The Experiences of Nurses Engaging in Therapeutic Relationships with Mothers of Newborns Diagnosed with Neonatal Abstinence Syndrome

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Preface

Ethical Approval Obtained to Conduct Research

I received ethical approval from both the University of Ottawa Research Ethics Board (Appendix A) as well as the Research Ethics Board of the Acute Care Hospital where this research was conducted (Appendix B)

Statement of Contributions and Co-Authorship

Multiple authors contributed to this thesis and were co-authors for the manuscript in Chapter 3. I have outlined the contributions of each author below.

1. Brett Aston RN, BScN

   Master of Science in Nursing Candidate, School of Nursing, Faculty of Health Sciences.

   This research was completed for my master's thesis. I conceived and conducted the research design, literature review, and data analysis using Interpretive Description. I wrote and revised all chapters within this thesis and am the primary author of the manuscript in Chapter 3.

2. Wendy Peterson RN, PhD

   Associate Professor, School of Nursing, Faculty of Health Sciences, University of Ottawa

   Dr. Wendy Peterson, my thesis supervisor, provided ongoing support and feedback throughout the conception and completion of this research. She helped identify the research question and purpose. Additionally, she contributed to the research design, literature review, and data-analysis, and critically revised every draft of each chapter.

3. Brandi Vanderspank-Wright RN, PhD

   Associate Professor, School of Nursing, Faculty of Health Sciences, University of Ottawa

Dr. Brandi Vanderspank-Wright, a thesis committee member, offered experienced guidance in the research design and ethics proposal. She also provided input within the data analysis, and she critically revised every chapter of this manuscript.

4. Christina Cantin RN, MScN

   Perinatal Coordinator, Champlain Maternal Newborn Regional Program

   Thesis committee member, Christina Cantin, provided a wealth of resources and references used throughout this manuscript. She also offered input and feedback within the research design and data analysis, in addition to critically revising chapters 1, 3, & 4.

Abstract

The therapeutic nurse-client relationship is at the core of nursing practice and is meant to benefit the health and wellbeing of clients (CNA, 2017; CNO, 2006; RNAO 2002). Mothers of newborns diagnosed with neonatal abstinence syndrome (NAS), however, have reported negative relationships with their newborns' nurses (Cleveland & Gill, 2013; Cleveland & Bonugli, 2014). Likewise, neonatal nurses have also discussed their challenges working with this population of mothers (Demirci et al., 2015; Murphy-Oikonen et al., 2010; Raeside, 2003; Romisher et al., 2018). The purpose of this study was to explore neonatal nurses' experiences of engaging in therapeutic relationships with mothers of newborns diagnosed with NAS. This qualitative study follows the methods of interpretive description (Thorne, 2016). Eligible participants were recruited using purposeful and convenience sampling. Data was collected by semi-structured telephone interviews. Interviews were audio-recorded and transcribed verbatim, and a thematic analysis was conducted following Thorne's (2016) alternative sorting technique. Two major themes were identified by researchers. The first theme, *building the relationship*, is broken down into subthemes *assessing the mother and choosing an approach, caring for and involving the mother*, *making a connection*, and *getting to know mom and her needs*. The second theme, *the competing pressures of working with NAS*, is further categorized into the subthemes *working with baby and mother, collaborating with the Children's Aid Society,* and *struggling with stigma*. The findings from this study have implications for nursing practice, education, policy, and research that promotes the success of establishing therapeutic relationships with mothers of newborns diagnosed with NAS.

Glossary

Neonatal intensive care unit: A level III newborn care facility. This unit can care for any gestational age or weight. This unit has ongoing access to a comprehensive range of subspecialty consultants.*

Special care nursery: A level II newborn care facility. This unit can care for newborns with a gestational age greater than or equal to 30 weeks and a birth weight greater than 1200 grams. Newborns may be moderately ill, but their conditions are expected to resolve within a week or they are recovering from intensive care.*

Neonatal nurses: Nurses that practice in a special care nursery or neonatal intensive care unit.

Children's Aid Society: The child protection service organization in Ontario, Canada. This organization is governed by the *Child, Youth, and Family Services Act, 2017*.

*Provincial Council for Maternal and Child Health (2013). *Standardized Maternal and Newborn Levels of Care Definitions*. https://www.pcmch.on.ca/wp-content/uploads/2015/07/Level-of-Care-Guidelines-2011-Updated-August1-20131.pdf

Acknowledgement

First and foremost, I would like to thank Dr. Wendy Peterson, my thesis supervisor, for her guidance throughout this entire process. Two years ago, I came to her with a nursing problem that I was passionate about, and she helped me create a study to try and combat it. I never thought I could do something like this, but Dr. Wendy Peterson made it possible. I am so grateful that I had the opportunity to work with someone so supportive, and someone who really believed in my academic potential.

Thank you to both Christina Cantin and Dr. Brandi Vanderspank-Wright, my thesis committee members. I felt like their strengths and expertise perfectly complimented our research team. Christina Cantin's experience with mothers of newborns diagnosed with NAS was invaluable. She helped assure the use of appropriate terminology and offered many great resources that truly benefitted this thesis. Dr. Brandi Vanderspank-Wright's familiarity with qualitative research in acute hospital settings and research on therapeutic relationships significantly supported the design and data analysis of this study. The positive guidance from Christina Cantin and Dr. Brandi Vanderspank-Wright empowered me throughout this thesis experience.

I would also like to thank the nurses who participated in this study. As a novice researcher, I was very nervous to interview them. However, each participant quickly made the conversations feel easy and offered rich narratives of their experiences. Their contributions to this study are what truly brought it to life.

To my family and friends, thank you. My parents, Diana and John, continuously reminded me of how proud they are of me throughout all the ups and downs of creating this manuscript. My older brother, Luke, you have always been my greatest role-model and

inspiration. To my partner, Aaron, thank you for being by my side since day one – I am truly grateful for all of your support and belief in me. To Jesse, my oldest friend, thank you for talking me through every bump in the road and cheering for me with every little accomplishment. I am extremely lucky to have every one of you in my life. Thank you.

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Chapter 1: Introduction

Both prescribed and illicit substance use has become a problem in Canadian populations (Fischer et al., 2014; Hadland & Kertesz, 2018). Opioids, specifically, contribute to the hospitalization of 16 Canadians a day (Belzak & Halverson, 2018). In a 2009 survey, approximately 7% of Canadian women reported using illicit substances within the three months prior to becoming pregnant; 1% of women reported using illicit substances during pregnancy which corresponds to approximately 3,836 women (O'Campo & Johnston, 2009; Statistics Canada, 2019). These data were self-reported, therefore it is likely that substance use before and during pregnancy was underreported due to the associated stigma (O'Campo & Johnston, 2009). The rate of illicit substance use continues to increase in Canada (Belzak & Halverson, 2018).

Substance use during pregnancy has been reported to be associated with negative short- and long-term outcomes for the fetus, and the mother. Examples of short-term outcomes include intrauterine growth restriction, premature birth, spontaneous abortion, and structural abnormalities (Bailey & Diaz-Barbosa, 2018; Ordean et al., 2017; Ordean, Wong, & Graves, 2017). Furthermore, cognitive and behavioural impairment are examples of long-term outcomes, as they may be observed in children who had in-utero substance exposure (Bailey & Diaz-Barbosa, 2018; Ordean et al., 2017; Ordean, Wong, & Graves, 2017). Therefore, substance use during pregnancy can cause poor obstetrical, neonatal and developmental outcomes.

Neonatal abstinence syndrome (NAS) is the manifestation of substance withdrawal in the newborn infant (Dow et al., 2012). In Canada, the prevalence of NAS has consistently risen over the last fifteen years – corresponding to the rate of opioid use by pregnant women (Brogely et al., Dow et al., 2012; Vogel, 2018). Newborns become at-risk of experiencing NAS when exposed to substances in-utero (Dow et al., 2012). There remains a gap in the literature on the correlation

between the type and amount of substance exposure and the severity of NAS (McQueen et al., 2015). Opioids and/or methadone exposure is most frequently associated with NAS, however, other substances such as barbiturates, benzodiazepines, and selective serotonin reuptake inhibitors can also contribute to signs of NAS after in-utero exposure (McQueen et al., 2015).

In up to 75% of newborns exposed to opioids in-utero, a physiological dependence on the substances and withdrawal symptoms result once the infant is born and they are no longer in contact with the substance (Dow et al., 2012; PCMCH, 2016; Vogel, 2018). Various signs and symptoms of NAS occur within 48-120 hours after birth, including but not limited to; increased tone, high-pitched cry, poor feeding, tremors, seizures, and abnormal sleeping patterns (Dow et al., 2012). Approximately 50% of symptomatic newborns require pharmacological treatment (Ordean et al., 2015). Between the years 2016 and 2017, it was estimated that 0.51% of all newborns born in Canada, excluding Quebec, were diagnosed with NAS – approximately 1850 newborns a year (Lacaze-Masmonteil & O'Flaherty, 2018).

In Canada, most of newborns exhibiting symptoms of NAS receive care in a neonatal intensive care unit (NICU) or special care nursery (SCN; Marcellus et al., 2015), in accordance with current clinical practice guidelines recommending newborns exhibiting symptoms of NAS be admitted into a NICU or SCN for continuous cardio-respiratory monitoring when pharmacological treatment is started (PCMCH, 2016).

Recently, the Canadian Paediatric Society (CPS) suggested that newborns remain with their mothers, rather than be admitted to an NICU, when the newborn is "term or near term, medically stable, and adequate resources are in place to support both the family and [health care providers]" (Lacaze-Masmonteil & O'Flaherty, 2018, p. 222). However, this may not be widely practiced yet. A 2018 survey distributed to physicians across Canada indicated that

approximately 51.7% of newborns diagnosed with NAS were still admitted into an NICU or SCN (Puvitharan et al., 2019).

Research Problem and Relevance to Nursing

According to the College of Nurses of Ontario (CNO), Registered Nurses Association of Ontario (RNAO), and the Canadian Nurses Association (CNA), the therapeutic nurse-client relationship is at the core of nursing practice and is meant to benefit the health and wellbeing of clients (CNA, 2017; CNO, 2019; RNAO 2002). Client-centered care, a component of this relationship, involves the nurse assuring that the client is involved in their own care and the therapeutic needs of the client are being met. Part of achieving client-centered care involves acknowledging biases and observing how these feelings can affect the nurse-client relationship (CNO, 2019). When an infant is admitted into a NICU or SCN for monitoring and/or treatement of NAS, both the infant and their family are cared for by an interdisciplinary team, which includes direct nursing care. Nurses work closely with parents and the rest of the health care team to create an optimal environment for the benefit of both the infant's and parents' health and wellbeing.

Studies of mothers of newborns diagnosed with NAS have revealed that these mothers feel negatively judged by nurses (Cleveland & Gill, 2012; Cleveland & Bonugli, 2014). Negative attitudes towards mothers of newborns diagnosed with NAS can seriously impede the development of therapeutic nurse-patient relationships. This is a significant nursing problem, as the poor therapeutic relationships formed between mothers of newborns diagnosed with NAS and neonatal nurses can create a barrier for various health promoting behaviours that contribute to mother-infant bonding and benefits both the mother and infant (Cleveland & Gill, 2013). For example, impaired mother-infant bonding has been associated with postpartum depression

(Lehnig et al., 2019). Likewise, newborns respond well to their mothers' presence – for newborns diagnosed with NAS, maternal involvement in care has been proven to shorten newborns' duration of pharmacological therapy and length of stay in the NICU (Hünseler, Brückle, Kribs, & Roth, 2013). In the long-term, a secure attachment relationship with a parent minimizes a child's health risk behaviours and later disease (Williams, Biscaro, & Clinton, 2019). Adverse childhood experiences – such as substance use, mental illness, and abuse within the household – increases children's future risk for substance use, alcohol misuse, mental illness, severe obesity, and other health risk factors and disease conditions that frequently cause death in adults (Felitti et al., 1998). Therefore, NICU health care providers have an important opportunity to facilitate bonding and attachment between mothers and their newborns. However, it has been reported that health care providers' negative attitudes produce a reluctance among pregnant women and mothers to work with health care teams (Finnegan, 2013; Peterson et al., 2007); mothers have avoided visiting their newborns in the NICU because of their negative experiences with staff (Cleveland & Bonugli, 2014). This nursing problem needs to be addressed as the negative health care experiences of mothers of newborns diagnosed with NAS is understood to act as a barrier to both the infant and mother's health and wellbeing.

There are nurses who are successful at forming therapeutic relationships with mothers perceived by other nurses as being more challenging to work with. Nurses identified by colleagues as experts in caring for adolescent mothers emphasized the importance of forming a connection to create a therapeutic relationship, as this helped the nurses assess the mothers more holistically and to better meet their individual care needs (Quosdorf et al., 2020). In a qualitative study by Cleveland and Bonugli (2014), several mothers of newborns diagnosed with NAS described having good relationships with their newborns' nurses and greater overall experiences

during their time in the hospital. One mother even continued to visit the nurses at NICU reunions (Cleveland & Bonugli, 2014).

Thesis Objective

Further research is needed to establish a more thorough understanding of how some neonatal nurses are skilled in forming therapeutic relationships with mothers of newborns diagnosed with NAS, as well as what nurses believe facilitates the establishment of therapeutic relationships with this marginalized population of mothers. The aim of this study is to explore neonatal nurses' experiences of engaging in therapeutic relationships with mothers of newborns with NAS, and answer the research question, "how do neonatal nurses form therapeutic relationships with mothers of newborns with NAS?". My hope is the findings of this research will stimulate self-reflection among nurses who find caring for mothers of newborns with NAS challenging, and potentially inform the design of interventions to improve therapeutic relationships in nursing practice.

Thesis Layout

This thesis follows a thesis-by-article format and is made up of four chapters. In this first introductory chapter, I have briefly described the research problem and its relevance to nursing, and defined my thesis objectives. Throughout the remainder of this chapter, I will expand on both the methodology and research design of this qualitative study.

The second chapter is a literature review that explores relevant research relating to the nursing problem. To better understand the relationship between mothers of newborns diagnosed with NAS and neonatal nurses, I describe the experiences of both the mothers and nurses within the context of caring for newborns with NAS. This chapter will reinforce the importance of

continued research on the therapeutic relationships between mothers of infant's diagnosed with NAS and neonatal nurses.

The findings from the interpretive description study make up the third chapter. Neonatal nurses' experiences in engaging in therapeutic relationships with mothers of newborns with NAS are described, and I answer the research question, "how do neonatal nurses form therapeutic relationships with mothers of newborns with NAS?". This manuscript has been prepared to be submitted for publication in *Qualitative Health Research*.

The fourth and final chapter of this thesis is a discussion of the study findings. My interpretive description is compared to current literature, and future implications for nursing research, theory, education, practice, and policy are discussed.

Methodology

Critical theory, as a research paradigm, is focused around challenging societal norms and power imbalances (Weaver & Olsen, 2006). Within nursing, critical theory allows us to use emancipatory knowledge to discover dominating groups and expose other pragmatic realities (Mill, Allen, & Morrow, 2001; Weaver & Olsen, 2006). Ontologically, the critical theorist often believes that one true reality exists, however, the way one views this reality varies depending on context and circumstance; therefore, the true objective reality can never be defined with absolution (Mill, Allen, & Morrow, 2001). Epistemology in critical theory is deeply connected with the ontology of the researcher (Guba & Lincoln, 1994), whereby the values and beliefs of the inquirer influences the preparation, collection, and interpretation of the research (Campbell & Wasco, 2000). Critical theorist researchers are unable to distinguish an objective reality; therefore, they often work interactively with their research subjects to expose the assumed reality within the given context and circumstance (Guba & Lincoln, 1994). Critical theory fits well with

my thesis; I aim to explore the power imbalance between mothers of newborns diagnosed with NAS and nurses through the therapeutic relationships formed, while simultaneously challenging this reality by seeking out ways to improve upon these relationships.

Research Design

For this study, I used Interpretive Description (ID) (Thorne, 2016) methods within the lens of critical theory. I chose Thorne's method because it promotes both auditable and logical qualitative research whilst allowing researchers to mold their design techniques to best fit their discipline and answer their research question (Thorne, 2016). Although ID is often used within constructivist research, Thorne's method allows for shared realities and can be "applied to qualitative inquiry into human health and illness experiences for the purpose of developing nursing knowledge" (Thorne et al., 1997, p.173). ID provides guidance for analytic frameworks, sample selection, data sources, data analysis, and rigour to promote the development of credible nursing knowledge with clinical applications (Thorne et al., 1997). ID is d. Integrity of purpose is required for the ID approach; this is derived from "an actual real-world question, an understanding of what we do and don't know on the basis of all available empirical evidence, and an appreciation for the conceptual and contextual realm within which a target audience is positioned to receive the answer we generate" (Thorne, 2016, p.40). My research was congruent with Thorne's (2016) ID approach, as my study was organized around the nursing discipline, my own disciplinary practice, and my understanding of the problem were derived from both real world and empirical evidence.

Reflexivity and Rigour

In order to create a high-quality interpretive description, it is important for the researcher to engage in reflexivity (Thorne, 2016). Reflexivity occurs when one questions their own

personal values and assumptions (Timmins, 2006). Thorne (2016) explains that it is important for researchers to reflect on and acknowledge any factors that may have influenced their research process. Procedures for enhancing rigour also aid in the process of reflection, as they provide a strategy for researchers to account for the conclusions made while maintaining focus on the purpose of their research throughout the evolving processes of data collection and analysis (Thorne, 2016). Throughout this section, I will first depict how I came to my research question and design. I will also describe the expertise of my thesis committee, as they helped guide me throughout the research process. Lastly, I will explain how and why I followed Lincoln and Guba's (1986) criteria of trustworthiness to increase rigour throughout my study.

I have been a registered nurse (RN) since February 2016. My first position in a hospital setting was a level 3b NICU in Southwestern Ontario. Substance use was an evident problem in this region, as I frequently cared for newborns diagnosed with NAS during my time at this NICU. Being a new nurse, I would often look to my more experienced colleagues for advice. I asked them about their experiences working with newborns diagnosed with NAS and their families, and quickly noticed there were mixed feelings regarding mothers of newborns diagnosed with NAS.

