# APPREHENSION OF NEWBORN INFANTS BY CHILD PROTECTION SERVICES: EXPERIENCES OF MOTHERS

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**Abstract**

In Ontario, 1% of women who give birth have their newborn infant apprehended by child protection agencies (~200/year). Hospital-based perinatal nurses are in a unique position to support mothers. However, there is a lack of research examining mothers' experiences of newborn infant apprehension. The purpose of this study was to explore mothers' experiences with nurses and other providers when newborn infant apprehension occurs. Doka's Disenfranchised Grief Framework was used as a lens to help guide the research questions, methods and analysis. Thorne's Interpretive Descriptive approach was employed. Mothers who had experienced newborn infant apprehension in the last 10 years were recruited from an agency in Ontario. Nine individual, semi-structured interviews were conducted. When analyzing the data, the researchers identified patterns and themes from among the mothers' varied experiences. The analysis resulted in four themes: Not good enough, I am a mother, I have rights, I live everyday like I'm grieving, and Hope in the face of adversity. The findings illuminated the imbalance of power that mothers face when experiencing newborn infant apprehension, where power and authority rest with health and social service providers. This research study will focus on the findings describing what mothers want - for nurses to be open-minded, non-judgmental, to teach mothers regarding cycles of violence, and to advocate for mothers' rights. Ultimately, the mothers posited that nurses are well positioned to empower mothers, thereby giving them the opportunity to begin recovery.

The findings indicate a need for nurses to provide safe, compassionate, competent, ethical care and inform how perinatal nurses can better support mothers experiencing newborn infant apprehension.

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**Acknowledgments**

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## Preface

Approval to conduct this study was provided by The Health Sciences and Science Research Ethics Board at the University of Ottawa. This thesis adds to the current state of literature by contributing in-depth understanding of mothers' experiences of newborn infant apprehension in one Canadian city. Additionally, this is the first study to explore the role of nurses during newborn infant apprehensions in hospitals and provide recommendations for nursing practice. Lastly, this study has contributed evidence to support the conclusion that newborn infant apprehensions at birth are an unethical practice. This research has contributed to my stance that the practice of newborn infant apprehensions occurring at birth should be ended. Instead, I advocate to keep mothers with their newborn infants at birth and provide them with the appropriate resources to support their mothering experiences.

I would like to inform the reader that I conducted this study to create space for mothers' voices to be heard. In doing so, it has become evident that the actions, or inactions, of providers are harmful to mothers affected by newborn infant apprehension. However, rather than blame providers, my intention is to further the development of knowledge surrounding the complex issues associated with newborn infants being apprehended at birth, the experiences of mothers (that are often overlooked), and the implications for improving the care of families.

# Chapter 1: Introduction

The research reported in this master's thesis was conducted through the disciplinary lens of nursing and explored mothers' experiences of having their newborn infants apprehended by child protection services shortly after birth, while still in hospital. This thesis aims to expand our understanding of mothers' experiences, with a specific focus on how the social context influenced their grief experiences, thereby providing insight into how perinatal nurses can better support this population.

## The Study Problem

During the years 2012 to 2015, one percent of women who gave birth in Ontario (approximately 200/year) were determined to be living in circumstances that were unsafe for their newborn infants (BORN, 2016). In these circumstances, child protection services remove the newborn infants from their mothers' care and place the infants in the care of family members or the foster system (Child and Family Services Act, 1990; Ontario Ministry of Children and Youth Services, 2007).

A plethora of long-term adverse outcomes are associated with the removal of newborn infants from their mothers, with a particular concern being mothers' immediate experiences of intense loss and grief (Everitt et al., 2015; Mason et al., 2019). Mothers living in poverty, and particularly those experiencing homelessness, are disproportionately represented among those who have their newborn infants apprehended at birth (Novac et al., 2006; Wall-Wieler et al., 2018b; Wall-Wieler et al., 2018c; Mason et al., 2019). Historically, racialized, and particularly Indigenous mothers, have been socially stereotyped as those living in 'precarious' circumstances, rendering them at greater risk of newborn infant apprehension (Denison, 2012; NWA, 2015; Kenny, 2017; Wall-Wieler, 2018b; Wall-Wieler et al., 2018c). Unfortunately, the grief

experienced by mothers affected by apprehension often goes unrecognized as there is a widespread lack of understanding of the impact of non-death losses; this is particularly seen when non-death losses occur in marginalized populations (Gitterman & Knight, 2018). Ultimately, mothers experience little recognition of their profound grief, and a pervasive lack of support from healthcare and social service providers (McKegney, 2003, Novac et al., 2006; Kenny et al., 2015; Kenny, 2017).

