and that's it, I think the parents will not feel a connection with those nurses, or feel like they can say things that they're feeling or, around those nurses who are kind of quick to be in and out.

RN #13 explained how some nurses in the NICU get very close to their patients who have spent a lot of time in the unit, but are not an OAMID. She described how they share with each other on social media sites, in contrast to the opioid addicted mother who she says would never get the chance to experience that level of connection. She stated:
I mean, I've seen, you know, like nurses become very close with certain moms where they're like friends, they're Facebook friends, they text each other, because that person spends a lot of time in the NICU and they become friendly with them. I don't think that that would ever happen with a mom who was using-Um, I mean ... they don't really become close with a mom who was like using.”

RN#20 described how the nurse’s prejudgment of the opioid addicted mother can impede her willingness to disclose pertinent information to the staff and result in a lack of trust of the mother toward the nurse. She described a broken relationship between two individuals who may need to interact for an extended period. She stated:

We have some nurses who treat the moms like crap when they walk in the door, not knowing their situation, and you know, judging them from the get go, just from on paperwork. And that may not be the exact truth, you know? And if you come in with a negative attitude those moms aren't going to be willing to, you know, talk to us or tell us anything, you know, be honest with you. That's going to be something that's going to be broken right off the bat, and here's those two people there for a month or so. I think it would be, difficult with those moms, to have trust in the nurses when they treat them with disrespect, just because they're on drugs.

**Concept 3: Lack of empathy for the opioid addicted mother.**

Several of the participants expressed a lack of empathy for the opioid addicted mother. The opioid addiction although acknowledged as a disease that is difficult to control was also seen as a conscious choice made by the mother. It seemed that any empathy that was expressed was for the circumstances of the infant. Some participants did express some empathy for the mother, but it was coupled with blame as well. In addition it was evident from
the interviews that mothers who admitted to having an opioid addiction or were in a rehabilitation program were viewed in a much more positive light than those that did not.

RN #11 felt that when if the opioid addicted mother admitted to feeling guilty and that her addictive behavior was wrong, then the nurse could feel more respect towards her. She stated:

I have a deeper respect obviously if they're ... if they know that they've done wrong and they are guilty and making changes in their life. I feel like they deserve that chance to be with their babies. And then the moms that are going through methadone. I feel like ... they are the most guilty and they try almost to like rectify what has happened, and I actually feel ... I feel the worst for them because I feel like they shouldn't feel guilty, because it's ... the way that they're living, this is how they're dealing with life, and I don't think it's ... I don't think it's wrong. I think they're like, giving the most effort to give a good life to their babies. So I like them the most.

RN #16 reported difficulty caring for an addicted mother that is not in a recovery program. She viewed her as selfish and only thinking of her own needs. She stated:

We hope that we've changed the mother but it depends on the mother. I think sometimes if a mother who had no prenatal treatment, or wasn't in a program it's much more difficult to feel, what's the word? …I think we almost respond differently to those mothers because, I mean, you try to be as objective as you can, but a mom who doesn't seek treatment for maybe her own reasons, is kind of selfish, where she puts herself first before her baby. Like a mom who can't ... she just can't even focus on her baby because all she cares about is herself, she's gotta eat, she's gotta go have a cigarette even though her kid is screaming and it's time for him to eat, but she's gotta take care of herself first. Like she hasn't assumed the mother role.
RN #7 described a sense of frustration at the mother who cannot just stop her opioid addiction. She suggested that caring for the opioid addicted mother may illicit a negative response for a nurse who is experiencing infertility. She stated:

I mean, there's always that frustration of why can't you just take care of your baby? Why can't you stop what you are doing and do that for this baby? I think that struggle's always there as a nurse and a mother. I think this kind of influences you know, we have a few nurses at work that are struggling to get pregnant, and they see this as, kind of, ‘why does she get to get pregnant, why does she get to have a baby and she can't even take care of it appropriately.

RN # 10 also viewed the opioid addicted mother as having a lack of real concern for her infant. She described someone that is self-absorbed and only concerned with her own drug needs. She stated:

They tend to care more about their own needs and meeting those needs as far as being addicted to the drugs and not so much caring for the baby and how the baby's going to be affected by it. I feel like from my personal experience, patients I've cared for, they come in and they are obviously in active labor or going to be in active labor and in pain. They want IV drugs they want epidurals, whatever, that method that they're going to utilize to control their pain during labor. And you know, normal moms come and they're like, ‘well, how is an IV narcotic going to affect my baby? ‘ or ‘How is the epidural going to affect my baby?’ Mothers that are on drugs typically don't show any kind of empathy or remorse or any concern for how that's going to affect the infant.

Category 4: Lack of Education

Study participants identified a lack of education in their nursing training regarding how to
provide best care to the OAMID (see Figure 4). This includes general knowledge on drug addiction as a disease in the maternal-child patient population. In addition, participants expressed a need for education in how to treat the infant with non-pharmacologic interventions, how to assess NAS, and how to educate the mother. The following concepts make up Category 4:

1. Understand addiction as a disease.
2. Lack of formal training on how to care for the OAMID using NAS scoring tools and pharmacologic/non-pharmacologic interventions to mitigate infant withdrawal symptoms.
3. Education for the opioid addicted mother.

Figure 4.

$Lack of Education$
**Concept 1: Understand addiction as a disease**

Participants in the study identified a knowledge gap in their own nursing education about addiction being a disease. Several expressed distress that without formal education about addiction and how it effects a person they cannot effectively advocate for the individual or anticipate their needs like they could with another diseases. RN #10 stated that what she knew about infant opioid withdrawal she had learned on the job. She has no formal education regarding that. She stated:

The only formal education that I've ever had with it would've been what I received in nursing school. So outside of that, as far as education on specifics as far as withdrawal symptoms or infant withdrawal symptom, it's kind of just you learn as you go. You know, from experience. I don't think that it would hurt to have any kind of specific training for that kind of clientele knowing specifically with drugs of abuse, what kind of drugs are contraindicated for the nurse to give. That would be something that's very beneficial because we've had situations at our hospital where drugs have been given and I can't even think of it specifically, that like it reverses the effects of one of the drugs that people abuse and it sends the patient into immediate withdrawal. We had a situation in the past couple of years where it was given and the patient immediately went into withdrawal and it was a really bad situation. So that would be definitely an area for education and then I guess just, withdrawal symptoms, especially for the baby.