One colleague told me a positive story where she cared for a newborn with NAS and the newborn's mother. The newborn had been apprehended by the Children's Aid Society (CAS), however, the nurse continued to care for the newborn and the mother, and together, they worked on getting the baby back into the mother's custody. The nurse talked amiably about this mother and how the experience helped her see that not all situations involving NAS are negative.

In contrast, I often heard colleagues talk poorly about mothers of newborns with NAS. They would talk about how the mothers would come in 'high' or behave erratically, and how

difficult they were to work with. One time I was discussing methadone treatment with another nurse, she stated, “methadone is just another drug they add to their cocktail”; insinuating that methadone was used to get high concurrently with illicit substances.

The different perspectives NICU nurses held regarding mothers of newborns with NAS surprised me. I soon became very interested in the relationship between nurses and mothers of newborns diagnosed with NAS. During the first year of my master’s degree, my course professors and thesis supervisor, Wendy Peterson (WP) helped me define my research question and shape my research design; enabling me to further understand and explore this topic.

At the end of my first year, WP assisted me in constructing my thesis committee. My committee was made up of two additional members, Christina Cantin (CC) and Brandi Vanderspank-Wright (BVW). Together, these three individuals have a breadth of expertise that greatly supported my endeavor to answer my research question. WP, Associate Professor with the School of Nursing, University of Ottawa, has NICU clinical experience, expertise in qualitative methods and a program of research that focuses on improving maternal-newborn care for marginalized mothers. CC, a perinatal coordinator with the Champlain Maternal Newborn Regional Program, also has expertise in maternal-newborn care in addition to a depth of knowledge about research and resources dedicated to marginalized mothers. BVW, Associate Professor with the School of Nursing, University of Ottawa, has qualitative research experience in critical care hospital settings in addition to research on establishing therapeutic relationships. The expertise of my thesis supervisor and committee members helped guide me through the process of conducting my research and completing my thesis.

I continued to maintain reflexivity throughout the process of conducting my research in order to enhance rigour. The strategy I followed was Lincoln and Guba’s (1986) criteria of

trustworthiness. Trustworthiness is analogous to rigour; it is a way in which researchers can demonstrate both themselves and readers that their findings are significant (Lincoln & Guba, 1986; Nowell et al., 2017). I chose to follow Lincoln and Guba's criteria of trustworthiness, as it aligns with my ontology and epistemology as a researcher; reality is influenced by both time and context and cannot be studied individually, only holistically (Lincoln & Guba; 1986). The criteria of trustworthiness is made up of credibility, transferability, dependability, and confirmability.

Credibility is how believable the findings are; co-researchers and readers should be able to recognize the experiences they are confronted with (Nowell et al., 2017). To enhance credibility, Lincoln and Guba (1986) recommend prolonged engagement and persistent observation. As an RN with several years of NICU experience, I have had prolonged and persistent contact with newborns diagnosed with NAS, their mothers, and nurses who have cared for them. I was mindful of the contextual components within my data collection, enabling me to establish believable and recognizable findings. *Transferability* refers to how well research findings can be applied to other populations (Nowell et al., 2017). To help readers identify the transferability of my findings, I offer a thorough description of the context in which my data was collected. *Dependability* indicates how consistent a study's findings would be if another researcher were to repeat the same study; therefore, the research process should be logical and well documented (Nowell et al., 2017). For greater dependability, I set up an audit trail. The audit trail describes everything I did within both my data collection and analysis. I kept minutes of the meetings held and noted the decisions made with my thesis committee. Lastly, *confirmability* refers to how well the researcher's interpretation of the data reflects the information provided by participants (Nowell et al., 2017). To enhance the confirmability of my

research, direct quotations from participants were used to describe my findings. I understand that my personal experiences with my research phenomena as an NICU nurse may have influenced how I perceived the data. Therefore, I continuously reflected on my own beliefs and potential biases in field notes throughout data collection and a journal throughout data analyses – demonstrating how conclusions and interpretations were made. Together, the credibility, transferability, dependability, and confirmability were continuously considered and enhance the trustworthiness of my study in accordance to Lincoln and Guba's (1986) criteria. By practicing reflexivity and acknowledging influential factors throughout my research, I have produced a high-quality interpretive description and rigourous qualitative study.

Ethics

Ethical approval was obtained from both the Health Sciences Research Ethics Board at the University of Ottawa (Appendix A) and the Research Ethics Board affiliated with the hospital where participants were recruited from (Appendix B). Participants were assured that their participation would not impact their current employment, and informed consent was obtained from each participant prior to data collection (Appendix C). I ensured time was allotted after interviews to discuss participant's emotional wellbeing in an effort to maintain an awareness that this sensitive topic had the potential of surfacing emotionally distressing information. The interview recordings were stored on a password protected computer and the consent forms obtained from participants were stored in a locked file cabinet in Wendy Peterson's (WP) locked office at the School of Nursing (Room 1118, Roger Guindon Hall). The transcripts and demographic information were de-identified; participants were assigned unique pseudonyms to maintain confidentiality. The members of my thesis committee had access to the

de-identified transcripts and demographic information; this information was kept on password protected laptops and WP's office computer.

Setting

Participants were sampled from a SCN in a large acute care hospital in Ontario. The hospital supports a NICU and a SCN. The NICU specializes in caring for extremely premature newborns or term newborns with significant health problems. The newborn population in the SCN includes those who are born moderately premature, have been transferred from the NICU, or are full term with health problems. There are 17 beds and approximately 50 RNs currently employed in this SCN. Both units care for newborns diagnosed with NAS; the unit the newborn goes to depends on the severity of symptoms, coexisting morbidities, and gestational age. While caring for newborns diagnosed with NAS is within the scope of practice for nurses at each site, I chose to recruit nurses from the SCN because I am currently employed as a RN in the NICU at this hospital. My decision to recruit outside of my unit of employment ensured there were no perceived conflicts of interest and limited concerns regarding participants' willingness to participate and their level of comfort in telling me their stories.

Sampling

ID does not specify how participants are to be sampled, however, there must be thought and logic behind the sampling strategies used. The findings are reflective only to those with likeness to the sample (Thorne, 2016). With that being said, I used convenience and purposeful sampling techniques to contact participants eligible for the study.

One of the SCN's clinical educators acted as a gatekeeper. The clinical educator emailed staff members an invitation to participate in the study (Appendix D), as well as a follow-up invitation reminder two weeks later (Appendix E). In addition, posters were displayed (Appendix

F) in the nurses' break rooms and staff bathrooms; a similar recruitment strategy was implemented successfully by Maguire et al. (2012).

Interview times were dependent on what was most convenient to the participants outside of their work schedule. Interviews were conducted by telephone instead of face-to-face due to the COVID-19 pandemic and the subsequent obligation to socially distance oneself from persons outside of your household. Although visual cues, or body language, is absent during telephone interviews, researchers who have used this interviewing method have described their participants as being more relaxed and willing to share intimate information (Novick, 2008). Interviewing by telephone has successfully been used before in an interpretive descriptive study where the experiences of nurses were analyzed (Stevenson et al., 2015).

Further sampling was completed using snowball sampling; a technique where the researcher asks participants to refer other potential participants (Polit & Beck, 2021). After interviewing participants, I asked them to tell their colleagues about the study and how to contact me. I assured participants that they did not need to do this if they did not feel comfortable doing so. Snowball sampling allowed me to be contacted by nurses who could provide more insight for my research objectives.

Purposeful sampling was implemented in Maguire et al.'s (2012) as well as Fraser et al.'s (2007) research studies that focused on a similar demographic and nursing problem. Through the use of purposeful sampling, these researchers were able to contact participants meeting their eligibility criteria. Maguire et al.'s (2012) continued to sample throughout their analysis using snowball sampling to ensure contact with nurses that had experienced their phenomena of interest. I used a similar approach. Throughout data collection and analysis, I reflected on the variability of the study participants. When more variation was desired, I asked the clinical

educator to reach out to other potential participants. These strategies enabled me to continue to recruit until I reached a sample size with enough variability for an interpretive description.

Previous qualitative studies focused on nurses' experiences in caring for newborns diagnosed with NAS obtained sample sizes of 14, 16, and 32 participants (Fraser et al., 2007; Maguire et al., 2012; Murphy-Oikonen et al., 2010). Fraser et al's (2007) sample of 32 participants, however, was obtained from four different sites. Additionally, these qualitative studies were part of a phenomenological exploratory design. Research following the ID design can be of any sample size (Thorne, 2016). Other published Canadian ID studies where nurses have been interviewed used sample sizes of six to 11 (Forozeiya et al., 2019; Hogan et al., 2016; Gibson et al., 2013). Therefore, I estimated that a sample size of approximately 6-11 nurses would be sufficient for my research. Table 1 represents the eligibility criteria along with the reasoning behind the inclusion and exclusion of specific participants.

Table 1:

Inclusion Criteria	Reasoning
Must be an RN currently working in the SCN at [redacted]	The purpose and objectives of this study can only be answered by the nurse's perspective. Newborns diagnosed with NAS are cared for by nurses in SCNs or NICUs. Nurses from other units would be less likely to provide current and sufficient insight. Additionally, only registered nurses, not registered practical nurses, are currently employed at the SCN.
Participant has provided direct nursing care for a newborn diagnosed with NAS and their mother within the last two years	The purpose and objectives of this study can only be answered by participants who have had this clinical experience. Nursing research and practice is also continually changing. Therefore, I aimed to recruit participants who had cared for a newborn diagnosed with NAS within the last two years, as their experiences may better reflect the current reality of caring for this population. Additionally, there are nurses in SCNs and NICUs who work in different roles other than providing direct care (i.e. clinical nurse educator). My research is exploring the relationship between a nurse directly caring for a newborn diagnosed with NAS and the mother of said newborn.

Data Collection

Data were collected through semi-structured, telephone interviews to gain direct and first-hand insight into the phenomenon of interest. Interviews lasted between 45 and 60 minutes. An interview guide was prepared in advance to ensure specific ideas of interest were covered (Appendix G). The guide was adjusted throughout the data collection process, as potential themes emerged throughout the interviewing process that required further exploration. The guide included seven demographic questions and approximately five open-ended questions focusing on the objectives of my research. Participants were given a $20 eGift card to Amazon.ca in appreciation for their time.

Individually interviewing participants is supported by the methods of interpretive description, however, contextual factors that may have influenced my findings need to be acknowledged (Thorne, 2016). For example, the strengths and limitations of using telephone interviews instead of face-to-face interviews. The demographic information I obtained prior to the interviews were reflected upon throughout the data analysis. I was aware that the topic of my research may have been perceived as distressing or of a sensitive nature to participants. In addition, I made field notes of any other contextual factors that arose throughout my data collection, as this information could have influenced my findings.

Data Analysis

Interviews were audio-recorded and transcribed verbatim following each interview. I completed a thematic analysis using an alternative sorting technique (Thorne, 2016). To begin my analysis, I immersed myself in the data by reading through each transcript at least twice. I then re-read the transcripts and wrote notes in the margins and highlighted quotes I felt may be important (Thorne, 2016). Once I picked out all of the information with perceived importance, I

organized and reorganized this information into various categories in an attempt to find relationships between the different data. I then reviewed the categories to seek out the embedded themes and assess how these themes related to one another as a whole. During the data analysis, WP and I met once a week to discuss our findings and ideas while considering the field notes made during data collection. This alternative sorting technique is congruent with the interpretive description design, as it is "less formalized and more creative than conventional coding systems" and allows for a more evolving analytic thought process (Thorne, 2016, p.161).

I took the lead role in the data analysis, however, WP independently analyzed two of the transcripts and Brandi Vanderspank-Wright (BVW) and Christina Cantin (CC) individually analyzed one transcript each. We then set up a time for all members of the thesis committee to meet and discuss our findings. All of my committee's and my own chosen quotations and categorizations were compared. The similarities and differences across the four analyses were reviewed until we arrived at consensus on the final themes.

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Chapter 2: Literature Review

Introduction

The purpose of this literature review is to synthesize the recent evidence on the experiences of mothers of newborns diagnosed with NAS and the experiences of nurses who care for both these mothers and their newborns. To provide background on this topic, I will describe the prevalence of NAS and the current treatment of this diagnosis in Canada. The nurse-client therapeutic relationships will also be described, and I will discuss its relevance within nursing theory and research. With this review, I hope to accomplish a better understanding of the experiences of mothers of newborns diagnosed with NAS within therapeutic relationships with neonatal nurses. To try to achieve this, I will be defining substance related disorders and discussing substance use and its relation to trauma. Mothers with a history of substance use frequently have socially complex backgrounds connected with trauma (Marcellus, 2014). Finally, I will review the existing evidence regarding the lived experiences of both sides of this relationship within the NICU to facilitate a more comprehensive understanding of the barriers and facilitators in forming therapeutic relationships between mothers of newborns with NAS and their nurses and inspire implications for future nursing practice and research.

Neonatal Abstinence Syndrome

Neonatal abstinence syndrome is the manifestation of substance withdrawal in the newborn infant, after they have been exposed to withdrawal-inducing substances in-utero (Dow et al., 2012). Over the last fifteen years, the rates of NAS in Canada have consistently increased (Dow et al., 2012; Vogel, 2018). Between the years 2006 to 2016, the rate of NAS in Canadian singleton newborns increased from 2.01 to 5.12 per 1000 live births (Lisonkova et al., 2019).

There remains a gap in the literature regarding how the type and amount of substance exposure affects the severity of NAS (McQueen et al., 2015).

The majority of newborns exhibiting symptoms of NAS are cared for in neonatal intensive care units (NICU) or special care nurseries (SCN), depending on the hospital's practices and resources (Lacaze-Masmonteil & O'Flaherty, 2018; Marcellus, Loutit, & Cross, 2015; Ordean et al., 2015). Current clinical practice guidelines by the PCMCH (2016) recommend newborns at risk of developing NAS are assessed for symptoms using a standardized NAS scoring tool, such as the Modified Finnegan's Neonatal Abstinence Scoring Tool (Appendix H), every 2-4 hours. Newborns with three consecutive scores equal to or greater than eight or two consecutive scores averaging 12 or greater initiate pharmacological treatment (PCMCH, 2016). Morphine, an opioid, is a pain relief medication and the first line of pharmacological treatment, as it helps alleviate symptoms of NAS; however, some newborns may also need additional sedatives, such as clonidine or phenobarbital. Pharmacological treatment is then gradually weaned. Depending on the newborn's stability and presence of any social risks that create concern for the newborn's safety, the weaning process can be completed either in hospital or at home (PCMCH, 2016).

The Therapeutic Nurse-Client Relationship

When an infant is admitted into a NICU or SCN for NAS, both the infant and their family are cared for by an interdisciplinary team, which includes specialized nursing care. Central to nursing care is the therapeutic nurse-client relationship (CNO, 2019). Nurses form therapeutic relationships with their clients in order to effectively promote the client's overall health and well-being (CNO, 2019). According to the CNO (2019), the therapeutic nurse-client relationship is

"based on trust, respect, empathy and professional intimacy, and requires appropriate use of the power inherent in the care provider's role" (p.3).

Nursing theory and research have established the essential nature of the nurse-client relationship to expert nursing practice. The therapeutic relationship is key to many nursing theories (Bergum & Dossetor, 2005; Patterson & Zderad, 2007; Peplau, 1991). Nursing theorist Hildegard Peplau (1991) created a framework for interpersonal relationships in nursing that is described in four phases: orientation, identification, exploitation, and resolution. In the orientation phase, the nurse and the client start as strangers and come into the relationship with preconceived expectations derived by previous experiences. This phase involves building trust and clarifying expectations within the relationship. Listening to and accepting the client is important for the nurse to establish the relationship. During the identification phase, the nurse and the client begin to align their goals. The nurse further assists the client in identifying concerns and making plans to address them. In the exploitation phase, they work towards meeting the goals set in the identification phase. The nurse also helps explore the thoughts, feelings, and behaviours of the client, and continually assesses the relationship. Lastly, the resolution phase is the termination of the relationship once the client's concerns have been addressed (Peplau, 1991).

Peplau's framework of interpersonal relations (1991) has been evident in research on various patient groups, such as women who suffer from antepartum depression, low-income single mothers, and mental health care recipients (Evans et al., 2017; Porr, Drummond, & Olson, 2012; Shattell, Starr, & Thomas, 2007). Evans and colleagues (2017) examined nursing telephone support services for antepartum mothers. Peplau's framework was used to guide their study, and they found that four of the components of the interpersonal relationship were evident

throughout the telephone interactions. The mothers who suffered from antepartum depression had improvements in their mental health after receiving this nursing telephone support (Evans et al., 2017).

Porr and colleagues (2012) examined how public health nurses develop therapeutic relationships with single mothers living in low-income circumstances in a Canadian grounded theory study. Porr and colleagues (2012) discuss the likeness of their findings to Peplau's interpersonal relations theory (1991). Public health nurses were mindful and accepting of the single mothers, and the nurses focused on gaining the mothers' trust in order to build therapeutic relationships.

Peplau's interpersonal relations theory also supported the theoretical background in an American qualitative phenomenological study where mental health care recipients shared their experiences of therapeutic relationships with various health care professionals (Shattell et al., 2007). Although Shattell and colleagues (2007) do not discuss the likeness of their findings to Peplau's theory (1991), the parallels remain interpretable. The participants expressed the importance of trust and acceptance. Furthermore, clarifying thoughts, feelings, and behaviours, as well as exploring solutions to the participants' problems were viewed as important to the therapeutic relationship (Shattell et al., 2007). One participant in the study explains, "it's incredibly beneficial to have somebody in health care that can take out the time individually, and understand what you're going through, and see what they can do to help you on a one-on-one basis […]" (p.281, Shattell et al., 2007).