RN #13 believed that education on opioid addiction as a disease would be helpful for the nurses to get a better understanding of what the patients go through. She stated:

I think that people know that people who do drugs, it's a disease. And
they can't help themselves a lot of times. So, it's not just that they're choosing to do this, they can't stop. People should be educated about the disease of addiction and that kind of thing.

RN#15 and RN #21 would like to see more education for the nurses concerning opioid addiction in the mother and how it can affect the maternal/infant bonding. In addition education on the different pharmacologic therapies the mother might be prescribed was deemed as being helpful. They stated:

RN # 15: “I definitely think we could learn more about addiction because I think a lot of times we write it off. You know, it's, they're addicted. Well, if you haven't been addicted you don't know what it feels like. So it's hard for me to imagine. I can't even imagine so I think that more education about addiction, and more about how we can help them in terms of bonding with their babies, or even learning more about the resources that are made available to them. Even probably more conversations about like buprenorphine or methadone, versus you know, all those drugs that they put them on.”

RN# 21: “I think a better understanding of drug addiction itself, having a good baseline of knowing that this wasn't a lifelong choice of these women that they're coming from all different walks of life, and things have happened to them, or they've experienced in life, that has brought them to make the choices that they've made. You know, just an addiction course in general might open people's minds or maybe more like a focus group type of thing where nurses can come and talk about why they act the way they do sometimes we do this...because that's what we've seen or done, but like, tell them, kind of open their eyes to what they're doing, and then why they're doing it and then
maybe we can kind of change their practice that way. I think a lot of it is perceptions that nurses have of these patients so we have to change that somehow.”

RN # 8 would like to see more education on how to recognize that someone is addicted and having withdrawal. RN # 4, # 6, and # 7 all expressed the need for education that would help the nurse interact better with the OAMID, and how to give them proper care, and what types of symptoms they should be alerted to. Their ideas follow:

RN # 8: I know this sounds so basic, but just going over like, the signs of symptoms of, a person addicted. Because you see it, and you're like okay. I think this is her maybe withdrawing because she's sweating, and she's shaking, and whatever, but I mean, you know, labor and delivery's so specific to an area. NICU's so specific to that area, that you don't see those people all the time. You're not like on a med-surg where we see withdrawals all the time. So, I think that education with withdrawing in general would help.

RN # 7: I think more education in addiction in general would be excellent for nurses and how to handle a patient, you have to be honest and you have to be truthful, but at the same time not be accusatory and judgmental, which I think is a hard thing not to do. I feel like it's so prevalent, it would be nice if there would be some sort of joining of arms between the behavioral health services and nursing structure. I think you'd almost have to start there and say, this is what we do when we quote unquote "detox" a patient and this is what we look for in addiction behaviors and these are some symptoms that they may have.

RN # 6: We need education on how to help prepare the nurses to take care of these opioid addicted mothers. How we can make the nurses more prepared; we can give them
education in the orientation or in-service to help the nurses and the patients too. To help take care of the patients who are addicted, it's really gonna be helpful for the nurses. At least they can expect what is going to be like, plus what is the expectation when you're taking care of a patient who is addicted to opioids.

RN#4: “I think there should be some type of course to educate us and give us a better framework for when we do have to take care of these patients that we at least get some type of background to really know how to manage them.”

**Concept 2: Lack of formal training on how to care for the OAMID using NAS scoring tools and pharmacologic/non-pharmacologic interventions to mitigate infant withdrawal symptoms.**

The participants in the study identified a general lack of formal training knowledge for the care of the OAMID. This included how the nurse should interact with the opioid addicted mother, how to properly score the infant through the use of an NAS scoring tools and pharmacologic/non-pharmacologic interventions to help the infant through the withdrawal process. NAS presents in the infant as severe neurologic and gastrointestinal manifestations. This manifests as excessive crying, irritability, jitteriness and gastrointestinal upset. Traditional care includes providing an environment of minimal stimulation and narcotic use. NAS scoring tools used by staff guide the adjustment of narcotics required to mitigate withdrawal symptoms. Trends that are more recent suggest that non-pharmacologic interventions could be used to ease withdrawal symptoms without narcotic exposure. A lack of formal education of how to care for the OAMID has been identified as a concern for the study participants. RN #2 discussed how incorporating the opioid addicted mother into the care of the infant can help mitigate the need to give the infant additional narcotics. She stated:
What we're learning is through all the new education is the mothers could be doing more, with these, babies, like putting the baby skin to skin and playing music for the baby, and trying to calm the baby down in other ways than giving the baby so much medication. Because we give the babies morphine to ween them off the opioids, and sometimes it takes a long time for them to withdraw it's very difficult for the healthcare staff.

RN# 20 explained how education on how to interact with the opioid addicted mother, by attending a counseling venue might give the nurse better insight into her struggles. She also expressed interest in learning other care modalities for the withdrawing infant. She stated:

I know we have never really been trained on how to care for these infants. You know, we just learned by the seat of our pants, what they need, and different things like that. I've never been taught how to interact with the mom. I think, like, going to a class about that, or going to a counseling class, or an Narcotics Anonymous meeting or something like that I think would be helpful. To see the interactions they have with one another and how to be on their side rather than feeling like you're against them. I think definitely being at a class having someone teach you what's good for these babies, you know, low stimulation, stuff like that.

Another concern that was expressed by the participants was to learn the proper technique for obtaining an accurate NAS score on the withdrawing infant. The NAS score is what helps drive the decision making of the healthcare provider on how much medication to give the infant to help resolve the withdrawal symptoms. RN # 19 said:

I think that nurses absolutely need to know how to score. Nurses don't have any training besides nurse to nurse on how to score babies. Or what kind of pharmacological and
nonpharmacological nursing interventions exists. And an understanding of the physiology of NAS, and approaching care, differentiating between how we approach poly-drug mothers, and then infants of mothers who have used opiates only.

**Concept 3: Education for the opioid addicted mother.** The study participants expressed concern that the mothers experienced a lack of education by the nursing staff. This included explaining to them how their infant is effected by opioids as well as engaging them in the scoring of the infant and in the infant’s plan of care. Several participants indicated that if they educated the mother, then the mothers would be more likely to stay in a rehabilitation program and achieve self-worth. RN #s 18, 16 and 19 stated:

RN # 18: There are some nurses that work harder because they know that the mom needs education even if she might not be kind and receptive. We would expect some to act like they know it all but I think a lot of us know she needs us. She needs kindness, and she needs the education. We need to work a little bit harder because ultimately the baby’s going to go home with the mom, more than likely, and so we need to give her all that we can.

RN # 16: In the beginning when they're first admitted we say, this is what we're looking for, this is what we score them on. Then I'll score them and I'll ask you if they agree, with our scoring. And then they'll see that at different times the kid can score different numbers. The more you involve them the more they trust you and the more empowered they become.

RN # 19: This is a time where we should be promoting them and empowering them and having them stay with the babies and hoping that they'll do their best to be able to, take over care one day.
Category 5: Conflicted Caring (Core Concept)

The participants in this research study acknowledged in their own voices, their responsibility as MCH nurses to provide care to the OAMID. In addition, they expressed a sense of personal struggle or conflict in providing that care. The conflict expressed, although slightly different for each individual MCH nurse, was imbedded in personal feelings and values. It seemed to be centered around a visceral need to provide protection for the infant and an inherent need to blame the mother for the circumstances of the OAMID. This sense of conflict led the MCH nurses to make an unconscious division of the dyad and view the infant and mother as two distinct entities. The resulting core concept is conflicted caring. Conflicted caring is defined as providing care to an individual based on role designation, or patient need without genuine self-engagement or presence (see Figure 5). The following concepts make up Category 5:

1. Experience of professional disharmony
2. Recognition of personal barriers causing judgmental behavior
3. Inability to change the circumstances of the OAMID
Figure 5.

*Conflicted Caring*

**Concept 1: Experience of professional disharmony.**

A sense of internal struggle was heard within the voices of the participants of this study. The struggle suggested a need for the nurses to perform in the role of caregiver, while having personal knowledge that the care being provided was not genuine. This struggle led the MCH nurses to experience professional disharmony. RN # 19 described the internal struggle she went through as she came to the realization of her care delivery to the OAMID. The emotion behind the description is noted in the way she tried to find the words to describe what she had identified about her care through, the hesitation and search of the right words. Her words. She said:

I know it starts with me, as far as the nurse in my perspective, and I had to really go through that change and go through that period of examining my ethical beliefs about the situation and listening to these mother's stories and changing my approach and then
moving forward I always think that it's the internalization of the nurse that needs to happen first and then, model of care and into like the involvement of everybody else. I think if I think that the mom is an enemy of the baby or I think that she's, it's her fault to watch this baby suffer and like, thinking of it that way, if I think that she's enemy I'm not going to treat her as a person who is capable of taking care of a child. I'm not going to, I'm not gonna ... It comes out in my, in my language to her, it comes out in my body language, it comes out in my you know, education to her, even if I know better, that I should be teaching her something, if I think that she's done something incredibly wrong, it's gonna come out in all aspects of care.

RN #7 expressed the difficulties she encountered in trying to have compassion for some opioid addicted mothers. She clearly knows compassion should be part of the care she provides, but she acknowledged that it is not always part of the care. She stated:

I'm just trying to get in my head to pinpoint what it is, I mean, I think post delivery often times is one of your most crucial times to be able to reach that patient and hopefully ... I don't know, I guess, it's just one of those times that I feel like you have the opportunity to say hey, here's your baby, what can we do to help you help your baby or, you know, things like that. And I think it takes that compassion, which is hard to pull out sometimes. And, I think that's, that's your lesson, you have to be able to do that and sometimes it does something and sometimes it doesn't, sometimes you know, you have the ability to plant the seed and sometimes nothing comes of it and you have to be willing to keep trying.

The manner in which the nurses live their own lives and the expectations and moral values they have can cause emotional barriers for them when they are expected to provide care to someone who in their view is following a different moral plan.
RN #10 expressed how her husband’s career in law enforcement, particularly in
narcotic enforcement affected her role as a nurse providing care for mothers
with an opioid addiction. She admitted to having knowledge of her negative feelings, and how
those feelings are contrary to the expectations of her role as a nurse. She said:

I think so, for sure we face more emotional, ethical challenges. For me, religious
challenges. I feel like I try really hard where I'm caring for these patients, not to let any of
my personal feelings get involved. You know, that's not what we do as nurses. But,
when you, when you're against that kind of lifestyle. And especially for me, I'm married
to an Indiana State Trooper and he has a narcotics canine and he works a lot with this
kind of clientele. So, I think I have a little bit more of a, maybe a biased view on these
people than the average nurse would. So I think it is challenging, just not to be
judgmental and treat them as the same as you would any other patient. I think that's
challenging in itself.

**Concept 2: Recognition of personal barriers causing judgmental behavior.**

The participants in the study were able to recognize their own personal barriers
which contributed to judgmental behaviors. They were aware that what they were experiencing
was judgmental and they could not disregard it as not being real. They consciously tried to
overcome it by acknowledging that it exists and worked through it, rather than trying to ignore it.
RN # 7 described her feelings taking care of the OAMID as being a personal struggle. She
viewed the mother as being the cause of the infants struggle with the opioid withdrawal, but she
recognized that it is out of the mother’s control. In spite of RN # 7s feelings, she chose to be
supportive and knew that sometimes it will be more challenging than others. She stated:
It’s hard to see babies struggle with NAS when the mother has caused them to have this struggle. Ultimately, I know the mother is also struggling with this disease of addiction so I am supportive to her. Some days situations are easier than others.

RN # 18 described how she was cognizant of her feelings toward the opioid addicted mother and how she tried to show compassion and support during care. She said, “though I try to always be aware of my own feelings and judgments, sometimes I do feel frustrated by addicted mothers. Most of the time I am compassionate and supportive.”

RN# 3 stated that she has ambiguous feelings for the opioid addicted mother because she has experienced a sister who is recovering from an opioid addiction who had children post recovery. But she acknowledged that she does have concern for this patient population. She stated:

I see the way some nurses respond to the opioid addicted mother, and I can understand if they have negative feeling toward them. I was in that same boat and then I found out my sister was using and I saw what it did to her life. It was sad, but she recovered now she has kids and she is doing well, but for awhile it was a struggle for her. So I now see a different side, and I try to avoid those negative feelings because of my family situation, but it’s hard to not put your feelings on them and have concerns for how they are going to do now with this baby, I guess I’m not really sure what to feel.