Looking more broadly at the empirical evidence examining the importance of therapeutic relationships, a systematic review and meta-analysis of randomized control trials examined the health impacts of patient-clinician relationships (Kelley et al., 2014). A total of thirteen

randomized control trials were included in the study. The randomized control trials focused on a breadth of patient groups, such as those with obesity, asthma, hypertension, and osteoarthritis. Interventions used to alter the patient-clinician relationships also varied; examples include improving communication skills, implementing shared decision making, and promoting patient-centred care. The authors concluded that patient-clinician relationships have a small, but statistically significant, impact on health outcomes such as weight, quality of life, blood pressure, and pain relief (Kelley et al., 2014).

It is clear from the theoretical and empirical literature that therapeutic relationships can facilitate improved health outcomes. Throughout the literature, however, mothers of newborns diagnosed with NAS have reported negative experiences working with neonatal nurses (Cleveland & Gill, 2013; Cleveland & Bonugli, 2014; Demirci et al., 2015) and nurses have reported having negative experiences and/or attitudes with regards to working with mothers of newborns diagnosed with NAS (Raeside, 2003; Murphy-Oikonen et al., 2010; Romisher et al., 2018). These negative experiences and/or attitudes are barriers to the development of therapeutic relationships between mothers of newborns diagnosed with NAS and nurses.

Substance-Related Disorders

The *Diagnostic and Statistical Manual: Fifth Edition*'s (*DSM-V*) chapter on substance-related disorders is divided into two categories, substance use disorders and substance-induced disorders. Substance use disorder is described as "a cluster of cognitive, behavioural, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems" (American Psychiatric Association, 2013, p.483). One of the key characteristics of substance use disorder is a change in the brain circuits; the changes may be exhibited by repetitive relapsing and intense substance craving (American Psychiatric

Association, 2013). There are 10 separate classes of drugs relating to substance use disorders; a few examples include alcohol, cannabis, opioids, and stimulants. However, any substance that is used in excess and directly activates the brain reward system, can influence the development of a substance use disorder (American Psychiatric Association, 2013). Substance-induced disorders include intoxication, withdrawal, and substance-induced mental disorders. Substance-induced mental disorders are acute or chronic central nervous system syndromes that develop from substance use; for example, substance-induced depressive, anxiety, and psychotic disorders (American Psychiatric Association, 2013). NAS, the withdrawal from substances in neonates, is an example of a substance-induced disorder.

Substance Use and Trauma

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), the concept of trauma is defined as, "an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being (SAMHSA, 2014, p.7). Traumatic events, such as adverse childhood experiences, intimate partner violence (IPV), and sexual assault are frequently reported by women who use and/or misuse substances (Edwards et al., 2017; Finnegan, 2013; Wiig et al., 2017). The nurse and the client have preconceptions and expectations of their therapeutic relationship based on previous experiences (Peplau, 1991); therefore, previous traumatic events experienced by women who use and/or misuse substances may influence their expectations of the nurse-client therapeutic relationship. Recognizing the existence of potential trauma in women with substance use disorders may assist nurses in establishing therapeutic relationships with this population.

Within Canada, there are high rates of adverse childhood events, such as physical and sexual abuse and neglect, reported by women who use substances (Finnegan 2013). Many women with substance use disorders have discussed being raised by parents with substance-related disorders (Edwards et al., 2017; Wiig et al., 2017). A Norwegian phenomenological study explored how mothers recovering from substance use described their childhood experiences with parents with substance-related disorders (Wiig et al., 2017). The mothers shared stories filled with violence and neglect. Some described how they found their parents unconscious from over-doses. They further explained how they used substances to cope with the memories of these traumatic experiences (Wiig et al., 2017).

In a qualitative study focused on the lived experiences of women recovering from substance use disorders and domestic and/or sexual violence, the women discuss their adverse childhood events within the theme, *fractured foundation*. One of the women shared, "my mom would just do horrible things to me, leave me outside from morning to the night-time, not let me in, not let me have food, not let me have anything to drink" (Edwards et al., 2017, p.78). The women go on to explain that the presence of physical and/or sexual violence and substance use in their childhoods normalized these behaviours within their lives (Edwards et al., 2017).

IPV is also more frequently reported in women involved with substance use (Finnegan, 2013). An Australian longitudinal study gathered data from participants at 21 years of age who had been victims IPV (Ahmadabadi et al., 2019). The participants were followed up again at 30 years of age and assessed for alcohol, substance, and nicotine use. IPV was found to be a pronounced risk factor for subsequent substance use disorders, even after controlling for pre-existing substance use that was assessed at the 21-year analysis. Although these findings were present in both male and female participants, the female participants had a more significant

association between IPV for subsequent substance use disorders. The authors of this study discuss that this finding may be due to females experiencing IPV more intensely and severely than their male counterparts (Ahmadabadi et al., 2019).

An American quantitative study analyzed the relationship between substance use and IPV towards women (Golinelli et al., 2009). A total of 590 women in relationships participated in the study. The researchers asked the women to report their substance use and whether they had experienced IPV from their partners in the past 6 months. The findings suggest that women who use substances are at a greater risk for IPV (Golinelli et al., 2009). The combined findings from Ahmadabadi et al's (2019) and Golinelli et al's (2009) research suggests that IPV increases the risk of developing substance use disorders, however, substance use disorders also increase the risk for IPV. Women who have experienced IPV are more likely to develop substance use disorders (Golinelli et al., 2009), and women with substance use disorders are more likely to experience IPV (Ahmadabadi et al., 2019).

There is an association between substance use disorders and trauma in women, however, trauma has also been associated with increased risk for other mental health disorders such as depression and post-traumatic stress disorder (PTSD; American Psychiatric Association, 2013). Substance use disorders can also instigate the development of substance-induced mental health disorders, such as anxiety, depressive, and psychotic disorders (American Psychiatric Association, 2013). Women who struggle with substance use disorders are at risk of developing substance-induced mental health disorders, from using substances, as well as trauma-induced mental health disorders, from their increased risk of traumatic events (Edwards et al., 2017; Golinelli et al., 2009). Therefore, mothers with a history of substance use and/or misuse, whose

newborns are diagnosed with NAS, have a unique risk for co-occurring mental health disorders relating to both substance use and trauma.

Mothers' Experiences in the NICU

In recent years, mothers of newborns diagnosed with NAS have reported negative experiences in NICUs (Atwood et al., 2016; Cleveland & Gill, 2013; Cleveland & Bonugli, 2014; Cleveland, Bonugli, & McGlothen, 2016; Demirci, Bogen, & Klionsky, 2015; Howard et al., 2018). In the United States, a qualitative descriptive study by Cleveland and Gill (2013) reveals how some mothers of substance-exposed newborns felt nurses in the NICU labelled them as "bad mothers" (p. 203) and never saw any of their strengths because of their history of drug use. The mothers expressed resentment and frustration towards nurses. They described feeling as though they were being watched by NICU nurses, and they needed to gain the nurses' approval and/or assert themselves as their newborns' mothers. Ultimately, these negative experiences made some of these mothers want to avoid entering the NICU all together (Cleveland & Gill, 2013). Comparable findings were reported in a similar qualitative descriptive study by Cleveland and Bonugli in 2014; mothers again felt negatively judged by nurses and would sometimes deter visiting the NICU because of these experiences (Cleveland & Bonugli, 2014).

A mother in Cleveland, Bonugli, and McGlothen's (2016) study tells a story where she overheard a nurse refer to her as "that junkie mom" (p.124). Following that incident, she would call the NICU prior to visiting to find out if that nurse was working that day. If the nurse was working, she would not visit (Cleveland et al., 2016). The other mothers in the study shared similar experiences of overhearing nurses labelling them. Several mothers explained that their interactions with nurses created stress for them, and one even stated that her relationship with the nurses was so strained that it could have triggered her to relapse (Cleveland et al., 2016).

"Trusting the nurses" was a theme in Cleveland and Bonugli's (2014) work, as trust was a challenge for the mothers. They feared for how their newborns were cared for when they were not present in the NICU, often feeling that the quality of care provided to their newborns varied depending on whether they perceived the assigned nurse liked them or not. One mother explained, "[…] we're gonna leave and he's gonna cry and they're gonna leave him crying because they're gonna be like, 'You know what? His parents are jerks!'" (Cleveland & Bonugli, 2014, p. 325). When NICUs have been understaffed, the mothers observed nurses become frustrated and sometimes felt the nurses displaced this frustration onto them (Cleveland & Bonugli, 2014). In a different study focused on breastfeeding decisions in women taking methadone, mothers described nurses as sabotaging their efforts to breastfeed. They shared that hospital-based nurses were often uninterested and would not take the time in helping them breastfeed and frequently lacked knowledge on breastfeeding while on methadone (Demirci, Bogen, & Klionsky, 2015).

Feeling negatively judged and unable to trust is an evident barrier to mothers of newborns diagnosed with NAS forming therapeutic relationships with nurses. It is also important to note that when mothers were well received by nursing staff, they recalled how much of a positive impact it had on their NICU experiences (Cleveland & Bonugli, 2014; Cleveland & Gill, 2013). Mothers of newborns diagnosed with NAS have explained that when they perceive their healthcare providers as not being judgmental and treating them equally, they felt more respected and empowered, and had greater confidence in caring for their newborns (Howard et al., 2018). Therapeutic relationships between nurses and mothers of newborns diagnosed with NAS may encourage mothers to be more involved in their newborns' care (Cleveland & Gill, 2013). Greater maternal involvement will promote mother-newborn bonding (Cleveland & Gill, 2013)

and potentially decrease the newborn's need for pharmaceutical interventions and overall length of stay in the hospital (Hünseler, Brückle, Kribs, & Roth, 2013). Mothers have reported that even small gestures – such as simply asking how they are doing – can make a difference in their NICU experiences (Cleveland & Gill, 2013).

Nurses' Experiences in the NICU

Neonatal nurses provide direct nursing care to newborns, however, they also work closely with parents throughout their newborns' stay in the NICU. Neonatal nurses help parents learn how to provide care for their newborns and offer support during the challenging journey of being in the NICU. To better understand neonatal nurses' experiences forming therapeutic relationships with mothers of newborns diagnosed with NAS, I first discuss nurses' experiences caring for newborns diagnosed with NAS, then review what is known about caring for the newborns' families. Lastly, I reflect on what is known in the literature about nursing education and current practice.

Caring for the Newborns with NAS

Several studies have described nurses' experiences and attitudes working with newborns diagnosed with NAS and their families. A 2010 Canadian study (Murphy-Oikonen et al.) and a 2012 phenomenological study conducted in the United States (Maguire et al.) reveal neonatal nurses' compassionate nature towards the newborns they care for. In Murphey-Oikonen et al.'s (2010) study, "a commitment to infants" (p.309) was an apparent theme, as nurses expressed their love for babies and desire to help them. Beneficence was an ethical principle nurses struggled with in Maguire et al.'s (2012) work; nurses wanted to do everything they could to provide comfort to withdrawing infants, yet they felt inadequate when their efforts were

unsuccessful. Evidently, despite nurses' compassion for infants diagnosed with NAS, the experience can be stressful and frustrating (Murphey-Oikonen et al., 2010).

The high-pitched, inconsolable, cries from newborns diagnosed with NAS echoes throughout the literature, as it creates great emotional distress for neonatal nurses (Maguire et al., 2012; Murphey-Oikonen et al., 2010). Newborns diagnosed with NAS have been described by nurses as time-consuming and difficult to care for (Fraser et al., 2007; Romisher, Hill, & Cong, 2018). A nurse in an Australian qualitative study explains how sometimes nurses need to ask their colleagues to step in for them when caring for newborns diagnosed with NAS, as the newborns' needs become too difficult to cope with (Fraser et al., 2007).

Nurses have also described feeling distressed by the unknown future of these newborns, as they rarely receive feedback of how they are doing post-discharge (Fraser et al., 2007; Murphey-Oikonen et al., 2010). The potential long-term effects of NAS, such as attention deficits or hyperactivity (Behnke & Smith, 2013), is a concern reported by the nurses who cared for them (Maguire et al., 2012). In addition, nurses have frequently expressed worry with regards to the home environments in which newborns diagnosed with NAS are discharged into, and the potential for abuse (Fraser et al., 2007; Maguire et al., 2012; Murphey-Oikonen et al., 2010). They fear that mothers who struggle with addiction will not be able endure the demanding care required by newborns diagnosed with NAS (Maguire et al., 2012).

Caring for the Families

Neonatal nurses often work closely with newborns' families, particularly newborns' mothers, throughout their stays in NICUs. Families of newborns diagnosed with NAS, however, have been described by neonatal nurses as the most challenging families to take care of, as they often have complex backgrounds and care needs (Fraser et al., 2007; Maguire et al., 2012).

Within the theme “coping with the families” (p.283), nurses in Maguire et al.’s (2012) study described abusive and aggressive behaviours of parents, and how parents would sometimes come into the unit ‘high’. Alternatively, in an American cross-sectional survey study by Romisher, Hill, and Cong (2018), nurses reported feeling that mothers do not visit their newborns enough and lack understanding of their newborns’ general care and overall treatment plan. Similar findings were presented in Fraser et al.’s (2007) work; nurses expressed frustration when parents did not visit.

Negative and judgmental attitudes towards mothers of newborns diagnosed with NAS have been reported throughout the literature (Murphy-Oikonen et al., 2010; Raeside, 2003; Romisher, Hill, & Cong, 2018). Within the theme of “Caring for the Infant” (p.283) in Maguire et al.’s (2012) work, a nurse expressed feelings of resentment as she explained how she wanted to “take a recorder and just record [the newborn] crying, and have the mom have to sit at the bedside and whenever they fall asleep just put it on and say, ‘Listen, we have to deal with this weaning process that you put them through’” (p. 283). In the same study, under the theme “Coping with the Family”, one of the nurses stated that mothers of newborns diagnosed with NAS “all have the same personality” (p.283) and will take advantage of the nursing staff who are nice to them (Maguire et al., 2012). “Difficult Relationship with the Mother” (p.E9) was a theme in Romisher, Hill, and Cong’s (2018) study; one nurse referred to mothers of newborns diagnosed with NAS as selfish and “wished they would just stop getting pregnant” (p.E9).

There is evidence that some nurses struggle to establish therapeutic relationships with mothers of newborns diagnosed with NAS (Maguire et al., 2012; Murphy-Oikonen et al., 2010; Romisher, Hill, & Cong, 2018). Nurses have expressed difficulty in communicating with mothers with a history of substance use (Maguire et al., 2012). Poor communication may be in

part due to the negative attitudes held by nurses, however, it may also be related to nurses' lack of training in how to work with mothers with addictions (Maguire et al., 2012). Mothers of newborns diagnosed with NAS often have complex backgrounds. Nurses are aware of this, and acknowledge the importance of adequate counselling and support, yet they are apprehensive in their ability to provide this care to such a vulnerable population (Fraser et al., 2007; Romisher, Hill, & Cong, 2018).

Nursing Education and Current Practice

Previous research has demonstrated that lack of knowledge regarding addictive substance use poorly influenced perinatal nurses' attitudes towards mothers with a history of substance use (Neary, 2018). Many nurses appear to lack knowledge in caring for newborns diagnosed with NAS and their mothers (Ludwig et al., 1996; Marcellus, 2002; Selleck & Redding, 1998). Two Canadian descriptive survey studies, one with data collection in 2002 and the other in 2013, described the state of nursing practice for substance exposed newborns across the country (Marcellus, 2002; Marcellus, Loutit, & Cross, 2015). In 2002, 42% of hospitals provided nurses with education on caring for substance exposed newborns and their families; in 2013, this statistic had increased to 53% (Marcellus et al., 2015). The need for more education of healthcare providers caring for clients involved in substance use, however, has been recognized by Canadian hospitals (Marcellus et al., 2015).

Newborns diagnosed with NAS admitted into the NICU/SCN are often treated with pharmacological therapies (Ordean et al., 2015), however, recent literature has been exploring non-pharmacological treatment options for NAS (Newman et al., 2015; MacMillan et al., 2018). 'Rooming-in', a practice in which newborns remain in close un-interrupted contact with their mothers, is a non-pharmacological approach that has been shown to decrease the severity of

NAS and length of stay in hospital (Newman et al, 2015). A systematic review focused on rooming-in and its associated outcomes for NAS analyzed six quantitative studies from the United States, Canada, and the United Kingdom (MacMillan et al., 2018). All six studies demonstrated that rooming-in decreased the need for pharmacological therapies and decreased length of stay in hospital by approximately 10-12 days (MacMillan et al, 2018). Currently, rooming-in is not a standard practice in Canadian NICUs and SCNs, however, Canadian researchers have recommended greater implementation and research on this practice (McQueen, 2018; Newman et al, 2015).

A trauma-informed care approach is also promoted by various Canadian organizations when health care professionals are working with individuals who use substances (British Columbia Ministry of Children and Family Development, 2017; Canadian Centre on Substance Abuse, 2014; RNAO, 2015). To the best of my knowledge, however, there is no current literature demonstrating whether trauma-informed care is being implemented in Canadian NICUs/SCNs. An American cross-sectional survey study examined NICU nurses' knowledge and competence in trauma-informed care (Salameh & Polivka, 2020). Salameh and Polivka (2020) recruited 150 NICU nurses and found that the nurses had low to moderate knowledge and perceived competence in trauma-informed care. Conversely, a Canadian qualitative descriptive study explored mental health nurses' knowledge and understanding of trauma-informed care and discovered that although the nurses were not familiar with the concept of trauma-inform care as defined in the literature, they still described many of the components of trauma-informed care throughout their interviews (Stokes et al., 2017). While there appears to be a lack of research in trauma-informed care in the NICU/SCN setting, the continued promotion by Canadian organizations and overall growing body of knowledge in trauma-informed care may still

influence neonatal nurses' practice of this care approach (British Columbia Ministry of Children and Family Development, 2017; Canadian Centre on Substance Abuse, 2014; RNAO, 2015; Stokes et al., 2017).

Conclusion

Throughout the literature, mothers of newborns diagnosed with NAS have described negative experiences with nurses. These experiences have made mothers apprehensive to visit their newborns in hospitals. Nurses, however, have explained how distressing and challenging caring for newborns diagnosed with NAS and their families can be. The importance of education for nurses in this context has been researched and recognized by Canadian hospitals. However, little research has been conducted to explore nurse-client therapeutic relationships within this context. Research in this area is needed, as the nurse-client therapeutic relationship may improve health and wellbeing in both mothers and their newborns (Kelley et al., 2014). Improved therapeutic relationships may encourage mothers visiting their hospitalized newborns more frequently. This may potentially promote mother-infant bonding, in addition to shortening newborns' duration of pharmacological therapy and length of stay in the NICU (Hünseler, Brückle, Kribs, & Roth, 2013). There are nurses who are successful in forming therapeutic relationships with mothers of newborns diagnosed with NAS, and who have created positive experiences for these mothers (Cleveland & Bonugli, 2014; Cleveland & Gill, 2013; Howard et al., 2018). There is a need to learn from these nurses, as their knowledge and experience can teach other nurses how to better engage in therapeutic relationships. Therefore, the aim of this proposed study is to understand neonatal nurses' experiences of engaging in therapeutic relationships with mothers of newborns diagnosed with NAS. This study will answer the

research question, “How do neonatal nurses form therapeutic relationships with mothers of newborns with NAS?”

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Chapter 3

Nurses Engaging in Therapeutic Relationships with Mothers of Newborns Diagnosed with Neonatal Abstinence Syndrome: A qualitative study

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Abstract

An interpretive descriptive research design was implemented to explore neonatal nurses' experiences of engaging in therapeutic relationships with mothers of newborns diagnosed with neonatal abstinence syndrome (NAS). Six registered nurses employed at a special care nursery provided insight through semi-structured telephone interviews. Upon analyzing and interpreting the data, the authors found the neonatal nurses described steps they commonly used to successfully build therapeutic relationships with mothers of newborns diagnosed with NAS. The nurses also shared the competing pressures they frequently managed when caring for newborns diagnosed with NAS, which ultimately made establishing therapeutic relationships with these mothers more challenging. The findings from this research compliments previous literature on therapeutic relationships, demonstrates how neonatal nurses can be successful at forming therapeutic relationships with mothers of newborns diagnosed with NAS, and provides implications for future nursing practice, policy, education, and research.

Background and Significance

Neonatal Abstinence Syndrome (NAS) refers to a collection of clinical signs in newborns exposed to opioids in-utero (Dow et al., 2012). Up to 75% of newborns exposed to opioids in-utero develop a physical dependence on the substance that results in withdrawal symptoms once they born and no longer in contact with the substance (Dow et al., 2012; Vogel, 2018). The clinical presentation resulting from opioid withdrawal includes effects on their "…central nervous system (e.g., tremors, irritability, increased crying, myoclonus and seizures), gastrointestinal tract (e.g., poor feeding, vomiting, and diarrhea) and the autonomic nervous system (e.g., sweating, temperature dysregulation and tachypnea)" (Turner et al., 2015, p.E55). The prevalence of NAS has consistently risen over the last fifteen years (Dow et al., 2012; Fischer et al., 2014; Vogel, 2018). In Ontario, from 2002-2014, the incidence of newborns born to opioid-dependent mothers had over a 16-fold increase, from 46 to 761 (Brogly et al., 2017). Likewise, the prevalence in the United States increased from 0.34% to 0.58% between the years 2009-2012 (Patrick et al., 2015). Although opioid exposure is most commonly associated with NAS, other substances such as barbiturates, benzodiazepines, and selective serotonin reuptake inhibitors can also contribute to NAS after in-utero exposure (McQueen et al., 2015). Approximately 55-94% of newborns exhibiting symptoms of NAS are admitted into a neonatal intensive care unit (NICU) or special care nursery (SCN) for monitoring, and approximately half require pharmacological treatment (Marcellus et al., 2015; Ordean et al., 2015). Current clinical practice guidelines by the Provincial Council for Maternal and Child Health (PCMCH; 2016) recommend that when newborns are started on pharmacological treatment, they remain in an NICU or SCN for cardio-respiratory monitoring for 4 days and/or until the dose is reduced. Further monitoring should then be at the discretion of the physician in charge.

In NICU or SCN, both the newborn and their family are cared for by an interdisciplinary team, which includes direct nursing care. According to the College of Nurses of Ontario (CNO; 2019), Registered Nurses Association of Ontario (RNAO; 2002), the Canadian Nurses Association (CNA; 2017), and the American Nurses Association (ANA; 2015), the therapeutic nurse-client relationship is at the core of nursing practice and is meant to benefit the health and wellbeing of clients. The therapeutic nurse-client relationship is "based on trust, respect, empathy and professional intimacy, and requires appropriate use of the power inherent in the care provider's role" (CNO, 2019, p.3).

However, both mothers of newborns diagnosed with NAS and nurses have reported having negative experiences and attitudes with regards to working with one another (Cleveland & Bonugli, 2014; Cleveland & Gill, 2013; Demirci et al., 2015; Fraser et al., 2007; Maguire et al., 2012; Murphy-Oikonen et al., 2010; Raeside, 2003; Romisher et al., 2018). In the United States, a qualitative descriptive study by Cleveland and Gill (2013) reveals how some mothers of substance-exposed newborns felt NICU nurses labelled them as "bad mothers" (p. 203) and never saw any of their strengths because of their history of drug use. The mothers expressed resentment and frustration towards nurses (Cleveland & Gill, 2013). They described feeling that they were being watched by NICU nurses, and they needed to gain the nurses' approval and/or assert themselves as mothers (Cleveland & Gill, 2013). Ultimately, these negative experiences made some mothers avoid entering the NICU all together (Cleveland & Gill, 2013) – impacting not only the nurse-client relationship but also the time mothers had to bond with their newborn children. Likewise, in a Canadian qualitative exploratory study, nurses expressed challenges when working with families affected by NAS and struggled to express empathy towards parents that misuse substances (Murphy-Oikonen et al., 2010). Nurses have described abusive and

aggressive behaviours from parents, and how they felt parents do not visit their newborn enough or sometimes visit while under the influence of substances (Maguire et al., 2012; Romisher et al., 2018).

Negative experiences and attitudes are significant barriers to the development of therapeutic relationships between mothers of newborns diagnosed with NAS and nurses. This is an important nursing problem, as poor therapeutic relationships inhibit optimal care. Mothers avoiding the NICU due to these poor relationships is a barrier for various health promoting behaviours that contribute to mother-infant bonding, which benefits both the mother and infant (Cleveland & Gill, 2013). Impaired mother-infant bonding has been associated with postpartum depression (Lehnig et al., 2019). Additionally, newborns respond well to their mother's presence – maternal involvement in care has been proven to shorten duration of pharmacological therapy and length of stay in the NICU for newborns diagnosed with NAS (Hünseler et al., 2013). Thus, when contact is reduced, newborns require more pharmacological therapy and remain in hospital longer. Additionally, secure attachment with a parent minimizes a child's health risk behaviours and disease in the long-term (Williams et al., 2019). A secure parent-child relationship is especially important for newborns diagnosed with NAS since they are at risk of being exposed to substance use within their household. Such adverse childhood experiences –substance use, mental illness, or violence within the household – increases future risk for substance use, alcohol misuse, mental illness, severe obesity, and other health risk factors and disease conditions that frequently cause death in adults (Felitti et al., 1998). Therefore, health care providers in the NICU have a valuable opportunity to facilitate bonding and attachment between mothers and their newborns diagnosed with NAS.

There are nurses who are successful at forming therapeutic relationships with mothers perceived as being more challenging to work with. For example, nurses identified as experts in caring for adolescent mothers emphasized the importance of forming a connection to create a therapeutic relationship, as this helped the nurses assess the mothers more holistically and to better meet their individual care needs (Quosdorf et al., 2020). In another qualitative study, several mothers of newborns diagnosed with NAS described having good relationships with their newborns' nurses (Cleveland & Bonugli, 2014).

There is, however, a paucity of literature describing *how* some neonatal nurses successfully form therapeutic relationships with mothers of newborns diagnosed with NAS, and what facilitates nurses' establishment of therapeutic relationships with these marginalized mothers. Therefore, the aim of this study was to explore neonatal nurses' experiences of engaging in therapeutic relationships with mothers of newborns with NAS, and answer the research question, "how do neonatal nurses form therapeutic relationships with mothers of newborns with NAS?". The findings may promote self-reflection among nurses who find caring for mothers of babies with NAS challenging, and potentially inform the design of interventions to improve therapeutic relationships in nursing practice.

Methods

This critical theory study was designed using interpretive description (ID; Thorne, 2016). ID promotes both auditable and logical qualitative research whilst allowing researchers to mold their design techniques to best fit their discipline and answer their research question (Thorne, 2016). ID allows for shared realities and can be "applied to qualitative inquiry into human health and illness experiences for the purpose of developing nursing knowledge" (Thorne et al., 1997, p. 173).

Participants were registered nurses (RN) recruited from a SCN, where it is within their practice to care for newborns greater than or equal to 1200 grams and gestational ages of 30 weeks and up in Ontario, Canada (PCMCH, 2013). The unit has 17 beds and approximately 50 RNs. A clinical educator informed nurses about the study by email at the beginning of recruitment and again two weeks later. In addition, posters were displayed in the break rooms and staff bathrooms. The emails and posters invited nurses to contact the research team if they had questions and/or were interested in participating in the study. After interviewing each participant, the researcher employed a snowball sampling approach by inviting them to tell their colleagues about the study and how to contact the research team. Throughout data collection and analysis, the research team reflected on the variation among study participants, such as differing age and years of experience. Recruitment stopped when a sample size with enough variability for an interpretive description was reached. The research team decided there was enough data when they observed recurring ideas throughout the interviews.

Data was collected through semi-structured, telephone interviews to gain direct and first-hand insight into the phenomenon of interest. Interviews lasted between 45 and 60 minutes and were conducted at times identified by the participants as convenient. An interview guide was prepared in advance to ensure specific ideas of interest were covered. The guide was modified throughout the data collection process, as potential themes emerged and required further exploration. The interviewer made field notes of any contextual factors, thoughts, and feelings that arose throughout the data collection, as this information could have influenced the findings. The field notes were reflected on throughout data collection and analysis to enhance the trustworthiness of the study (Lincoln & Guba, 1986)

Interviews were audio recorded and transcribed verbatim. An alternative sorting technique was used to analyze the data (Thorne, 2016). Two members of the research team immersed themselves in the data by reading through each transcript at least twice. They then re-read the transcripts and wrote notes in the margins, highlighting quotes with perceived importance while reflecting upon any apparent themes (Thorne, 2016). This information was then organized and reorganized into various categories in an attempt to find relationships between the different data. The categories were reviewed to identify the embedded themes and assess how themes related to one another. The other two researchers each read one transcript. Throughout the data analysis, the team met regularly to discuss and reach consensus on patterns emerging from the data.

To increase study rigour, Lincoln and Guba's (1986) criteria of trustworthiness was followed. The context in which information was collected was defined, and direct quotations from participants were used to describe the findings. For greater dependability, an audit trail was maintained. Minutes were kept of meetings and decisions made by the research team. The principal investigator also continuously reflected on her own beliefs and potential biases in field notes and a journal throughout the data collection and analyses processes.

This principal investigator in the study was a graduate student, completing this research for her master's thesis. At the time of this study, she was working as an RN in a NICU at a different hospital. Her thesis supervisor and one committee member have experience in maternal-newborn research, furthermore, the supervisor has previously been involved in qualitative interpretive descriptive studies. The other committee member has experience in research in the critical care setting, qualitative interpretive description research, as well as research focused on establishing therapeutic relationships.

Ethical approval was obtained from the research ethics boards at the hospital in which the study took place, as well as the affiliated university. No conflicts of interest were declared.

Results

Six nurses participated in interviews. Participants ranged in age from 23 to 45 years. All participants identified as female and held bachelor's degrees in nursing. Their years of experience working as RNs ranged from 1.3 to 14 years, and their years of working in neonatal care also ranged from 1.3 to 14 years. Two participants had completed a one-day course on substance use during the perinatal period.

Upon analyzing the six interview transcripts and field notes, two major themes became apparent. The first theme, *building the relationship*, is broken down into subthemes *assessing the mother and choosing an approach, caring for and involving the mother*, *making a connection*, and *getting to know mom and her needs*. The second theme, *the competing pressures of working with NAS*, is further categorized into the subthemes *working with baby and mother, collaborating with the Children's Aid Society,* and *struggling with stigma*.

Building the Relationship

The therapeutic relationships formed between nurses and mothers of newborns diagnosed with NAS were described as being not easily formed – they are different in comparison to the relationships made with mothers within other populations. One of the participants described the challenges of building a relationship with mothers of newborns diagnosed with NAS:

> Often times they'll withdraw a little bit from you, which I totally understand, but...that can mean...that they don't come in as often as maybe as other moms or maybe they just don't open up to you as much (Interview 1).

Throughout the interviews, participants described steps they commonly used to build therapeutic relationships with this population, which included: *assessing the mother and choosing an approach*, *caring for and involving the mother*, *making a connection*, and *getting to know mom and her needs.*

Assessing the Mother and Choosing an Approach

Prior to engaging with mothers of newborns diagnosed with NAS, the participants in this study described assessing the mother and choosing an appropriate approach. For example, one nurse stated:

> Every situation is so different, so it's kind of very much mom and baby dependent, and depends a lot on their social history too…so there's just so many different situations that…you kind of have to read into and interpret and like make your own judgement call (Interview 1).

The nurses' assessments, based on their observations of the mother, facilitated their decisions on how to further support the mothers. One participant stated, "When I go into the room, I'm going to assess…I'm going, I'm going to take a pause and assess the room and see how I feel the room". She added,

> If I walk into the room and all I feel is, like, I feel like she's tense, like I'm not going to go into, 'let's do all this care today', you know? It's going to be, 'ok, you know what? Let's focus on taking time with your baby and just bonding with your baby today'. That's what I'm going to focus on. Whereas, if I go into the room and they're in a really happy mood and they're joyful…they appear relaxed and calm, then I'm going to say, 'ok, let's do some teaching today, let's do some more hands on, let's do something that really

> involves you but also really involves the care of the baby, and not just snuggling and kissing and hugging'.

She continued further, "I'm going to have to assess their behaviour…and looking for myself, kind of going into my 'rolodex' and picking out which therapeutic approach I'm going to use for this situation." (Interview 3)

Participants spoke of various types of approaches they preferred. One referred to using a 'transparent' approach. She explained she is forthcoming about the history of substance use and subsequent NAS diagnoses,

> It's not like this is a secret to anyone on the team, social work is aware…and when they come in, the labour and delivery nurse knows, you know? Like…if you're hiding it, it just seems like it's a taboo or stigma thing, like something that we shouldn't be talking about or something that 'no we can't go there', you know? Whereas like if you're transparent I just feel like it's more successful because you're telling them basically that it's ok to talk about these things, right? Rather than hide them, like…and its…a lot of the time I'll approach it like that with them too and just say like, 'so this is the situation, the best way we can provide care for your baby is if we know… what substances you've been using', and they respond well to that, you know? Just explain to them that it's for the best possible care for their baby, and they generally want that too, so…I think that's usually the best approach, just to be transparent when possible" (Interview 1).

Another participant reflected on using a 'neutral' approach,

> Any sort of teaching, you have to be careful to approach it as in a neutral tone and using neutral language rather than, you know, it's really important not to approach it as, you

> know, 'your baby is rigid because,'…or 'your baby is sick because you're an addict.' Like if you approach it like that, then right away you've lost. (Interview 4).

A more novice nurse described the challenges in assessing and approaching moms of newborns diagnosed with NAS. She reflected,

> As a nurse you kind of have to…assess…is the mom really ready right now to take in this information or how is she going to respond to it as well, and sometimes dealing with these types of mothers I do feel that they're more quickly to react…I think it just makes it difficult for me to like approach mom with these conversations. Just worried about how they're going to react [e.g., withdrawal, frustration, tears]. (Interview 5)

In multiple interviews, nurses brought up that experience with this population helped them to better assess and approach mothers. For example, one nurse explained, "interacting with parents like, just the more time, and experience, and knowledge you have, the more comfortable you are just interacting with them, and explaining things and bonding with them" (Interview 2). Another nurse further clarified,

> I think just seeing different situations that moms are in too like opens your eyes to the possibilities and …you sometimes see babies that go home with mom in certain situations and babies that don't in other situations and like you get a really good gauge I guess of…different behaviours, so that you can provide the best care I think. Like the same with seeing moms that are impaired too, like over the years I've seen moms impaired with different things and you kind of get a good idea of how to handle the situation. So just probably like lived experiences within that clinical setting has helped a lot. (Interview 1)

Caring for and Involving the Mother

"We're not just taking care of the baby, we're also taking care of the mom, so it's just important to kind of follow up with mom and seeing how we can support her in this experience" (Interview 5). One participant explained how she tries to show mothers that she is caring for them as well,

> I usually try to always know the parents' names and just like talk to them by their first names, so they feel like they're, you know, not just the baby's mom but they're someone and an important someone. So, you know, every time she would come in, I would say her name and you know, ask her how she's doing, how she's feeling (Interview 6).

The nurses in this study often described how involving the mothers in their newborns' care helped build the relationships between the nurses and mothers. One participant depicted how she does this, "keep the mother as involved as possible, for sure, like in every step of the care too", she further explained,

> Sometimes us nurses like we over-step and we do the bath when we maybe don't need to, or we would maybe, you know, give even them the like vitamins and stuff when we know mom's coming in and it's just like having that opportunity to involve mom in every step of the care, I think is the best way to have her open up to you (Interview 1).

Another participant talked about teaching,

> I really do just focus more on the teaching…I think when they see, when they see me caring for their baby, and doing what I can to make their baby…their baby's life a little better and like sharing this tidbits that are going to help their baby feel more comfortable even if they're, you know, experiencing difficulties, I think that's when…that's when I guess most of them have been more open and I think that's when they start talking.

She goes on to state, “we’re on the same team here” (Interview 4). With this statement, she was describing that she shares the same goal as mothers to help their newborns, and she understands that working together, as a team, will facilitate their success.