**Concept 3: Division of care.**

The participants in the study frequently described their care of the OAMID in terms of two separate entities. They provided care for the infant that was viewed as expected and necessary and care for the opioid addicted mother, which was viewed as burdensome and frustrating. This division of care resulted in a dissolution of the mother-infant dyad. That care connectedness of mother and infant did not exist. The MCH nurses were not conceptualizing the
opioid addicted mother and her infant as one, as they would have done for a “normal” mother-infant dyad. RN # 11 said, “I think what happens is ... we stop ... we just stop thinking of these people as parents, we forget what they're going through...you just figure oh, well, she obviously didn't care enough to change her lifestyle habits or seek help. You almost like, disregard her as a mom sometimes.” RN # 13 said, “Well, I think some people think that the mom shouldn't have anything to do with the baby. That they shouldn't have any interaction.”

RN # 5 said “Your empathy or any sort of remorse feelings that you have always go towards the infant. You know, the poor infant. I'm telling you, it rarely goes towards the mom because you already know the mom would sell her soul just to get another fix of drug.” RN # 16 said, “I think first and foremost she's (the nurse is) caring for the baby.

The Theory of Conflicted-Caring: Summary

This chapter identified the process of how MCH nurses provide care to the OAMID. The intricate nature of the OAMID and the complex care that is required by the MCH nurses is as much emotional as it is technical. The MCH nurses described their ability to care for the OAMID as trying to adhere to the code of their job description while simultaneously trying to navigate through their own emotional turmoil. Caring was thought by many to be the foundation of nursing care. It is a fundamental expectation to receive care that is knowledgeable, safe and without bias. Nurses who encounter personal feelings contrary to being unbiased are in direct conflict with their role as caregiver. The MCH nurses caring for the OAMID self-identified as exhibiting behavior that was judgmental toward the opioid addicted mother. This led to the development of the theory of Conflicted Caring.

Conflicted Caring is defined by this researcher as providing care to an individual or individuals based on role designation or patient need without genuine self-engagement
or presence. The categories that led to the construction of the theory of conflicted caring included, challenging care, fear for the infant’s future, judgmental behavior and lack of education. The participants in the study clearly indicated that although they were willing to provide care to the OAMID, it almost always was perfunctory care. Care that is perfunctory in nature, although appropriate for the basic patient needs, is executed in an automatic, detached manner. This form of care was not unnoticed by the MCH nurses, as they were aware that they were not engaging with the opioid addicted mother and they were very much engaged with the infant.

This disconnection in care was due to strong emotional dissatisfaction with the mother’s opioid addiction. The MCH nurses displayed tremendous empathy and concern for the infant’s wellbeing and viewed the infant’s care as difficult only when trying to soothe its pain during the withdrawal process. They expressed fear and anxiety concerning the infant’s discharge home with the opioid addicted mother. Several stated that a discharge to social services was desired over a discharge to the mother. The MCH nurses very clearly articulated the frustration and challenges that caring for the OAMID caused them. They identified the ethical and emotional toll the care of the OAMID represented to them personally, and they recognized how the care they provided the OAMID was significantly different from what they termed a “normal mother/infant”, or one without addiction issues. The recognition of this different kind of caring, was disconcerting to the MCH nurses as it was contrary to the foundation of their core nursing identity, which is theoretically composed of unbiased care. The result of conflicted caring caused the nurses to subconsciously divide the OAMID into separate entities.

Based on the data obtained from the one-to-one interviews and through the use of constant comparative analysis, several theoretical construct where identified that led to the Theory of Conflicted Caring (see Figure 6.).
Fear of the infant’s future
- Poor support system for the OAMID
- Lack of trust in the Mother’s ability to care for the infant
- Concern for the infant’s safety

Lack of Education
- Understand addiction as a disease
- Lack of formal training on how to care for the OAMID using NAS scoring tools and pharmacologic/nonpharmacologic interventions to mitigate infant withdrawal symptoms
- Education for the opioid addicted mother

CONFLICTED CARING
- Experience professional disharmony
- Recognition of personal barriers causing judgmental behavior
- Division of care

Challenging Care
- OAMID care is challenging
- A need for support to assist the nurse with the care of the OAMID
- Lack of collaboration with

Judgmental Behavior
- Bias toward the opioid addicted Mother
- Difficulty engaging with the opioid addicted mother
- Lack of empathy for the opioid addicted mother

Figure 6.
*Theory of Conflicted Caring*
Chapter Five: Discussion and Recommendations

Introduction

In grounded theory research, the literature review provides a foundation for what is known about the study topic. This preliminary literature review helped in the development of the research question for this study and assisted this researcher in understanding the existing gaps in the literature. The purpose of this research was to explore, identify and learn how care rendered to the OAMID is perceived through the lens of the MCH nurse. This grounded theory study utilized the methodology of Strauss and Corbin (1998) to collect, analyze and synthesize the data through constant comparative methodology. The process involved the identification and classification of similar concepts and categories, which generated the substantive theory of Conflicted Caring. In this chapter, the methodological issues, study limitations and major findings are discussed. Implications for nursing education and nursing practice are described along with recommendations for future research. Major findings are supported by the secondary literature review.

Methodological Issues

Recruitment for this study included purposive sampling, which is based on a specific type or characteristic of population and its relevance to what is being studied. The original intent of this study was to obtain nurses that worked for at least one year in a maternal-child health setting taking care of an OAMID. The final pool of participants included 19 nurses with representations from labor and delivery, postpartum, NICU, mother/baby, and special care nursery. In addition, two NICU nurse practitioners, one that is also a lactation consultant and one additional lactation consultant participated in the study. The data obtained from the perspective of the nurse practitioners and lactation consultant added additional support for the emerging theory.
Limitations

Participant interviews were conducted for this study via face-to-face (10 participants) and over the telephone (11 participants). Both of these interview strategies can have limitations. The face-to-face interviews provided the researcher with the ability to observe body language along with the discussion. However, in that experience the researcher noted that several of the participants were reluctant to give eye contact and sat in a formal manner, possibly due to the sensitive nature of this study topic. The face-to-face interviews may have caused some discomfort for those particular participants and their posture may have been reflective of that discomfort. None however identified any significant discomfort or wanted to end their interview. They were also quite verbal about the study topic and were clearly able to express sufficient thoughts and personal feelings.

Telephone interviews can also present limitations for data collection. Interviews conducted over the telephone limit the researcher’s ability to view body language of the participants. The body language adds another dimension to the conversation such as feelings, similar to what intonation adds to conversation. In addition, it is difficult to distinguish natural pauses in conversation over the phone from pauses due to a hesitation to share information. Two of the telephone interviews had gaps in conversation that were not clearly discernable to the transcription service, possibly due to the participants’ accent. However this researcher easily recognized the content when the recordings were verified against the transcripts.