Making a Connection

Through caring for the mothers and involving them in the care of their newborns diagnosed with NAS, the nurses in this study were able to establish meaningful connections with the mothers. One participant reflected,

> I think giving moms kind of like your trust and your faith in them to take care of their own baby is positive in itself because they are then able to open up to you more. Like I feel like then they trust you more, you know, they see that you are like, ok, you’re the primary caregiver for your own baby and we are going to like just be here on kind of on the sidelines rather than like taking over and doing all the care for the baby. I feel like you just build a better trusting relationship, you know what I mean? (Interview 1).

Connecting with the mothers was described in participants’ positive experiences. One participant remarked, “it’s definitely more therapeutic. I feel like we’re able to have deeper connections and talk about conversations more openly” (Interview 5). Another participant added,

> I think, if you get the chance to interact with the mom…I don’t know, just try and find some kind of common ground or just like get them talking, [be]cause usually I find if you...just have a conversation with them at least then you have a better idea of, kind of, what they’ve been through, and, like, what their story is, yeah I, and I feel like that just makes it a lot easier. (Interview 2).

Getting to Know Mom and her Needs

The participants remarked that when they were able to create meaningful connections with the mothers then they can continue to build their therapeutic relationship by getting to know the mothers and their needs in more depth. When asked what advice she would give to nurses that have a more challenging time forming relationships with moms in this population, one participant answered,

> I think it's important to… [get] to know mom, asking her…how she's doing and getting to know her and what are ways we can support her and just being more informed about what it's like to have an addiction as well and becoming more compassionate (Interview 5).

Learning about the mothers' lives was described as beneficial to the therapeutic relationship, "…it's easier I think to have compassion if you have a little bit more understanding of where they're coming from. It's easier to develop that therapeutic relationship if there's a little bit of give and take" (Interview 4). Getting to know the mom and her needs enabled the nurses in this study to further care for and involve the mother in her newborn's care. One participant described mothers visiting during the daytime,

> They have the opportunity to chat with everyone and be a part of the team…and just dialogue with everyone, you know? And we get to know mom too, so we might…like get to know what supports she needs or on a more personal level (Interview 1).

Despite the nurses' best efforts to build therapeutic relationships with mothers of newborns diagnosed with NAS, they explained they often must manage other competing pressures when working with NAS that can make forming these therapeutic relationships more challenging.

The Competing Pressures of Working with NAS

Throughout the six interviews, the participants spoke of competing pressures they encounter within the context of working with NAS. They explained that these competing pressures create obstacles that hinder their abilities to form therapeutic relationships with mothers of newborns diagnosed with NAS. The competing pressures the nurses in this study experienced have been categorized into three subthemes: *nursing care of baby and mother, collaborating with Children's Aid Society,* and *struggling with stigma*.

Nursing Care of Baby and Mother

Nurses described how being assigned to care for newborns diagnosed with NAS is a challenge due to both physical and emotional- exhaustion. One participant reflected:

> It's just, it's so sad to see…I do find…you just feel like a lot of sadness for these babies, and…I do find that they're…it's not like they're a baby who's ventilated or on a ton of IV drips, and like all that, but these ones I find that they're very…they really stick with me, and it's always…a hard shift when I have babies like this (Interview 2).

Another participant added:

> NAS babies, they're hard. You know, they're really exhausting. Like at the end of a 12-hour shift with an NAS baby, I'm sometimes as exhausted as the end of a 12-hour shift with a really like physically sick baby because they're just so demanding. And so when you're going into… a shift knowing that you've got an NAS kid, sometimes your back is up already because you're like 'Oh man, I'm in for a lousy night' (Interview 4).

Because of the physical and emotional exhaustion experienced by the nurses caring for babies with NAS, participants reflected on how this could affect the therapeutic relationship, "if the

nurse is irritable…then they might not be able to approach the mom with the therapeutic way that they might want to" (Interview 3).

The nurses also described competing pressures when working with the mothers of newborns diagnosed with NAS. The participant in interview 1 reflected, "…definitely working with moms with NAS babies I find like one of the most stressful situations", earlier in the interview she described,

> The issue there is that we're just thinking of babies' safety first, and sometimes that can come across kind of…negatively towards moms…there's not as many opportunities to develop a good relationship, and a good therapeutic relationship with mom is if the only time you see her it's not necessarily safe or it's to reprimand her for maybe not calling social work back or to tell her something negative (Interview 1).

Frustrations also arose when the nurses in this study felt mothers were not receptive to their teachings about NAS:

> They still are involved in the care, but they just don't have the…capacity to be *exhales* what's the word I'm looking for? Like to be receptive to our teaching…we don't want to over-stimulate these babies, but yet they go in and they're poking and prodding and touching them constantly and it's like AHH! You know?...It's not good for the baby, and you repeat yourself and repeat yourself but it's just there's no, it's not, it's not being received…so that definitely creates a frustration on our part…that affects the relationship for sure (Interview 3).

Some of the participants described the competing pressure of being concerned for their own safety, "it's hard to be therapeutic when you have to be very cautious and mindful of your physical safety" (Interview 4). Concern for safety was often mentioned when participants spoke

of parents appearing to be under the influence, “if like there’s an issue with safety for baby, or for their partner, or for myself, or the other staff, I think that’s always a little, a bit of a concern when parents come in using substances” (Interview 5).

When the six nurses discussed the competing pressures of trying to care for both newborns and their mothers, they shared that they do not have very much training on caring for this population of mothers. This further created an obstacle for them, as they lacked information on how to provide teaching or manage safety concerns when working with mothers of newborns diagnosed with NAS. When asked about training, one participant explained,

> I don’t remember anything specific in terms of the articles or like resources I’ve used in terms of like working with the mom or even just like in general orientation when we learned about NAS, I don’t remember anything specific in terms of like this is how to care for the mom as well. (Interview 6)

Collaborating with Children’s Aid Society (CAS)

Involvement with CAS was frequently mentioned when speaking with the participants. Although CAS intervenes to protect the baby, over half of the nurses in this study explained how CAS can interfere with their ability to build and maintain therapeutic relationships with mothers. One participant reflected:

> I just felt like a little torn about was that I believe that CAS was going to be involved or was involved, and I’m not sure that she was going to be able to take her baby home, but they were not allowing us to like to tell her this, or they hadn’t told her that. So I felt, like through my job that I was you know, being truthful in caring for her baby and that we had a good therapeutic relationship, but then I felt like I was kind of leaving out a really

> big…sort of like almost lying to, I wasn't lying to her but I was not telling her everything that was potentially going to be happening. So I didn't love that part of it.

She continued,

> Trust and being truthful and like sharing information you have, is a big pillar of a therapeutic relationship and then when that… you're not supposed to tell them that part, which is like a huge chunk, that's basically the whole relationship with her baby. Like you know, coming down to them coming home and I wasn't allowed to say anything or prepare her for that kind of thing that was happening. I feel like it did affect, and I felt like, you know, I wasn't… I couldn't build the relationship as best as I could because I was hiding this big thing that we were told not to tell her (Interview 6).

In addition to being unable to tell mothers about CAS involvement, a participant also explains how they are asked to document on the mothers' behaviours,

> Sometimes I feel like us having to document about the mother's attachment or like different decisions she makes, it does make me feel a little like guilty documenting that but then not telling the mom. So, yeah, there is this one circumstance where the mom was like on the phone talking about the situation or some situation with her friend and like it was not a good situation and the nurse had to document that. But then…I don't believe we ever talked to her mom or…inquired to what she was talking about on the phone. Like why this might not be good for the baby to go home in. So sometimes when you have to document that stuff but then you're not able to…go in and talk to the mom about it, I feel like that kind of breaks some of the therapeutic relationship" (Interview 6).

When asked how withholding information about potential CAS involvement affects the therapeutic relationship, another nurse explained:

> I try to focus on the now…honestly I try to avoid the situation, because it's not my place to be saying that…it's, you know, there are social workers…and there are workers and CAS workers to, to deal with that. So it's not my place to be giving them that information.

She explained further,

> I think we're pretty…I mean… it is ultimately a confidentiality thing and just like anything in nursing care…and I think often, when that situation arises, I don't even think they come back to think, 'oh maybe the nurse knew about it first' (Interview 3).

Struggling with Stigma

Participants were well aware of the stigma and negative perceptions associated with substance use within their workplace. They shared how the stigmatizing behaviour influenced their practice, and how they struggled to remove stigma from their unit. A participant shared her observations of stigma,

> There are definitely still some stigmas around substances users that prevail like despite what you try to do and what you try to encourage other nurses to do, right? Which I think is just like a major barrier. Even like in getting everyone on the same page I think, for the most part we're pretty good, but I do find that there are some groups of nurses that will have kind of the attitude of like…just that mom's a burden for being there (Interview 1).

The nurses in this study spoke of how these perceptions give them preconceived notions,

> There's going to be, like, those older nurses, close to their retirement, who just…say things that probably…are not as…the politically correct to say…and if you're getting report from them, … and they're like, 'Oh my gosh, like this mom is, is something and, like, get ready'…then it does kind of set you up, like, oh, ok… so what am I walking in

> on here? and then you kind of do have your guard up, I think…and a little bit of, like, preconceived notions… which doesn't help the situation (Interview 2).

Participants were honest about their own feelings and personal struggles with bias. One participant described,

> I know, like…you're supposed to remove your personal bias…from nursing and everything, but I feel like…its more challenging…when you have moms who are…still actively using drugs…who are still…like…when the, when the baby has not necessarily been apprehended yet, and are still able to come in, but it's very…umm…it's just like chaotic […] I find that tends to be the more negative experiences (Interview 2).

Another participant spoke about how previous experiences with mothers of newborns diagnosed with NAS can influence their future experiences with this population,

> I think that nurses are, like and even myself too. Like not necessarily understanding the full, like what it means to be addicted to drugs. And since that has like a negative connotation too, we just kind of assume the worst of mom. And I think just having that, like having that judgment, that preconceived notion that because mom is using substances she's going to be like X, Y, Z and this is going to be our experience with her because we've had mothers in the past who were exactly like that and we kind of like put them in a cookie cutter of what they're going to be like and then I think that really affects the way that we can form a relationship because we just, we don't necessarily see them as for who they are. We just kind of cloud our minds with the idea of substances and … a lot of the nurses too are mothers and I think they're kind of upset as well as how could you do this to your baby. Also just kind of a little bit of anger. I think anger for sure. Frustrations

with mom. Fear for not knowing how mom's going to react to certain things (Interview 5).

Discussion

Six neonatal nurses were interviewed about their experiences forming therapeutic relationships with mothers of newborns diagnosed with NAS and two main themes were identified: *building the relationship* and *the competing pressure of working with NAS*. *Building the relationship* described how these nurses try to form these therapeutic relationships. The subthemes – *assessing the mother and choosing an approach*, *caring for and involving the mother*, *making a connection*, and *getting to know mom and her needs* – are reflective of the active processes nurses use to establish and continue to build and maintain therapeutic relationships with mothers of newborns diagnosed with NAS. When participants spoke of their *competing pressures of working with NAS*, they discussed how *caring for the baby and mother*, *collaborating with children's aid society*, and *struggling with stigma* can interfere with their engagement in therapeutic relationships.

The nurses in this study explained a process of how they build therapeutic relationships with mothers of newborns diagnosed with NAS that compliments existing literature (Quosdorf et al, 2020; RNAO, 2002). The international best practice guideline by the RNAO (2002) on establishing therapeutic relationships emphasises the importance of gaining mutual trust, listening to and accepting the client, and identifying and addressing care needs. The actions of the nurses in this study are congruent with recommendations in the RNAO guidelines, as they also express the importance of trust in *collaborating with children's aid society,* listening to and accepting the client in *struggling with stigma*, and identifying and addressing care needs in *get to know mom and her needs*. This study also reflects the findings of Quosdorf and colleagues'

(2020) study, which explored adolescent-friendly care from the perspectives of perinatal nurses. Connecting with adolescent mothers, although sometimes difficult due to differing life experiences and stigma, was described as being essential to having a therapeutic relationship. Additionally, when discussing individualizing nursing care, the perinatal nurses explain that although they try to care for all mothers the same, they realize that they all have unique needs that require differing approaches (Quosdorf et al., 2020). The similarities between the findings of Quosdorf et al (2020) and this study may demonstrate their transferability across different marginalized populations and should be considered when analyzing therapeutic relationships that are perceived as more challenging to form.

Caring for and involving the mother helped the nurses in this study build therapeutic relationships. Demonstrating to mothers that the nurses are also caring for them promotes trust and open communication within the therapeutic relationship. In a previous study by Cleveland and Gill (2013), mothers of newborns with diagnosed NAS expressed a desire to also be cared for by nurses in the NICU. They explain that even small gestures, such as asking how they are doing, strengthened their relationship with nurses (Cleveland & Gill, 2013). The nurses within the current study, however, had little to no training on how to care for mothers of newborns diagnosed with NAS. Mothers with a history of substance use frequently have more socially complex backgrounds connected with trauma (Marcellus, 2014). Trauma-informed care (TIC) approaches have been recommended for the care of mothers with a history of substance use (Marcellus, 2014; RNAO, 2015). A pre-/ post-test study found increased knowledge and skills in undergraduate and graduate nursing students after completing 75-160-minute courses and supplemental readings on TIC. The education was also found to be transferrable to non-nursing students (Cannon et al., 2020). Future research and practice should urgently focus on the

implementation of TIC within the NICU/SCN practice settings to strengthen nurses' abilities to care for mothers of newborns with diagnosed NAS and subsequently improve their therapeutic relationships.

Several of the findings within the major theme, the competing pressures of working with NAS, are also consistent with findings previously discussed in the literature. Previous research has also brought to attention the pressures of providing nursing care to newborns with NAS and their families (Fraser et al., 2007; Maguire et al., 2012; Murphy-Oikonen et al., 2010; Raeside, 2003; Romisher et al., 2018). Nurses describe parents of newborns diagnosed with NAS as challenging to work with, sharing experiences of parents being a potential safety concern for themselves and the newborns and not visiting their newborns in the unit enough (Fraser et al., 2007; Maguire et al., 2012; Romisher, Hill, & Cong, 2018). Newborns diagnosed with NAS have a significantly higher acuity compared to newborns in the NICU without this diagnosis; caring for this population require nurses' time to meet their medical needs, and to address complex social needs of the parents (Smith et al., 2018).

The negative influence of CAS involvement on the therapeutic relationships between nurses and mothers of newborns diagnosed with NAS is a significant finding described in this current study. Nurses have a professional obligation to report any risk of abuse and may disclose personal health information to CAS, if it enables CAS to fulfil their statutory functions (The Government of Ontario, 2004; The Government of Ontario 2017). Although nurses' involvement with child protective services has been explored in the literature before (Barrett et al., 2017; Saltmarsh & Wilson, 2017), extant literature does not elaborate on how the involvement of these services can interfere with the nurse-client therapeutic relationship. Trust is a critical component of this relationship (CNO, 2019), and mothers of newborns diagnosed with NAS have previously

reported difficulty trusting nurses (Cleveland & Bonugli, 2014). The nurses in this study describe how having to withhold information about the involvement of CAS from mothers is detrimental to the therapeutic relationship between nurses and mothers, as it can hinder nurses' ability to earn trust. Communication between nurses and the CAS regarding the disclosure of CAS involvement needs to be further addressed in nursing policy and practice. Furthermore, future research focusing on the impact of CAS involvement on the therapeutic relationship between nurses and mothers is recommended.

Nurses' negative and judgemental attitudes towards mothers of newborns diagnosed with NAS have been reported in the literature (Raeside, 2003; Murphy-Oikonen et al., 2010; Romisher et al., 2018). This current study goes beyond identifying the existence of nurses' negative attitudes and provides examples of how nurses skilled in establishing therapeutic relationships openly practice reflexivity. Critical reflexivity occurs when one questions their own personal values and assumptions, allowing for greater personal and professional development in addition to benefiting therapeutic relationships (Timmins, 2006). The nurses in this study openly shared their personal values and assumptions and identified how they could influence their practice. Additionally, the nurses in this study describe striving to remove their biases. The nurses pointed out how the *competing pressures of working with NAS* affect their therapeutic relationships with mothers. Self-reflection expands clinical knowledge and helps nurses cope with emotional burdens (Caldwell & Grobbel, 2013). Mentor support and non-judgemental environments where nurses can safely communicate and reflect on their thoughts and feelings about working with NAS may improve nursing practice and emotional distress, enabling nurses to provide better care for newborns diagnosed with NAS and their mothers (Marcellus, 2014).

There were several strengths and limitations within this study. Telephone interviews were viewed as a strength in this study and facilitated recruitment during the COVID-19 pandemic. Although visual cues are absent during telephone interviews, researchers who have used this interviewing method have described their interviewees as being more relaxed and willing to share intimate information (Novick, 2008). The participants in this study seemed comfortable sharing personal details regarding their experiences when working with mothers of newborns with diagnosed NAS, as this was reflected in the richness of the data. The second strength to this study is the principal investigator's experience as a RN in NICU settings, where she has worked with newborns diagnosed with NAS, their mothers, and CAS. Her familiarity with this research topic enabled a greater understanding and relation to participants throughout their interviews. This allowed the principal investigator to gain a greater depth of data and identify what participants perceived as most important surrounding this topic. Limitations within this study include lack of gender diversity among participants and recruitment from a single setting. All of the participants self-identified as female. Experiences of working with mothers of newborns with diagnosed NAS may differ among those who identify as male or non-binary. Additionally, recruitment only took place at one setting. Neonatal nurses from other hospitals may have different experiences when engaging in these therapeutic relationships and may have precipitated different themes.

Conclusion

Therapeutic relationships are essential to nursing practice (ANA, 2015; CNA, 2017; CNO, 2019; RNAO, 2002). The competing pressures of working with NAS can interfere with nurses' ability to form these relationships with the mothers of diagnosed newborns. Some nurses, however, have had positive experiences supporting this population. Mitigating the competing

pressures associated with NAS outlined in this study can promote more effective therapeutic relationships, and subsequently benefit the health and wellbeing of these marginalized mothers. Furthermore, the findings from this study can support the development of future research, such as examining these therapeutic relationships from mothers' perspectives. Greater understanding of therapeutic relationships between nurses and mothers of newborns diagnosed with NAS can facilitate solutions for practice, policies, and education.

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Chapter 4: Discussion

Introduction

Nurse-client therapeutic relationships are central to nursing practice (CNO, 2019; RNAO, 2002; CNA, 2017; ANA, 2015). Mothers of newborns diagnosed with NAS, however, have reported negative relationships with their newborns' nurses (Cleveland & Gill, 2013; Cleveland & Bonugli, 2014). Likewise, neonatal nurses have also discussed their challenges working with this population of mothers (Demirci et al., 2015; Raeside, 2003; Murphy-Oikonen et al., 2010; Romisher et al., 2018). Yet, not all therapeutic relationships between mothers of newborns diagnosed with NAS and neonatal nurses are unsuccessful. Some mothers have reported good relationships with their nurses (Cleveland & Bonugli, 2014; Cleveland & Gill, 2013; Howard et al., 2018), although this is the exception. The purpose of this research was to explore neonatal nurses' experiences of engaging in therapeutic relationships with mothers of newborns diagnosed with NAS. My goal was to answer the research question, "how do neonatal nurses form therapeutic relationships with mothers of newborns diagnosed with NAS?". Within this chapter, I summarize my research findings. These findings are then be compared to the current literature in an integrated discussion. Following which, I will discuss implications for nursing practice, education, policy and research. Lastly, the strengths and limitations of this thesis study are described before making concluding remarks.

Summary of Findings

A total of six neonatal nurses, who were employed in a SCN at the time of this study, participated in telephone interviews where they discussed their experiences forming therapeutic relationships with mothers of newborns diagnosed with NAS. The participants ranged in age from 23 to 45 years and neonatal care experience from 1.3 to 14 years. In the interviews, the

nurses refer to engaging with mothers of newborns diagnosed with NAS from a variety of contexts, such as mothers with prescribed substance use, substance misuse, and substance use disorders.

Two major themes were identified: *building the relationship* and *the competing pressures of working with NAS*. The theme, building up the relationship, was further categorized into subthemes: *assessing the mother and choosing an approach, caring for and involving the mother, making a connection,* and *getting to know mom and her needs.* Within *assessing the mother and choosing an approach*, the nurses in this study shared how every mother within this population is different. The nurses explained that when they interact with mothers of newborns diagnosed with NAS, they first assess the mothers' behaviours and feelings in order to decide how they are going to approach her to provide care at that time. Different approaches that these nurses used included being 'transparent' about the mothers' histories of substance use or 'neutral' when discussing care. When discussing caring for and involving the mother, participants explained that they are not only caring for the newborn, they are also caring for the mother. The nurses talked about trying to make the mother feel important and involving her in the baby's care. *Making a connection* was also relevant in building the therapeutic relationship; finding common ground with the mothers helped them both talk more honestly and build trust. Lastly, *getting to know mom and her needs* was described as being easier after making a connection. The nurses spoke of the importance of getting to know mothers better, so they can better support them and further encourage their involvement in their newborns' care.

The second major theme, competing pressures of working with NAS, was also further broken down into subthemes *nursing care of baby and mother, collaborating with the Children's Aid Society (CAS),* and *struggling with stigma*. When discussing *nursing care of baby and*

mother, the nurses in this study described the pressures of caring for newborns diagnosed with NAS and how this can sometimes interfere with their care for the mothers. Additionally, they spoke of the challenges in teaching mothers of newborns diagnosed with NAS. Parents would sometimes come into the unit under the influence, creating a safety concern for both the babies and hospital staff. The participants talked about the pressures of *collaborating with the CAS*; they shared how they felt they were withholding information from mothers when they could not share their interactions with the CAS. Ultimately, they believed this interfered with the establishment of trust within their therapeutic relationships. Lastly, within *struggling with stigma,* the nurses explained that stigma towards mothers of newborns diagnosed with NAS was something that they struggled with. They shared that it is challenging to maintain a positive perception when colleagues speak negatively about the mothers, and they find it difficult to remove personal biases when they have had previous negative experiences caring for mothers of newborns diagnosed with NAS.

Discussion

Much of the findings from this study reflect and enhance what has previously been identified in the research literature. The following integrated discussion will compare and contrast my findings to those of other researchers. The major theme *building the relationship* and its subthemes – *assessing the mother and choosing an approach, caring for and involving the* mother, *making a connection*, and *getting to know mom and her needs* – will be discussed together, as many researchers have identified a combination of these subthemes within their own research. However, the subthemes within *the challenges of working with NAS – nursing care of baby and mother, torn by the CAS,* and *struggling with stigma* – contribute unique insight into

nurses' experiences of engaging in therapeutic relationships with mothers of newborns diagnosed with NAS and will be discussed individually.

Building the Relationship

This study contributes to the existing literature, as the participants provided a focused insight from a neonatal nurses' perspectives regarding the establishment of therapeutic relationships specifically with mothers of newborns diagnosed with NAS. From what I have reviewed in the literature, researchers and theorists have not examined the development of therapeutic relationships for this dyad. Throughout the remainder of this section, I will discuss how the study findings reflect and complement the existing literature.

The nurses in this current study explained a process of how they build therapeutic relationships with mothers of newborns diagnosed with NAS that complements existing literature (Peplau, 1991; Quosdorf et al., 2020; RNAO, 2002). The RNAO's guideline on establishing therapeutic relationships describes a process of developing therapeutic relationships influenced by Peplau's phases of the nurse-client relationship: orientation, identification, exploitation, and resolution (Peplau, 1991; RNAO, 2002). In the orientation phase, the nurse and the client start as strangers and come into the relationship with preconceived expectations derived from previous experiences. They begin to trust each other and clarify their expectations within the relationship. Listening to and accepting the client is important for the nurse to establish the relationship. During the identification and exploitation phases, the nurse further helps the client identify any concerns and make plans to address them. The nurse helps explore the thoughts, feelings, and behaviours of the client, and continually assesses the relationship. Lastly, the resolution phase is the termination of the relationship once the client's concerns have been addressed (Peplau, 1991). The nurses in this study explained a process of how they build

therapeutic relationships with mothers of newborns diagnosed with NAS that compliments the RNAO guideline (2002) and Peplau's theory (1991), as they provided insight from a neonatal nursing perspective when establishing therapeutic relationships with mothers of newborns diagnosed with NAS. Similar to the orientation phase, the nurses used their personal experiences to aid in the process of *assessing and approaching the mother*. Reflecting the identification and exploitation phases, when the nurses were *getting to know mom and her needs*, they were identifying her concerns and working to address them.

This study also reflects the findings of Quosdorf et al. (2020) in their study exploring care for adolescent mothers from the perspectives of perinatal nurses. The nurses in Quosdorf and colleagues' (2020) study shared that connecting with adolescent mothers is essential to having a therapeutic relationship. When discussing individualizing nursing care, the perinatal nurses explained that although they try to care for all mothers the same, they realized that they all have unique needs that require differing approaches (Quosorf et al., 2020). Although Quosdorf and colleagues (2020) study focused on the experiences of nurses caring for adolescent mothers, as opposed to caring for mothers of newborns diagnosed with NAS, the findings of both studies share great similarities. The nurses in this current study shared that *making a connection* was a significant factor in *building the relationship*, as this helped promote trust and honesty between the mothers and nurses. The nurses in this study also explained that every mother is unique and requires different approaches to care within the subtheme, *assessing the mother and choosing an approach*. This current study also adds to these findings, as the nurses specifically described how they form these unique therapeutic relationships through commonly used steps. For example, they discussed how the different approaches they use, such as being 'transparent' or 'neutral', and their promotion of maternal involvement in care enabled them to establish their therapeutic

relationships. Nonetheless, the strong similarities between Quosdorf and colleagues' work and this thesis research demonstrate the transferability of these findings between various therapeutic relationships between nurses and marginalized clients.

The nurses in this study discussed the different approaches they use when trying to build therapeutic relationships. Some examples include being 'transparent' or 'neutral'. To decide on which approach to use, the nurses made personal assessments by observing the mothers and their cues. *Assessing the mother and choosing an approach* helped the nurses to continue building their therapeutic relationships. Similar findings were presented in a New Zealand study which explored how RNs in a surgical unit establish when and how to use humour with their patients (Rose, Coombs, & Rook, 2020). Humour, within this qualitative descriptive study, is described as a strategy for building and maintaining therapeutic relationships. One of the major themes presented by Rose and colleagues (2020) was *assessing openness*. The nurses in their study explained that they assessed patients' openness to humour by using patient-initiated cues and nurse-initiated assessments. Patient-initiated cues were described as being mostly non-verbal, referencing to the patient's demeanor or body-language. Nurse-initiated assessments were depicted as being informal. The nurses explained that they "test the waters" (p.25) by making a humorous comment and assessing the patient's response. Rose and colleagues' (2020) study continues to share likeness to the research in this thesis, as *building a connection* was the next major theme. Within *building a connection*, the nurses explained why they use humour with their patients. They described humour as a tool that they used to build therapeutic relationships. Humour helped these nurses establish rapport and communication, in addition to having genuine connections with their patients (Rose et al., 2020). The findings within this thesis research complement Rose and colleagues work, as the nurses in this study shared other various

approaches they used to build therapeutic relationships, such as ‘transparency’ and ‘neutrality’. *Assessing the mother and choosing and approach* was also just one of the steps they commonly used to build therapeutic relationships. For example, the nurses within this study shared the importance of getting to know the mother and understanding her needs when trying to establish a therapeutic relationship.

Mothers of newborns diagnosed with NAS have previously spoken about wanting to also be cared for by their neonatal nurses (Cleveland & Gill, 2013). Within the subtheme, *caring for and involving the mother*, the nurses in this study discussed the importance of supporting these mothers and involving them in the care of their newborns when trying to form therapeutic relationships. One nurse stated, “we’re on the same team here”. *Negotiated partnership* was conceptualized by Reis and colleagues (2010) when exploring nurse-parent relationships in a Canadian NICU. Ten parents were interviewed and asked about their experiences and satisfaction with care in the NICU; their relationships with their nurses was the most influential factor. The parents described artful and observable nursing actions that promoted family-centred care and achieved *negotiated partnership*; this concept is categorized into three themes: *perceptive engagement*, *cautious guidance*, and *subtle presence*. *Perceptive engagement* includes assessing the parents’ readiness to participate in their newborns’ care and encouraging them to be involved. *Cautious guidance* involves teaching parents about care and carefully promoting their independence. *Subtle presence* is when the nurse is able to support the parents’ needs while the parents independently care for their newborn. Overall, *negotiated partnership* strengthens parents’ relationships with their nurses, and promotes a safe environment where parents can confidently and independently care for their newborns (Reis et al., 2010).

The statements made by the nurses in this current study are similar to Reis and Colleagues (2010) model of *Negotiated Partnership*, as both studies speak to assessing parents, teaching them, and supporting their specific needs (Reis et al., 2010). The participants in this thesis spoke about assessing the mothers to see what kind of care approach would be most appropriate. For example, teaching how to bath her baby versus encouraging her to cuddle her baby that day. The nurses within this current study explained that they try to show mothers of newborns diagnosed with NAS that they are also caring for them and try to get them involved in care. This then enabled them to make a connection with the mothers, and subsequently better get to know her to be better acquainted with her and her specific needs.

Achieving *negotiated partnership* with mothers of newborns diagnosed with NAS may be more challenging compared to other mothers in the NICU. Nursing workload is significantly higher when caring for newborns diagnosed with NAS compared to caring newborns in the NICU without this diagnosis (Smith et al., 2018), and their mothers often have more complex social backgrounds connected with trauma (Marcellus, 2014). Withdrawing newborns not only require nurses' time to meet their medical needs, their parents also more frequently require additional nursing time to address complex social needs (Smith et al., 2018). These factors may pose as a challenge for neonatal nurses to fully understand these mothers and be able to meet her specific needs in comparison to other mothers in the NICU.

The Competing Pressures of Working with NAS

The nurses in this study shared experiences of the competing pressures of working with NAS that reflects much of what has already been discussed in previous literature. The nurses, however, also shared how these competing pressures affect their therapeutic relationships with mothers of newborns diagnosed with NAS. Throughout the remainder of this section, I will

compare the competing pressures of working with NAS identified in this study to what has previously been described in the literature.

Nursing Care of Baby and Mother

Nurses have openly spoken about the challenges of caring for newborns diagnosed with NAS and their families in previous studies (Fraser et al. 2007; Maguire et al., 2012; Murphey-Oikonen et al., 2010; Romisher et al., 2018). In this current study, the nurses spoke about the demanding nature of caring for newborns diagnosed with NAS, comparing it to caring for critically ill newborns. Similar findings were presented by Fraser and colleagues (2007) as well as Romisher and colleagues (2018). In Fraser et al.'s (2007) work, nurses explained that newborns diagnosed with NAS are time-consuming and difficult, as they try to balance keeping the withdrawing baby comfortable on top of their regular nursing responsibilities. The nurses in Romisher and colleagues' (2018) study also described newborns diagnosed with NAS as time-consuming, as much of their time was spent trying to calm and comfort the newborns. They expressed feeling stressed and frustrated when they were unable to respond to the newborns needs as quickly as they would like to (Romisher et al., 2018).

Within this current study, the nurses also spoke of the emotional burden of caring for newborns diagnosed with NAS. They expressed feelings of sadness, irritation, and stress. *Stress, frustration, and burnout* was a theme in Murphy-Oikonen and colleagues (2010) research. The nurses in their study explained that they have a commitment to caring for newborns. However, when unable to console the high-pitched cries of a newborn diagnosed with NAS, they often felt frustrated and burnt out. Their stress also heightened when they had to balance their care of a newborn diagnosed with NAS with additional newborns with more complicated medical needs (Murphy-Oikonen et al., 2010). Similarly, the nurses in Maguire and colleagues (2012) research

expressed stress and frustration when unable to console newborns diagnosed with NAS. The nurses in this current study further explained that sometimes their irritability from the time-consuming and demanding nature of caring for newborns diagnosed with NAS can interfere with their therapeutic relationships with mothers.

Emotional distress was not only described when caring for newborns diagnosed with NAS; the nurses within this thesis study also expressed feeling stressed and frustrated when caring for the mothers, which ultimately had a negative effect on their therapeutic relationship. Maguire and colleagues' (2012) also reported that nurses in their study felt that caring for parents of newborns diagnosed with NAS was a "significant cause of distress" (p. 283). They shared that they often experience abusive and aggressive behaviors from parents. This finding was also represented in this current study when participants shared that they struggled to form therapeutic relationships when they were concerned for their own safety. The nurses in this study also expressed frustration when they felt mothers were not receptive of their teaching about caring for newborns experiencing withdrawal. Within the theme *difficult relationship with the mother*, nurses in Romisher and colleagues' (2018) research shared that they felt mothers of newborns diagnosed with NAS often do not understand their babies' treatment plans. Negative experiences with mothers of newborns diagnosed with NAS can interfere with nurses' abilities to be non-judgemental and care for them (Fraser et al., 2007; Murphy-Oikonen et al., 2010).

Collaborating with CAS

The influence of CAS involvement and the therapeutic relationships between nurses and mothers of newborns diagnosed with NAS was a significant finding in this study. Previous research has demonstrated the challenges nurses face when caring for families involved with child protective services (Barrett et al., 2017; Saltmarsh & Wilson, 2017). Nurses can be

judgemental and struggle to form trust with these families. Ultimately this can lead to the parents avoiding the nurses and to the deterioration of the nurse-client relationship (Saltmarsh & Wilson, 2017). Nurses in Barrett and colleagues' (2017) study identified that nurses valued maintaining family-centred care, regardless of their negative feelings towards parents who have caused non-accidental injuries to their children. Previous literature has revealed that nurses can struggle to form relationships with parents involved with child protective services due to their negative perceptions towards the parents (Saltmarsh & Wilson, 2017). However, to the best of my knowledge, there are no other studies that discuss how child protective services can interfere with the nurse-client therapeutic relationship.

In Ontario, nurses have a professional obligation to report any child safety concerns and may disclose personal health information to the CAS, if it enables the CAS to fulfil their statutory functions (The Government of Ontario, 2004; The Government of Ontario, 2017). The nurses in this study described how sometimes they are requested to withhold information about the involvement of CAS from mothers of newborns diagnosed with NAS. They felt that this restricted their ability to be trustworthy and honest with the mothers. Trust is a critical component to the nurse-client therapeutic relationship (CNO, 2019), and mothers of newborns diagnosed with NAS have previously expressed that they struggle to trust nurses (Cleveland & Bonugli, 2014). Within this study, the nurses made apparent that their obligation to the CAS can be detrimental to their nurse-client therapeutic relationships in addition to inducing nurses' stress and frustration.

Struggling with Stigma

Link and Phelan (2001) conceptualized stigma as "the relationship between attributes and stereotypes" (p.366). They theorized that stigma occurs when labelling, stereotyping, separation,

as well as status loss and discrimination exist within an imbalance of power (Link & Phelan, 2001). The nurses in this thesis study acknowledged the presence of stigma towards mothers of newborns diagnosed with NAS. Evidence of stigma, in accordance to Link and Phelan's (2001) conceptualization of stigma, is also present in previous literature. Mothers are labelled, as they are often referred to as 'substance users' or 'drug-abusing moms' (Fraser et al., 2007; Maguire et al., 2012). A nurse in Maguire and colleagues' (2012) study demonstrated stereotyping, as she stated that mothers of newborns diagnosed with NAS "all have the same personality" (p.283). Within the study reported in this thesis, another nurse observed stereotyping while talking about preconceived notions, stating, "we kind of like put them in a cookie cutter of what they're going to be like". According to Link and Phelan (2001), separation is when labelling and stereotyping permits a "separation of 'us' from 'them'" (p. 370); promoting a belief that the stigmatized person is completely different in comparison to the non-stigmatized person. Separation is apparent as nurses can struggle to have empathy for mothers of newborns diagnosed with NAS (Murphy-Oikonen et al., 2010). Status loss and discrimination is almost inevitable for negatively labelled individuals, resulting in disadvantages to their health, education, and employment (Link & Phelan, 2001). A nurse in this current study provided an example of discrimination when she explained, "I do find that there are some groups of nurses that will have kind of the attitude of like…just that mom's a burden for being there". We know that mothers have also avoided entering NICUs because of their negative experiences with nurses (Cleveland & Bonugli, 2014; Cleveland & Gill, 2013), which is a disadvantage because maternal involvement in care is not only essential for mother-infant bonding, but it also can decrease newborns' need for pharmacological interventions and overall length of stay in the hospital (Hünseler et al., 2013).