Another limitation to this study was that the sample of participants was all women making it a homogenous pool. The inclusion criteria did not limit participation to only females, however the abundance of female participants could be explained by the predominance of females in the field of maternal child nursing. The participation of male MCH nurses may have
added a different perspective to this study. Male MCH nurses are not commonly employed in such settings and none volunteered to participate in this study.

The background of this researcher as a former NICU nurse and clinical educator in a NICU, could potentially be viewed by some as a limitation to this study. However, through the use of bracketing and remaining ever cognizant for the potential to bias the data, this researcher is confident that data integrity was maintained throughout both the collection and analysis phases of the study. In order to assist with maintaining the data integrity none of the participants were previously known to this researcher or were employed in the same organization as this researcher.

**Study Strengths**

A strength of this study was in the diversity of geographic locations represented by the participants. The geographic locations included volunteer participants from, New York, New Hampshire, Indiana, Kentucky and Canada. Several ethnic groups were represented by the participants including; white non-Hispanic, Black non-Hispanic, Asian and Hispanic. This geographic and ethnic diversity helped to support the findings.

A major strength of this study was in the diversity of the maternal child health nursing areas represented. The data collected was representative of nurses working across the continuum from labor, delivery, postpartum, mother/baby, special care nursery, NICU, lactation consultants, and nurse practitioners. This blend of participants and the information they shared about their care of the OAMID, provided powerful information that supported the development of the theory of conflicted caring. This blend across the continuum of the maternal child setting has not been part of any prior research studies on this topic. The inclusion of nurses employed in all these settings provided inclusive data that helped form a grounded theory that spans the time from
admission to a laboring setting, to delivery, to a stay on a postpartum unit with the infant in a NICU, to the mother’s discharge home. It also encompassed the infant’s stay that lingered longer in the NICU after the mother was discharged home and ended with an eventual infant discharge. Prior studies have focused on various settings such as only the NICU. This study was able to draw upon nursing experiences from all these settings across the continuum of a mother’s birth experience and her infant’s stay so as to contribute to a valid theory grounded in that data.

**Major Findings**

The major findings in this study included the core concept of Conflicted Caring and the basic psychosocial problem in which the opioid addicted mother and infant were viewed by the MCH nurses as two distinct entities instead of one single dyad. The concepts that became the foundation of conflicted caring included; a) professional disharmony b) recognition of personal barriers causing judgmental behavior and c) division of care. These findings as well as support for the development of the grounded theory of conflicted care will be explained in conjunction with a secondary literature review.

**Discussion of Major Findings**

The basic social problem identified was that the MCH nurses did not view the opioid addicted mother and her infant as a single dyad. The MCH nurses were very willing to provide care to the infant who may or may not be experiencing withdrawal symptoms, because the infant was viewed as vulnerable. In contrast, the MCH nurses viewed the opioid addicted mother as the reason for the infant’s vulnerability, but they did not view the mother in terms of her vulnerability. Compartmentalizing the caring was necessary for the MCH nurses to reconcile the frustration and anger they felt for the mother and her “behavior” and to protect themselves from their own inner turmoil. The MCH nurses were aware that the care they provided these mothers
and their infants was different from other mother infant dyads who were considered in their words to be “normal.” The recognition of this division of care based solely on the duty of their nursing role that was in direct contrast to the care they would like to have been able to provide. That is care that is rendered beyond their duty as nurses, and provided with authenticity and presence. They were experiencing conflicted caring.

Secondary Review of the Literature

The internal struggle the MCH nurses expressed regarding the type of care they provided the OAMID and the impact they felt upon recognition of that care was described within the concepts of experiencing professional disharmony and recognition of personal barriers causing judgmental behavior and division of care. The lack of congruence in their role as nurse and caregiver was lacking for the MCH nurses with this patient dyad. The categories interwoven together became a core concept of conflicted caring. Ultimately the integration of all the categories within this study led to the development of the grounded theory of Conflicted Caring.

A phenomenological study by Vatne (2017), examined the vulnerability of mental health nurses working in a seclusion unit of a mental health hospital in Norway. The study showed how the personal norms and feelings of the nurses caused them to distance themselves emotionally from their patients as a means of self-preservation. The similarity of Vatne’s study to this grounded theory study, was that the nurses in Vatne’s study also recognized a disconnect in what they actually were experiencing in caring for their patients and what they believed they should be experiencing in caring for their patients. The nurses in both studies expressed having complex negative feelings for their patients, and a sense of discomfort related to that.

A study by Ford, Bammer and Becker (2009), examined if education on alcohol and illicit drug use was adequate to help enhance nurses’ therapeutic attitudes toward patients that
use illicit drugs. Therapeutic attitudes were described as patient engagement and nurses’ commitment to their role. The findings of the study suggested that education alone was not enough to help the nurses with patient engagement and role satisfaction. The suggestion was that in addition to education, role support from management along with enhanced policies and procedures for the care of this patient population was indicated. The addition of these supportive measures along with the education would give the nurses the resources they need to improve their role satisfaction and patient engagement. The study by Ford, Bammer and Becker was similar to this grounded theory study because it addressed an aspect of the nurse’s difficulty with personal barriers which can hinder engagement with the patient, as was found with conflicted caring. The study stressed the importance of organizational wide support and assistance to help guide the nurse in the proper care of these patients. Possessing the knowledge base about the substance use was not sufficient for the nurse’s development of confidence with this patient population.

A qualitative study by Johansson and Wiklund-Gustin (2016) examined how nurses working in an inpatient psychiatric care unit experience caring with patients that have substance use disorder. The researchers concluded that the nurses experienced multifaceted vigilance when caring for these patients. This multifaceted vigilance was described as being due to having caring ideals, such as wanting to form a relationship with the patient and provide a holistic healing environment. They experienced conflict with patient behaviors and organizational boundaries that can challenge those caring ideals. This conflict leads to an internal struggle with personal reactions to caring for these patients. That conflict can be directed toward their colleagues and patients. The researchers suggest that nurses need to be cognizant not only of the needs and feelings of the patients but their own as well in order to maintain a balance and protect
their own vulnerability while caring for this challenging patient population. This study supports the theory of conflicted caring by suggesting that personal vulnerabilities can hinder patient caring.