Lastly, there is an imbalance of power between nurses and mothers of newborns diagnosed with NAS. Within the CNO's (2019) practice standard for nurse-client therapeutic relationships, power is described as a component of this relationship. The College explains that nurses have more power than clients, as "the nurse has more authority and influence in the health care system, specialized knowledge, access to privileged information, and the ability to advocate for the client" (p. 4). Specifically within the NICU setting, a study by Sigurdson and colleagues (2020) interviewed families about their NICU experiences. The researchers found a lack of power-sharing was frequently evident throughout interviews when discussing gaps in family-centred care; powerlessness was apparent when parents tried to obtain resources or influence hospital policies and procedures, additionally, families shared accounts of standing up for their self-worth as parents (Sigurdson et al., 2020). Overall, power imbalances are inherent to NICU settings and greater facilitate the stigma towards mothers of newborns diagnosed with NAS.

The nurses in this current study, however, went beyond identifying the existence of stigma and negative attitudes towards mothers of newborns diagnosed with NAS. This study provides examples of how nurses skilled in establishing therapeutic relationships can openly reflect on these feelings and behaviours. The nurses discussed trying to understand where these feelings and behaviours come from and how they influence their nursing practice. They were able to describe how these challenges affect their therapeutic relationships, and they strived to overcome these challenges. A literature review which explored reflective practice in nursing found that self-reflection expands clinical knowledge and helps nurses cope with emotional burdens (Caldwell & Grobbel, 2013). Stigma towards mothers of newborns diagnosed with NAS is inappropriate. The practice of self-reflection in nursing is significant, as this may help reduce the existing stigma towards this marginalized population.

Nursing Implications

The research findings within this thesis have implications for nursing practice, education, policy, and research. In the following section, I describe and discuss these implications.

Nursing Practice

When the nurses in this study discussed the challenges of NAS and how they impact their therapeutic relationships, they shared that caring for newborns diagnosed with NAS and their mothers is difficult and demanding. Implications for nursing practice include an interdisciplinary and collaborative approach to family-centred care, implementation of structured mentorship, and promoting self-reflection.

The nurses within this study expressed frustration when they felt unable to engage mothers of newborns diagnosed with NAS in teaching about how to care for their withdrawing babies. This ultimately affected their therapeutic relationships. Previous research has also demonstrated that nurses have felt that mothers of newborns diagnosed with NAS often do not understand their newborns' care plan (Romisher et al., 2018). Family-centred care focuses on the inclusion of family within the healthcare team, and can improve mother-child interactions, reduce hospital length-of-stay, and increased parent and staff satisfaction (Serlachius et al., 2018). An interdisciplinary and collaborative approach enables family-centred care to be more tailored to meet the needs of each specific family (Craig et al., 2015). A study by Trujillo and colleagues (2017) analyzed the effectiveness of interdisciplinary family conferences within the NICU setting, where parents met with the physicians, social workers, and the rest of the interdisciplinary team to discuss their newborn's care. The interdisciplinary family conferences improved parents' understanding of their newborn's care plan and their satisfaction with their NICU stay (Trujillo et al., 2017). Greater collaboration with mothers with a history of substance

use and/or misuse is also recommended by the British Columbia Women's Hospital and Health Centre (2020), suggesting health care providers share decision making power and partner with mothers to support their individual care needs. Using an interdisciplinary and collaborative approach to family-centred care could increase mothers' understanding of how to care for their withdrawing newborns, and ultimately reduce some of the challenges felt by nurses when trying to form therapeutic relationships with this population.

The second implication for nursing practice is implementation of structured mentorship for nurses who are novice to working with NAS. The nurses in this study shared that they had little training on how to care for mothers of newborns diagnosed with NAS. Nevertheless, there are nurses who are good at establishing therapeutic relationships with these mothers, and they could offer mentorship to their colleagues to promote greater engagement in therapeutic relationships. The College and Association of Registered Nurses of Alberta (CARNA) recommends nursing mentorship, "…as it supports professional socialization, fosters a professional and safe work environment, supports professional growth, increases job satisfaction, improves recruitment and retention, and supports nurses to provide safe, competent, and ethical care" (CARNA, 2019, p.1). Abdullah et al. (2018) described the outcomes of mentoring within the Registered Nurses' Association of Ontario (RNAO) Best Practice Guidelines Implementation/Knowledge Transfer Fellowship program. Both mentees and mentors enhanced their professional development; mentees felt more confident and mentors felt rewarded through mentoring. In addition, the mentees and mentors developed an ongoing relationship; mentees felt comfortable going back to their mentors for more help even after the mentorship intervention was over (Abdullah et al., 2018). Structured mentorship for caring for mothers of newborns

diagnosed with NAS could greatly promote therapeutic relationships with this population. Nurses would feel more confident and supported in providing safe, competent, and ethical care.

Throughout the literature, nurses have previously reported negative and judgemental attitudes towards mothers of newborns diagnosed with NAS (Murphy-Oikonen et al., 2010; Raeside, 2003; Romisher et al., 2018). However, this current study goes beyond identifying the existence of nurses' negative attitudes, as it provides examples of how nurses who have had some successful therapeutic relationships openly reflect on these feelings. Critical reflexivity occurs when one questions their own personal values and assumptions, allowing for greater personal and professional development in addition to benefiting therapeutic relationships (Timmins, 2006). The nurses in this current study demonstrated reflexivity, as they tried to understand and explain where their attitudes come from and how it influenced their practice. Additionally, the nurses within this study described striving to remove their biases. The nurses pointed out how *the challenges of working with NAS* affect their therapeutic relationships with mothers. Self-reflection expands clinical knowledge and helps nurses cope with emotional burdens (Caldwell & Grobbel, 2020). Mentor support and non-judgemental environments where nurses can safely communicate and reflect on their thoughts and feelings about working with NAS may improve nursing practice and emotional distress, enabling nurses to provide better care for newborns diagnosed with NAS and their mothers while not ignoring their feelings (Marcellus, 2014).

Nursing Education

Currently, the CNO entry-to-practice competencies state that RNs, as clinicians, are to incorporate "principles of harm reduction with respect to substance use and misuse into plans of care" and provide "recovery-oriented nursing care in partnership with clients who experience a

mental health condition and/or addiction" (CNO, 2019b, p. 5). The Canadian Association of Schools of Nursing (CASN), Association of Faculties of Pharmacy of Canada (AFPC), and Canadian Association for Social Work Education – Association Canadienne pour la Formation en Travail Social (CASWE-ACFTS) also has established a guideline for interprofessional education on opioid use and opioid use disorders (AFPC, CASN, & CASWE-ACFTS, 2020). The nurses in this current study, however, expressed that they lacked education on how to work with individuals who use substances. The RNAO's clinical best practice guideline, *Engaging Clients Who Use Substances*, notes that when health-care providers have poor confidence, self-efficacy, and perceptions of skill, their care for clients who use substances is negatively affected (RNAO, 2015). Therefore, the primary implication for nursing education is to critically examine how undergraduate nursing students are taught about substance use and misuse and identify more effective educational strategies. Second, the nursing curriculum should highlight the prevalence of trauma and stigma in those who use and misuse substances.

Within the interprofessional education guideline on opioid use and opioid use disorders, the relationships between opioid use disorders and trauma and stigma is highlighted (AFPC, CASN, & CASWE-ACFTS, 2020). The CNO entry-to-practice competencies note that RNs must be able to use the principles of trauma-informed care, however, it does not specifically recognise an association between substance use and trauma. Stigma is not explicitly mentioned within the entry-to-practice competencies, but RNs are expected to identify "the influence of personal values, beliefs, and positional power on clients and the health care team and acts to reduce bias and influences" (CNO, 2019b, p. 6). The concepts of trauma and stigma may already be individually taught in undergraduate nursing education, however, their connection to substance use and misuse should be highlighted within curriculum.

Several Canadian organizations identify trauma as a risk factor for substance use and/or misuse (British Columbia Ministry of Children and Family Development, 2017; Canadian Centre on Substance Abuse, 2014; RNAO, 2015). Traumatic events, such as adverse childhood experiences, intimate partner violence (IPV), and sexual assault are frequently reported in women who misuse substances (Edwards et al., 2017; Finnegan, 2013; Wiig et al., 2017). Within the subthemes, *making a connection* and *getting to know mom and her needs*, the nurses in this study expressed that it was easier to build a therapeutic relationship when they were empathetic to the possibility that mothers may have experienced trauma in the past. Teaching undergraduate students the prevalence of trauma among individuals who use and/or misuse substances may benefit their future engagement in therapeutic relationships with this population.

Stigma towards individuals who use and/or misuse substances also creates a disadvantage within this population (RNAO, 2015). Stigmatized individuals whoe use and/or misuse substances are at greater risk for "poor mental and physical health, barriers to engagement or completion of substance use interventions, delayed recovery or reintegration processes, and increased involvement in risky behaviour" (RNAO, 2015, p. 19). The nurses in this study explained that although they are aware of the existing stigma towards mothers with a history of substance use and actively try to avoid stigmatizing behaviour, they still struggle with mitigating stigma in their workplace. Nurses' ability to openly reflect on stigma was an important finding within this study, as this helped them overcome this challenge when working with mothers of newborns diagnosed with NAS and better their therapeutic relationships. The RNAO clinical best practice guideline also recommends that nurses reflect on their attitudes, perceptions, beliefs, biases, and values when working with individuals who use and/or misuse substances, as this can reduce stigma (RNAO, 2015). Undergraduate nursing students should not only be taught

about the prevalence of substance use and misuse and its association with stigma, but also how to critically reflect on their own potential biases towards substance use. Additionally, students should learn how stigma creates barriers to health and wellness in individuals who use substances, and how to strive towards reducing this stigma within nursing practice. Understanding and reflecting on the nature of stigma towards individuals who use substances within nursing is necessary, as this could improve therapeutic relationships with mothers of newborns diagnosed with NAS and other marginalized populations.

Nursing Policy

There are several implications for nursing policy that are relevant from my findings, such as policies for greater collaboration between nurses and the CAS, as well as implementation of rooming-in and trauma-informed care.

When the nurses in this study discussed what makes forming therapeutic relationships more difficult, the majority explained that CAS involvement can interfere with their ability to build and maintain this relationship. Nurses have a professional obligation to report any child protection concerns and may disclose personal health information to the CAS, if it enables the CAS to fulfil their statutory functions (The Government of Ontario, 2004; The Government of Ontario, 2017). Currently, some of the nursing regulatory bodies across Canada offer standards and guidelines to RNs that explain the professions' duty to report, when RNs should report, and how RNs can report (British Columbia College of Nursing Professionals, 2020; CNO, 2019c). Hospitals may have independently developed policies that clearly outline the role of nurses when working with CAS and guide them on how to respond to child protection concerns whilst maintaining therapeutic relationships with the parents. However, this information is often only available to the nurses currently employed at the organisation. Nursing regulatory bodies are

lacking publicly available policies and guidelines that enable nurses to navigate collaboration with CAS while simultaneously engaging in therapeutic relationships with mothers being followed by CAS. The nurses in this study shared that they were often aware that CAS was getting involved, or even apprehending a newborn, prior to the mother knowing. They also explained that they are sometimes asked to document mothers' behaviours for CAS, and they do not always inform the mother of what they are documenting. This led them to feeling dishonest, which they believed affected their ability to form trust and establish therapeutic relationships. Nursing policies should be developed in a manner that permits nurses to maintain trust and continue building their therapeutic relationships whilst continuing to collaborate with CAS.

In Ontario, the field of social work has examined how they maintain and/or repair their therapeutic relationships with clients throughout the process of reporting to CAS (Tufford, 2014; Tufford & Lee, 2020). Social workers will frequently offer clients additional sessions, emotional support, and prepare clients for child protection interventions (Tufford & Lee, 2020). These actions are described as paramount, as they assist families in understanding and navigating the systems of care in addition to encouraging parents to strive for positive change (Tufford & Lee, 2020). Collaboration between the fields of social work and nursing could inform the development policies that promote therapeutic relationships whilst working with the CAS.

The next implication for nursing policy is greater implementation of rooming-in. Rooming-in is the care practice of maintaining continuous close contact between the mother and newborn (MacMillan et al., 2018). Several studies have demonstrated that rooming-in practices reduce the need for pharmacological treatments and hospital length-of-stay in newborns diagnosed with NAS (Edwards & Brown, 2016; MacMillan et al., 2018; Newman et al., 2015). Rooming-in may also decrease mothers' psychosocial stressors, as the mother-newborn dyad is

kept together in the immediate postpartum period which enables the development of mother-infant bonding (Newman et al., 2015). When the nurses in this study discussed building therapeutic relationships with mothers of newborns diagnosed with NAS, they explained the importance of involving the mothers in the care of their newborns. Rooming-in practices would greatly promote this involvement, as the mother would have the opportunity to be present in every step of her newborn's care.

Women who use and/or misuse substances frequently report traumatic events, such as adverse childhood experiences, intimate partner violence (IPV), and sexual assault (Edwards et al., 2017; Finnegan, 2013; Wiig et al., 2017). The nurses in this current study shared that they had little training in this area. Within the RNAO best practice guidelines, a trauma-informed care approach is recommended when caring for individuals that use and/or misuse substances (RNAO, 2015). There are six key principles to the RNAO's guiding framework for a trauma-informed care approach: *safety* – promoting physical and psychological safety throughout the organization; *trustworthiness and transparency* – operations and decisions are made transparent to promote trust; *peer support* – promoting recovery and healing through the support of other trauma survivors; *collaboration and mutuality* – levelling power differences and encouraging shared decision making; *empowerment, voice, and choice* – recognizing individual's strengths and supporting self-advocacy; and *cultural, historical, and gender issues* – actively moving past cultural stereotypes and biases (RNAO, 2017). Implementing policies that promote some or all of these key principles for a trauma-informed care approach may benefit nurses when caring for mothers of newborns diagnosed with NAS.

Nursing Research

The findings from this study support multiple implications for future nursing research. There are implications for research that explores therapeutic relationships from the mothers' perspective and research that investigates CAS involvement and nursing practice.

The purpose of this thesis was to explore neonatal nurses' experiences of engaging in therapeutic relationships with mothers of newborns with NAS. However, there is still much to learn about how mothers of newborns diagnosed with NAS experience therapeutic relationships. Within the theme *building the relationship,* we discussed subthemes: *assessing the mother and choosing an approach*, *caring for and involving the mother*, *making a connection*, and *getting to know mom and her needs*. These subthemes could be further explored through the mothers' perspective. How do mothers of newborns diagnosed with NAS prefer to be approached? How do they like to be involved in care? What does *making a connection* look like to them? What are their needs? Investigating this therapeutic relationship from the mothers' perspective could greatly improve how nurses build and maintain their therapeutic relationship.

Research that focuses on the collaboration between neonatal nurses and the CAS as well as research that further investigates how CAS involvement affects nurse-client therapeutic relationships could greatly benefit nursing practice. Further investigating these topics could help develop policies that promote nurse-CAS collaboration whilst maintaining therapeutic relationships with parents. Collaborative nursing-social work research could also optimize this investigation, as research within social work has already begun to explore how social workers can maintain therapeutic relationships with parents throughout the course of collaborating with child protective services (Tufford, 2014; Tufford & Lee, 2020).

Strengths and Limitations

There were several strengths and limitations of this study. Telephone interviews were viewed as a strength in this research study and facilitated recruitment during the COVID-19 pandemic. Although visual cues are absent during telephone interviews, researchers who have used this interviewing method have described their interviewees as being more relaxed and willing to share intimate information (Novick, 2008). The participants in this study seemed comfortable sharing personal details regarding their experiences when working with mothers of newborns diagnosed NAS, as this was reflected in the richness of the data. The second strength to this study is my experience as a RN in NICU settings. I have personal experience working with newborns diagnosed with NAS, their mothers, and CAS. My familiarity with this research topic enabled me to understand and relate to participants throughout their interviews. This allowed me to probe further throughout the interviews to gain a greater depth of data and identify what participants perceived as most important surrounding this topic.

Limitations within this study include lack of gender diversity among participants and recruitment from a single setting. All of the participants self-identified as female. Experiences of working with mothers of newborns with diagnosed NAS may differ among those who identify as male or non-binary. Additionally, recruitment only took place at one setting. Neonatal nurses from other hospitals may have different experiences when engaging in these therapeutic relationships and may have precipitated different themes.

Conclusion

The purpose of this research was to explore neonatal nurses' experiences of engaging in therapeutic relationships with mothers of newborns diagnosed with NAS, and my goal was to answer the research question, "how do neonatal nurses form therapeutic relationships with

mothers of newborns diagnosed with NAS?". Six neonatal nurses provided a wealth of information from their individual practices. They shared their hardships and their successes. With this rich data, I was able to describe the strategies these nurses use to successfully build and maintain therapeutic relationships with mothers of newborns diagnosed with NAS. Additionally, the nurses' contributions helped us better understand the challenges they face when trying to form these relationships. These findings have the potential to advance nursing practice, education, policy, and research – which may contribute enhanced support for mothers of newborns diagnosed with NAS.

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Appendix A: Research Ethics Board Approval from The University of Ottawa

27/03/2020

Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

Lettre d'approbation administrative | Letter of administrative approval

Numéro de dossier / Ethics File Number	H-03-20-5558
Titre du projet / Project Title	The Experiences of Nurses Engaging in Therapeutic Relationships with Mothers of Infants Diagnosed with Neonatal Abstinence Syndrome
Type de projet / Project Type	Thèse de maîtrise / Master's thesis
CÉR primaire / Primary REB	Réseau de science de la santé d'Ottawa (RSSO) / Ottawa Health Science Network (OHSN)
Statut du projet / Project Status	Approuvé / Approved
Date d'approbation (jj/mm/aaaa) / Approval Date (dd/mm/yyyy)	27/03/2020
Date d'expiration (jj/mm/aaaa) / Expiry Date (dd/mm/yyyy)	28/02/2021

Équipe de recherche / Research Team

Chercheur / Researcher	Affiliation	Role
Brett ASTON	Ecole des sciences infirmieres / School of Nursing	Chercheur Principal / Principal Investigator
Wendy PETERSON	Ecole des sciences infirmieres / School of Nursing	Superviseur / Supervisor
Brandi VANDERSPANK	Ecole des sciences infirmieres / School of Nursing	Autre / Other
Christina CANTIN	Champlain Maternal Newborn Regional Program	Autre / Other

Conditions spéciales ou commentaires / Special conditions or comments:

OHSN REB Protocol ID: 20190775-01H

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27/03/2020

Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

L'Université d'Ottawa a signé une Entente, conforme aux exigences de la plus récente version de l'EPTC et tout autre règlement ou législation applicable, permettant au CÉR ci-haut nommé d'être désigné comme CÉR primaire pour les projets de recherche où

1) les activités principales de recherche sont menées sous l'autorité ou sous les auspices de l'établissement lié au CÉR primaire et

2) Une partie du projet est également réalisé sous l'autorité ou sous les auspices de l'Université d'Ottawa.

Cette lettre confirme que l'Université d'Ottawa a autorisé que le CÉR primaire soit le CÉR officiel pour l'évaluation et la supervision de ce projet de recherche. Ceci n'est pas une approbation éthique.

Afin de nous aider à garder votre dossier à jour, veuillez soumettre une copie de toutes demandes de modification, renouvellement d'approbation éthique etc. soumis à et approuvé par le CÉR primaire dès qu'elles sont disponibles.

Cette approbation administrative est valide pour la durée indiquée ci-haut et est sujette aux conditions énumérées dans la section intitulée « Conditions spéciales ou commentaires ».

The University of Ottawa has signed an Agreement, compliant with current TCPS guidelines and any other applicable guidelines or legislation regarding multisite review, allowing the REB named above to serve as Board of Record (BoR) for research projects where

1) the main research activities are conducted within the auspices or jurisdiction of the BoR's institution and

2) parts of the project are also conducted under the jurisdiction or auspices of the University of Ottawa.

This letter confirms that the University of Ottawa has authorized the REB named above to serve as Board of Record for the review and oversight of this research project. This is not an REB approval.

In order to help us keep your file up to date, please submit a copy of all amendment requests, project renewals or any other changes submitted to and approved by the BoR, as they become available.

Administrative approval is valid for the period indicated above and is subject to the conditions listed in the section entitled «Special conditions or comments».

Catherine PAQUET
Directeur / Director
Pour/For Daniel LAGAREC President(e) du/ Chair of the Comité d'éthique de la recherche en sciences de la santé et sciences / Health Sciences and Sciences Research Ethics Board

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Appendix B: Research Ethics Board Approval from Research Setting Hospital

[redacted]

February 28, 2020

Ms. Brett Aston

[redacted]

Protocol ID#: 20190775-01H;

The Experiences of Nurses Engaging in Therapeutic Relationships with Mothers of Infants Diagnosed with Neonatal Abstinence Syndrome

Dear Ms. Brett Aston,

This letter serves as O[redacted] Institutional Approval for the above-referenced study. Please maintain this documentation in your investigator study file.

Based on the information you provided about this study through the Clinical Research Registration Form, you have satisfied the requirements for institutional ([redacted]) approval. This includes initial research ethics approval by [redacted] REB, appropriate departmental/service area notifications and execution (fully signed versions) of all agreement(s) required to begin the study locally. Please note there may be additional agreement(s) pending execution that are required to send funds, samples, or data to external sites, but are not required for you to begin your study locally.

Changes and/or additions to your study that may require additional agreement(s) or revisions to existing agreement(s) must be communicated to the [redacted] Contracts Office. This should be undertaken simultaneously with any related [redacted] amendment submission.

Changes and/or additions to your study that affect various hospital/institution departments (e.g., pharmacy, Department of Medical Imaging, EORLA, EEG, etc.) must be communicated to the relevant departments.

As mentioned in the 'Response' tab of the Ethics application, you have 3 months from the date of initial [redacted] approval to submit French documents including the translation certificate to [redacted] through the Translated Documents section of the ethics application (if applicable).

Should you have any questions, please contact [redacted]

[redacted]

[redacted]

Appendix C: Participant Consent Form

[redacted]

uOttawa

Minimal Risk Informed Consent Form for Participation in a Research Study

Study Title: The Experiences of Nurses Engaging in Therapeutic Relationships with Mothers of Infants Diagnosed with Neonatal Abstinence Syndrome

[redacted] **Number**: 20190775-01H

Investigators:

Brett Aston (Principal Investigator), Graduate Student, School of Nursing, University of Ottawa, Telephone: [redacted]

Wendy Peterson, Associate Professor, School of Nursing, University of Ottawa

Brandi Vanderspank-Wright, Associate Professor, School of Nursing, University of Ottawa

Christina Cantin, Perinatal Consultant, Champlain Maternal Newborn Regional Program

INTRODUCTION

You are being invited to participate in a research study. You are invited to participate in this study because you are a registered nurse who has experience working with mothers of infants diagnosed with neonatal abstinence syndrome (NAS). This consent form provides you with information to help you make an informed choice. Please read this document carefully and ask any questions you may have. All your questions should be answered to your satisfaction before you decide whether to participate in this research study.

Please take your time in making your decision. You may find it helpful to discuss it with your friends and family.

Taking part in this study is voluntary. You have the option to not participate at all or you may choose to leave the study at any time. Whatever you choose, it will not affect your employment or academic prospects.

IS THERE A CONFLICT OF INTEREST?

There are no conflicts of interest to declare related to this study.

WHY IS THIS STUDY BEING DONE?

The purpose of this study is to explore neonatal nurses' experiences of engaging in therapeutic relationships with mothers of infants with NAS.

HOW MANY PEOPLE WILL TAKE PART IN THIS STUDY?

It is anticipated that about 6-11 nurses from [redacted] will take part in this study.

This study should take 1-2 years to complete and the results should be known in about 1-2 years.

WHAT WILL HAPPEN DURING THIS STUDY?

You will be asked to participate in one audio-recorded telephone interview. During this interview, you will speak with the Principal Investigator of the research team. The interview will be about approximately 45-60 minutes in length. You will be asked to speak about your experiences of engaging in therapeutic relationships with mothers of infants diagnosed with NAS.

You will be audio recorded during the interview.

At the beginning of your interview, you will be asked several demographic questions. The purpose of these questions is to understand how demographic information, such as age and years of experience, may correlate to nurses' experiences of engaging in therapeutic relationships with mothers of infants diagnosed with NAS.

The information you provide is for research purposes only. Some of the questions are personal. You can choose not to answer questions if you wish.

HOW LONG WILL PARTICIPANTS BE IN THE STUDY?

Your participation on this study will last for approximately 1 hour.

CAN PARTICIPANTS CHOOSE TO LEAVE THE STUDY?

You can choose to end your participation in this research (called withdrawal) at any time without having to provide a reason. If you choose to withdraw from the study, you are encouraged to contact the research team.

You may withdraw your permission to use information that was collected about you for this study at any time by letting the research team know. However, this would also mean that you withdraw from the study.

If you decide to leave the study, you can ask that the information that was collected about you not be used for the study. Let the research team know if you choose this.

WHAT ARE THE RISKS OR HARMS OF PARTICIPATING IN THIS STUDY?

You may become uncomfortable while discussing your experiences. You may choose not to answer questions or leave the interview at any time if you experience any discomfort.

WHAT ARE THE BENEFITS OF PARTICIPATING IN THIS STUDY?

You may not receive direct benefit from participating in this study. We hope the information learned from this study will stimulate self-reflection among nurses who find caring for mothers of babies with NAS challenging and potentially inform interventions in undergraduate nursing program curriculum or continuing professional education programs to improve therapeutic relationships in nursing practice.

HOW WILL PARTICIPANT INFORMATION BE KEPT CONFIDENTIAL?

If you decide to participate in this study, the research team will only collect the information they need for this study.

Records identifying you at this centre will be kept confidential and, to the extent permitted by the applicable laws, will not be disclosed or made publicly available, except as described in this consent document.

Authorized representatives of the following organization may look at your original (identifiable) records at the site where these records are held, to check that the information collected for the study is correct and follows proper laws and guidelines.

- [redacted]
- [redacted]

Communication via e-mail is not absolutely secure. We do not recommend that you communicate sensitive personal information via e-mail.

During the discussions, participants will be encouraged to refrain from using names. If names or other identifying information is shared during the discussion, it will not be

included in the written records. The audio recordings will be transcribed and de-identified, using a unique numeric identifier.

This study requires the transfer of identifiable information to the University of Ottawa for the purposes of conducting the study. The following information will be transferred:

- Full Name
- Telephone Number and/or Email
- Audio recording

This consent document and the audio-recorded interview, will be securely stored at Brett Aston's home office until they can be separately transferred to Wendy Peterson's office at Roger Guindon Hall by Brett Aston.

The audio recordings will be stored in a secure location and viewed only by members of the research team. The recordings will be kept until data analysis is completed, and then they will be destroyed.

Information from this research study will be stored in a secure location and deleted and/or shredded by Wendy Peterson or the individual responsible for deleting confidential files at the School of Nursing, Faculty of Health Sciences, University of Ottawa in 10 years.

If the results of this study are published, your identity will remain confidential. It is expected that the information collected during this study will be used in analyses and will be published/ presented to the research community at meetings and in journals.

Your de-identified data from this study may be used for other research purposes. If your study data is shared with other researchers, information that links your study data directly to you will not be shared.

Even though the likelihood that someone may identify you from the study data is very small, it can never be completely eliminated.

WHAT IS THE COST TO PARTICIPANTS?

Participation in this study will not involve any additional costs to you.

ARE STUDY PARTICIPANTS PAID TO BE IN THIS STUDY?

You will be compensated with a $20 eGift card to Amazon.com as an appreciation for your time

WHAT ARE THE RIGHTS OF PARTICIPANTS IN A RESEARCH STUDY?

You will be told, in a timely manner, about new information that may be relevant to your willingness to stay in this study.

You have the right to be informed of the results of this study once the entire study is complete. If you would like to be informed of the results of this study, please contact the research team.

Your rights to privacy are legally protected by federal and provincial laws that require safeguards to ensure that your privacy is respected.

By signing this form, you do not give up any of your legal rights against the researcher or involved institutions for compensation, nor does this form relieve the researcher or their agents of their legal and professional responsibilities.

You will be given a copy of this signed and dated consent form prior to participating in this study.

WHOM DO PARTICIPANTS CONTACT FOR QUESTIONS?

If you have questions about taking part in this study, you can talk to the principle investigator who oversees the study at this institution. That person is:

Brett Aston	[redacted]
Principal Investigator Name	Telephone

If you have questions about your rights as a participant or about ethical issues related to this study, you can talk to someone who is not involved in the study at all. Please contact The [redacted]

[redacted]

uOttawa

Study Title: The Experiences of Nurses Engaging in Therapeutic Relationships with Mothers of Infants Diagnosed with Neonatal Abstinence Syndrome

SIGNATURES

- All my questions have been answered,
- I understand the information within this informed consent form,
- I do not give up any of my legal rights by signing this consent form,
- I agree to take part in this study.

Signature of Participant	Printed Name	Date

Signature of Person Conducting the Consent Discussion	Printed Name and Role	Date

Appendix D: Initial Recruitment Email

Recruitment Email

Study Participant ID

Subject Line: Invitation to participate in nursing research

Hello,

You are being asked to participate in a nursing research study that we are conducting. The title of the study is, "The Experiences of Nurses Engaging in Therapeutic Relationships with Mothers of Infants diagnosed with Neonatal Abstinence Syndrome". One of the investigators, Brett Aston, is a graduate student at the University of Ottawa and is conducting this study for her master's thesis. Wendy Peterson is her thesis supervisor.

Participation is voluntary.

Briefly, the study involves partaking in a 45- to 60-minute telephone interview where participants will be asked to speak about their experiences of engaging in therapeutic relationships with mothers of infants diagnosed with neonatal abstinence syndrome (NAS). Participation in this study will take approximately 1 hour. Participants will be compensated with a $20 eGift card to Amazon.com as an appreciation for their time

The Informed Consent Form is attached for your review.

If you have any questions or if you are interested in participating, please contact Brett Aston at [redacted]

I will be sending a reminder email in 2 weeks.

Thank you,

Brett Aston
University of Ottawa
[redacted]

Version date of this form: March 30, 2020

Appendix E: Reminder Recruitment Email

Reminder Recruitment Email

Study Participant ID

Subject Line: Invitation reminder to participate in research

Hello,

An email was sent to you two weeks ago about participating in a nursing research study that we are conducting. The title of the study is, "The Experiences of Nurses Engaging in Therapeutic Relationships with Mothers of Infants Diagnosed with Neonatal Abstinence Syndrome". One of the investigators, Brett Aston, is a graduate student at the University of Ottawa and is conducting this study for her master's thesis. Wendy Peterson is her thesis supervisor.

Participation is voluntary.

We wanted to send you a quick reminder. Briefly, the study involves partaking in a 45- to 60-minute telephone interview where participants will be asked to speak about their experiences of engaging in therapeutic relationships with mothers of infants with neonatal abstinence syndrome (NAS). Participation in this study will take approximately 1 hour. Participants will be compensated with a $20 eGift card to Amazon.com as an appreciation for their time.

The Informed Consent Form is attached for your review.

If you have any questions or if you are interested in participating, please contact Brett Aston at [redacted]
Thank you,

Brett Aston
University of Ottawa
[redacted]

Version date of this form: March 30, 2020

Appendix F: Recruitment Poster

[redacted] uOttawa

Recruitment Poster

PARTICIPANTS NEEDED FOR RESEARCH IN NURSING

We are looking for volunteers to take part in a study of nurses' experiences in forming therapeutic relationships with mothers of infants Diagnosed with Neonatal Abstinence Syndrome. Participants must meet the following criteria:

- Must be an RN currently working in the SCN at [redacted]
- Has provided direct nursing care for an infant diagnosed with NAS and their mother within the last two years

If you are interested and choose to participate you would be asked to partake in a telephone interview where you will be asked to speak about your experiences of engaging in therapeutic relationships with mothers of infants diagnosed with neonatal abstinence syndrome (NAS).

Your participation in this study would take approximately 1 hour.

In appreciation for your time, you will receive a $20 eGift card to Amazon.com

For more information about this study, please contact
Brett Aston (investigator).

Phone: [redacted]

Email: [redacted]

[redacted]-REB Protocol # 20190775-01H

Version date of this form: March 30, 2020

Appendix G: Interview Guide

Interview Questions

Start: This is Brett Aston and I am interviewing [name] on [date] for the study "The Experiences of Nurses Engaging in Therapeutic Relationships with Mothers of Infants Diagnosed with Neonatal Abstinence Syndrome". Before we begin, do you have any questions for me? OK, and remember if you want me to turn off the recording at any time please just let me know. Also, if you don't want to answer a question just say so – you don't have to explain why.

1. Tell me a story where you had a positive experience working with a mother of an infant with NAS?
    - Tell me more about your relationship with the mother
    - Tell me more about who else what involved in caring for the infant
2. Can you tell me a story where you had a challenging experience working with a mother of an infant with NAS?
    - Tell me more about your relationship with the mother
    - Tell me more about who else what involved in caring for the infant
3. Do you have any work/life experiences, other than working in a SCN/NICU, that you think influences your ability to care for mothers of infants with NAS
4. From your perspective, what makes forming therapeutic relationships with mothers of infants diagnosed with NAS easier?
5. From your perspective, what makes forming therapeutic relationships with mothers of infants diagnosed with NAS more challenging?
6. What strategies have you found to be effective in creating a trusting relationship?
7. What advice would you give to a new nurse who has not yet worked with mothers of infants diagnosed with NAS?

Appendix H: Modified Finnegan Scoring Tool

SAMPLE: Modified Finnegan Neonatal Abstinence Scoring System

DOB _____

Birth Weight _____ grams (x 10% = _____)

Today's Weight _____ grams

Start new scoring sheet daily.

Signs		Score									
Date:	Time:										
Excessive Cry	2										
Excessive cry (inconsolable)	3										
Sleeps <1 hour after feeding	3										
Sleeps 1-2 hours after feeding	2										
Sleeps 2-3 hours after feeding	1										
Hyperactive Moro Reflex	1										
Markedly hyperactive Moro reflex	2										
Mild tremors: disturbed	1										
Moderate/severe tremors: disturbed	2										
Mild tremors: undisturbed	1										
Moderate/severe tremors: undisturbed	2										
Increased muscle tone	1 - 2										
Excoriation: skin red, intact	1										
Excoriation: skin broken	2										
Generalized Seizure	8										
Hyperthermia: axilla temperature ≥ 37.3°C	1										
Frequent yawning (≥ 4 / interval)	1										
Sweating	1										
Nasal stuffiness	1										
Sneezing (≥ 4 / interval)	1										
Tachypnea (rate > 60/minute)	2										
Poor feeding	2										
Vomiting	2										
Loose Stools	2										
Weight loss / Failure to thrive	2										
Excessive irritability	1 - 3										
	Total Score										
	Initials of Scorer										

Name of Scorer	Initials	Signature/Title	Name of Scorer	Initials	Signature/Title

Adapted from: Jansson L, Velez M, Harrow C. (2009). The Opioid Exposed Newborn: Assessment and Pharmacologic Management. *J. Opioid Manag.* 2009; 5(1), 54

Image retrieved from: Provincial Council for Maternal and Child Health (2012). Neonatal abstinence syndrome (NAS) clinical practice guidelines. http://www.pcmch.on.ca/wp-content/uploads/2016/05/NAS-Clinical-Guidelines-Final-March-30-2012-for-website-May-2016.pdf