Additional support for the development of the grounded theory of conflicted caring comes from an Australian study by Fraser, Barnes, Biggs and Kain (2006). This qualitative study examined NICU nurses experience caring for drug exposed newborns and their parents throughout the treatment for NAS. The study results suggested that negative attitudes and organizational barriers impacted parent-infant attachment and optimal care delivery. Similar to this researcher’s grounded theory results, Fraser and colleagues discovered that care of the infant and parents was parallel and not in partnership, resulting in a division of care of the patient dyad. Nurses described the difficulty of combining the infant and family for the provision of family centered care and suggested their client was only the infant. The infants care was regarded as necessary but it was fraught with barriers such as requiring a lot of time, limited staffing resources, and that discharge was an infant safety consideration. A need for self-preservation by distancing themselves in the care of this patient dyad was expressed by the nurses, as was negative and judgmental feelings toward this patient dyad. The results of the study indicated that educational resources and additional staffing support might enhance the nurse’s ability to provide improved care to this patient dyad. It validated the assumptions that nurses struggle with internal barriers they know are not conducive to providing authentic care to this patient dyad. In addition their view of the infant as their client separate from the mother supports the findings of this researcher’s study that nurses see the opioid addicted mother and infant as two separate entities and not a patient dyad.
Theoretical Framework

The theoretical framework underpinning the concept of how the MCH nurses render care to the OAMID for this grounded theory research came from Jean Watson’s theory of Human Caring/Caring Science (2008). Watson’s theory of Human Caring, involves the essential components of being authentic and present with the patient during care. She outlines the tenets of her theory in her 10 carative factors and the caritas process (see Appendix A), necessary for the provision of those factors. The results of this grounded theory study and the development of the theory of Conflicted Caring has relevance to Watson’s work. MCH nurses described having an internal struggle with what they were experiencing with the care of the OAMID and what they felt they should be experiencing with their care. The Caritas process is one that incorporates a healing, trusting, loving and accepting relationship. Watson makes a distinction between following what is expected for the role of nursing and actually expressing care to a patient, which is not one in the same in her view. She describes that a nurse may perform patient care out of moral obligation or a sense of duty and would be considered acting as an ethical practitioner. That does not however qualify as having cared for the patient, that requires a higher sense of spirit of self (Watson, 1999). Watson teaches that presence with the patient is essential for the delivery of care. One does not perform the necessary tasks of care delivery without loving kindness and authenticity of self. RN #14 described this notion as she recalled an opioid addicted mother’s description of how she could tell that the nurses were judging her. When RN #14 inquired as to how she could help alleviate this type of judgmental behavior among the nurses, the mother simply stated, “you can’t, it’s in their hearts.” The patient described her sense of awareness of lacking care that is delivered with authenticity and loving kindness. RN #11 recalls an interaction with an opioid addicted mother who tried to articulate how she felt ignored
and insignificant unlike the other mothers in the NICU. The mother stated that although there was no rudeness toward her and her needs were met, the nurses did not engage her like they did with the other mothers. She described having a feeling or a vibe, that she was not as important because of how they saw her. This mother was not being cared for with wholeness, dignity and comfort, described by Watson as caring with engagement of the patient. Watson’s Theory of Human Caring was chosen as the theoretical framework for this study because it provides a holistic design that captures the needs of the patient and the nurse from the core of caring which is more than just providing therapeutic interventions and meeting basic human comfort needs. It transcends these ideas and goes to a deeper level. It is where one human being sees another human being through loving kindness and without thought of judgement. It is providing the essence of caring and allowing the patient to know they are worthy and valued.

**Significance to Nursing Practice and Education**

This grounded theory study examined care of the OAMID through the lens of the MCH nurse across the continuum from labor and delivery, postpartum, mother-baby, NICU to discharge. There was no difference found among the MCH nurses from all these various areas in this study. Input from nurse practitioners and lactation consultants who were participants in this study concurred with those of all the other MCH nurses leaving no variation in information. The core concept of conflicted caring resounded in the responses of the participants validating that the substantive Theory of Conflicted Caring was indeed grounded in the data. The results of this grounded theory research have implications for both nursing education and practice. A theme that was evident throughout the participant responses was a need to have educational resources available for the MCH nurses. The need for educational resources include information on the proper use of NAS scoring tools that are available to help determine the correct
pharmacologic interventions for these babies. Providing the nurses with educational information about non-pharmacologic interventions to help with the mitigation of NAS symptoms was also indicated. Education on addiction in general, as a disease process, and what to expect from the patient, as well as how to provide more comprehensive care to patients was an evident need. Enhanced education on engaging the opioid addicted mother into the infants care is also needed to support the maternal-infant bond.

Implications for nursing practice include the development of best practice standards for early intervention to assist the OAMID from the onset of pregnancy through to the postpartum period. Best practice protocols will help to insure the OAMID receives the support they need for a successful pregnancy, delivery, and stay in the NICU as indicated. The establishment of collaborative work groups between nursing and social services for community resources to continue the care of the OAMID after discharge might best provide essential support for a healthier transition into community living. Steps need to be taken to establish collaboration between the opioid addicted mother and the MCH nurses from antepartum through the postpartum period to create and maintain a plan of nursing care for the mothers’ successful care of their infants while also providing a supportive environment for maintaining sobriety.

**Future Research**

This grounded theory study was unlike the studies in both the preliminary literature review and the secondary literature review because it looked at MCH nursing care of the OAMID across the continuum from labor and delivery through postpartum, mother/baby, NICU and through to discharge. The participants in this study were primarily MCH nurses however; the addition of input from the nurse practitioners and lactation consultants added richness to the data. Some suggestions for future research studies would include, a quantitative study design
examining the MCH nurses’ care of the OAMID across the continuum from labor and delivery through postpartum, mother/baby and NICU through to discharge for a comparison of results to the findings in this study. Another research study suggestion is to investigate care resources in the community for the OAMID after discharge from the hospital. Although not a part of this study design, future studies could also include the participation of midwives, obstetricians and social workers care of the OAMID.

Continued research is needed in this area of nursing care because opioid addiction is a healthcare crisis that has implications for future generations to come. Nursing has to be on the frontline of new ideas and innovations for the development of nursing practice standards in order to meet this growing need. Nursing practice will need to find ways to implement guidelines and strategies in order to provide quality care for this vulnerable patient dyad. Mothers and their children need the support of nurses in order to remain as a single patient dyad for a chance at their own health and welfare. Nursing is poised to best support this dyad in the generations to come.
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## Appendix A: Watson’s Caritas Processes

<table>
<thead>
<tr>
<th>Carative Factors</th>
<th>Caritas Processes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The formation of a humanistic-altruistic system of values</td>
<td>Practice of loving-kindness and equanimity within the context of caring consciousness</td>
</tr>
<tr>
<td>2. The instillation of faith-hope</td>
<td>Being authentically present and enabling and sustaining the deep belief system and subjective life-world of self and one being cared for</td>
</tr>
<tr>
<td>3. The cultivation of sensitivity to one’s self and to others</td>
<td>Cultivation of one’s own spiritual practices and transpersonal self-going beyond the ego self</td>
</tr>
<tr>
<td>4. Development of a helping-trust relationship</td>
<td>Developing and sustaining a helping, trusting authentic caring relationship</td>
</tr>
<tr>
<td>5. The promotion and acceptance of the expression of positive and negative feelings</td>
<td>Being present to, and supportive of, the expression of positive and negative feelings</td>
</tr>
<tr>
<td>6. The systematic use of the scientific problem solving method for decision making</td>
<td>Creative use of self and all ways of knowing as part of the caring process; to engage in the artistry of caring-healing practices</td>
</tr>
<tr>
<td>7. The promotion of interpersonal teaching learning</td>
<td>Engaging in genuine teaching-learning experience that attends to wholeness and meaning, attempting to stay within others’ frame of reference</td>
</tr>
<tr>
<td>8. The provision of supportive, protective, and (or) corrective mental, physical,</td>
<td>Creating healing environment at all levels, whereby wholeness, beauty, comfort, dignity, and peace are potentiated.</td>
</tr>
<tr>
<td>sociocultural, and spiritual environment</td>
<td></td>
</tr>
<tr>
<td>9. The assistance with gratification of human needs</td>
<td>Assisting with basic needs, with an intentional caring consciousness, administering ‘human care essential,’ which potentiate alignment of mind-body-spirit, wholeness, in all aspects of care</td>
</tr>
<tr>
<td>10. The allowance for existential phenomenological forces</td>
<td>Opening and attending to mysterious dimensions of one’s life-death; soul care for self and the one-being cared for; “allowing and being open to miracles.”</td>
</tr>
</tbody>
</table>
Date: May 1, 2017
To: Alice Marie Nash
From: Kathleen Maurer Smith, Ph.D.
Co-Chair, Molloy College Institutional Review Board
Patricia Eckardt, Ph.D., RN
Co-Chair, Molloy College Institutional Review Board

SUBJECT: MOLLOY IRB REVIEW AND DETERMINATION OF EXPEDITED STATUS
Study Title: Maternal Child Health Nurses Care of the Opioid Addicted Mother and Infant: A Grounded Theory Study
Approved: May 1, 2017
Approval No: 01140119-0501

Dear Alice:

The Institutional Review Board (IRB) of Molloy College has reviewed the above-mentioned research proposal and determined that this proposal is approved by the committee for the Molloy subjects and pending approval for any other schools that you may use. It is considered an EXPEDITED review per the requirements of Department of Health and Human Services (DHHS) regulations for the protection of human subjects as defined in 45CFR46.101(b) and has met the conditions for conducting the research. Note that as Principal Investigator, please send us evidence of completing the CITI certification required for your study.

You may proceed with your research. Please submit a report to the committee at the conclusion of your project.

Changes to the Research: It is the responsibility of the Principal Investigator to inform the Molloy College IRB of any changes to this research. A change in the research may change the project from EXPEDITED status that would require communication with the IRB.

Sincerely,

Kathleen Maurer Smith
Kathleen Maurer Smith, Ph.D.

[Signature]
Patricia Eckardt, Ph.D., RN
Appendix C: Study Announcement

Volunteers Needed for a Research Study

Research Title: Maternal Child Health Nurses Care of the Opioid Addicted Mother and Infant: A Grounded Theory Study

Hello,

I am a doctoral candidate at Molloy College in Rockville Center, New York. I am conducting a research study about how care is provided to opioid addicted mothers and their infants by nurses from pregnancy through to post-partum. This study is going to satisfy the requirements to complete my doctoral studies.

Eligible Participants are:

- Nurses working in the following areas:
  - Antepartum
  - Labor & Delivery
  - Postpartum
  - Well Baby Nursery
  - Neonatal Intensive Care Nursery (NICU)
- Nurses with at least 1 years’ experience working with opioid- addicted mothers and their infants in at least one of the areas noted above.

The required commitment to participate in this study includes:

- (1-2) 60-120 minute interviews conducted at a mutually agreed upon place or via phone.
- That interviews will be audio recorded and the researcher will take notes.
- Privacy and confidentiality will be assured

Compensation:

- Participants will be compensated with a $25.00 Visa gift card.

To participate in this research please phone, text or email the researcher: Alice M. Nash
Phone: (516) 965-4081 or Molloy email: anash@lions.molloy.edu
Appendix D: Letter/Statement to the Participants

Date____________________
Dear______________________,

Thank you for your interest in participating in the research study about how care is provided to opioid addicted mothers and their infants by nurses from pregnancy through to post-partum. My interest in this study is generated by my past experience as neonatal ICU nurse caring for opioid-addicted women and their infants. I am conducting this research study as a PhD student at Molloy College in Rockville Centre, NY. The purpose of this research study is to explore, identify, and learn how care provided to an opioid-addicted mother and her infant is perceived through the lens of the nurse. In addition, this researcher hopes to gain insight about where nurses may benefit from education opportunities about this patient dyad.

Volunteers will be interviewed and asked about the care they render to the opioid-addicted mother and her infant. The interviews will last approximately 1-2 hours and be audio taped. In addition the researcher may take memos or field notes to aid in the data collection process. Names and any other personal information will not be used or shared. Pseudo-names or other chosen names will be used during data collection and within written papers to preserve confidentiality. Direct interview and a follow up interview via email, telephone, or direct contact will be used. I appreciate your input and perspective on this topic.

Interview questions will focus on how you provide care to this patient dyad. Your perspective will be explored. You will be provided a consent form that must be read by you and signed by you prior to your participation in the interview process. After reading the informed consent please let me know if you have any questions about the study process. Thank you for your consideration to participate in this study.

Sincerely,

Alice M. Nash
Molloy College
1000 Hempstead Ave., Rockville Center, NY 11571
anash@lions.molloy.edu
Appendix E: Informed Consent

Title: Maternal Child Health Nurses Care of the Opioid Addicted Mother and Infant:

A Grounded Theory study

Researcher: Alice M. Nash MA, RNC-NIC

I am a doctoral student at Molloy College and my interest in this study is generated by my past experience as neonatal ICU nurse caring for opioid-addicted women and their infants.

You are being asked to join a research study to answer specific questions.

This consent form will explain:

- the purpose of the study
- what you will be asked to do
- the potential risks and benefits of participating in this research study

You should ask questions before you decide to participate. You can also ask questions at any time during the study.

Purpose of the Research: The purpose of this research study is to explore, identify, and learn how care provided to an opioid-addicted mother and her infant is perceived through the lens of the nurse. In addition, this researcher hopes to gain insight about where nurses may benefit from education opportunities about this patient dyad.

Expected Duration of the Study: This research study is expected to take place over approximately 6 months. Within the timeframe approximately 20-30 participants will be interviewed.

Description of Procedures/Methodology: If you agree to participate in this study, you will discuss how you provide care to opioid-addicted mothers and their infants. You will be asked to express the experience in your own words and feelings. After reviewing and signing the consent you will be given a copy of it to keep. You will also be given a demographics form to complete.
which should not take longer than 10 minutes to complete. You will be asked to participate in 1-2 interviews lasting approximately 1-2 hours each. You will choose a time and place for your convenience to participate in these interviews. A semi-structured interview guide will be used for the interview process. You may ask to review these questions prior to the actual interviews. The interviews will be audio taped and later transcribed verbatim to written form by a professional transcription service. In addition the research may take memos or field notes to aid in the data collection. Your confidentiality will be maintained by only using pseudo-names (not your real name). An additional contact with you may be requested for clarification and review of the interview analysis. This may consist of a subsequent interview of approximately 30-60 minutes, or by telephone or email for your convenience. The data collected from all participants will be analyzed by grounded theory methodology.

**Possible Benefits to Participants or to Others:** There is no direct benefit to you from participation in this study. However the study results may provide insight into potential changes to current care practices for this particular patient-dyad.

**Reasonably Foreseeable Risks or Discomforts:** There is no direct risk to you from participation in this study. You will be asked to share personal insight and feelings, and there is a potential for strong emotions to surface during the interview process. If at any time you feel discomfort or distress you can choose to take a break or discontinue the interview. You always have the option to opt out of the study at any time. You can also choose to have any part of your data deleted at any time.

**Cost/Compensation:** There is no cost to participate in this study. You will be provided with a $25 Visa gift card at the completion of your participation in the study.
**Confidentiality:** Your interview will be kept confidential. Your name will not be used in the interview data or the audio-recordings. You will be identified by a number and a pseudo-name. All data will be stored by the researcher in a locked box and only those individual involved with the research (researcher, faculty dissertation committee and transcriber) will be able to review the data. None of your personal identification such as name, address or place of employment will be used to identify you within the study data. No personal identifying data will be used in any final written document or publication.

**Contacts for questions about the research:** If you have any questions about the study, you may contact: Alice M. Nash at anash@lions.molloy.edu

Or Susan Vitale PhD RN PNP ANP-C Professor
Molloy College, Division of Nursing
1000 Hempstead Ave., Rockville Centre, NY 11571
svitale@molloy.edu or (516) 323-3000

An explanation of the procedures to be employed in this study, in which I have voluntarily agreed to participate, has been offered to me. All of my inquiries concerning the study have been answered to my satisfaction. I understand that the information collected will be held in confidence, and that my name will not in any way be identified. I understand that additional information about the study results will be provided, at its conclusion, upon my request. I know that I am free to withdraw from the study without penalty at any time.

The above information has been provided to me (check one): ______In writing ______Orally

Signature of Participant_________________________________ Date__________

Signature of Researcher_________________________________ Date__________
If you wish to receive a copy of the study results please complete the following:

(Please Print)

Name: ________________________________
Address: ______________________________
          (Number & street)
          ________________________________
          (City)                               (State)                 (Zip code)
Telephone: ____________________________
          Please indicate the preferred time to call you ________________________
Email: ________________________________
Appendix F: Demographic Inventory

Please fill in the blank or circle the appropriate answer

1. What is your age____________

2. What is your gender:
   a. Male
   b. Female

3. Do you belong to any racial/ethnic group? Please place a check next to the group with which you most identify:
   a. White (non-Hispanic)
   b. Black (non-Hispanic)
   c. Hispanic
   d. Asian
   e. Native American
   f. Pacific Islander
   g. Other (Describe if more than one or other not listed)__________________

4. What is your Martial Status?
   a. Married
   b. Single (never married)
   c. Partner
   d. Widow/widower
   e. Divorced
   f. Separated

5. Number of children you have_________

6. Highest level of education completed:
   a. Diploma
   b. Associates degree
   c. Baccalaureate degree
   d. Master’s degree
   e. Doctorate degree
   f. __________________________

7. How many years have you been working as a Maternal Child Health nurse (MCH)
   a. 1-3
   b. 4-10
   c. 11-15
   d. 16-20
   e. More than 20
8. Has a family member ever exposed you to opioid addiction? Yes or No
   If yes, please explain______________________________

9. Has a close friend ever exposed you to opioid addiction? Yes or No
   If yes, please explain______________________________

10. Have you ever had an addiction to opioids? Yes or No
    If yes, please explain______________________________

11. How often do you render care to an Opioid addicted mother-infant dyad (OAMID)?
    a. Never
    b. 1-3 times a month
    c. 4-7 times a month
    d. 8-10 times a month
    e. More than 10 times a month

12. Do you have any negative feelings toward people have an opioid addiction? Yes or No
    If yes, please explain______________________________

13. How often do you render care to an Opioid addicted mother-infant dyad (OAMID)?
    a. Never
    b. 1-3 times a month
    c. 4-7 times a month
    d. 8-10 times a month
    e. More than 10 times a month

    Thank you for your participation
Appendix G: Researcher-Developed Interview Guide with Probes

1. As a nurse working in the maternal/child health arena, what is it like to render care to an OAMID?

2. How does the nurse perceive the maternal-infant relationship when caring for the OAMID?

3. What expectations does the nurse have of the opioid-addicted mother and her interaction with her infant?

4. Are there any personal challenges that may influence the nurse when caring for the OAMID?

5. What can be learned from the experience of the nurse caring for the OAMID?

6. Does the interaction between the nurse and the opioid addicted mother have any influence the mother’s ability to care for her infant?

7. What educational preparation is needed in order to care for the OAMID?