Many in our society believe that these women are at fault for having placed themselves in the unacceptable circumstances that lead to apprehension (McKegney, 2003, Novac et al., 2006; Wells, 2011; Kenny et al., 2015). Mothers are then left feeling blamed by society and denied their right to grieve the loss following their experiences of apprehension (McKegney, 2003; Wells, 2011; Kenny et al., 2015). Ultimately, based on the cumulative findings presented in the literature, when "apprehensions occur at birth, a marginalized birth experience results" (Robertson & Kinsella, 2014, p.20).

Nurses are in a unique position to make a positive impact on the health of populations by using their position of trust to advocate for health promotion and health equity (CNA, 2004; Kearvell & Grant, 2008; Smith & Parker, 2015). Unfortunately, nurses may contribute to stigma and discrimination against marginalized groups (Ebrahimi et al., 2012). Given that nurses are directly involved in caring for mother-newborn infant dyads at birth, they have an obligation to provide equitable support and reduce the disparities for mothers experiencing newborn infant apprehension. The projection of stigmatizing attitudes towards mothers threatens nurses' abilities to develop the trusting relationships that are essential to effectively support mothers as they grieve their loss (Dilworth, 2006; Mill et al., 2010). This missed opportunity to offer immediate

support likely contributes to mothers' experiencing a deep-felt, profound grief (McKegney, 2003; Kenny et al., 2015; Kenny, 2017).

Existing research describes that a profound grief is often experienced by mothers who have had their newborn infants apprehended from their care. Despite identifying mothers' grief as a concern for their long-term well-being, little research has been conducted to understand mothers' grieving in more depth and how the social context influences their grief experiences (Everitt et al., 2015; Kenny et al., 2015; Kenny, 2017; Mason et al., 2019). The study described in this thesis recognizes the need to understand mothers' experiences more fully, and to appreciate the nursing role in situations where newborn infants are apprehended from their mothers in hospital, shortly after childbirth. Therefore, the purpose of this study was to develop understanding of mothers' experiences of having a newborn infant apprehended by child welfare authorities and to inform how perinatal nurses can best support these mothers. The disenfranchised grief framework (Doka, 1989; Doka, 2002) was used to ensure that consideration was given to the social factors influencing mothers' experiences.

### *Child Protection in Ontario*

In Ontario, the Child and Family Services Act (1990) was created to promote the well-being of children in need of protection by offering, wherever appropriate, services that are designed to maintain, support and preserve the family in the least disruptive manner (Ontario Ministry of Children and Youth Services, 2007). A total of 50 mandated Children's Aid Societies (CASs) and Indigenous Child and Family Well-Being Agencies are specifically designated by the Minister of Children and Youth Services to investigate child abuse and neglect, and take the necessary steps to care for children and youth in need of protection (Wegner-Lohin et al., 2014; Ontario Association of Children's Aid Society, 2020). Despite their mission to preserve families,

sometimes these child protection services (CPS) must remove or 'apprehend' children from their parent(s) or guardian(s) to ensure the children's safety (Child and Family Services Act, 1990; Ontario Ministry of Children and Youth Services, 2007). In many of these cases, there is evidence of the children being subjected to abuse or neglect (Child and Family Services Act, 1990; Ontario Ministry of Children and Youth Services, 2007; Fallon et al., 2018). If CPS determines that the safety of a child is at risk, action to remove the child is sought through a court apprehension order whereby a social worker must demonstrate to a judge that the family cannot ensure the safety of a child (Child and Family Services Act, 1990). If other family members are not available to care for the child, they enter the foster system (Child and Family Services Act, 1990; Ontario Ministry of Children and Youth Services, 2007; Statistics Canada, 2011; Brownell & McMurtry, 2015). The final outcome of these temporary placements is unknown at the time of apprehension, yet range from returning the child to their respective parent(s) or guardian(s), receiving services at home to assist in the transition to parenting, voluntary surrender of parental rights, and in more extreme cases, permanent loss of custody of the child (Larrieu et al., 2008). Healthcare providers, teachers and in fact anyone who has suspicions that a child is in need of protection must report their suspicion to a CAS (Healthy Babies Healthy Children Protocol, 2012; Child, Youth and Family Services Act, 2017; Public Health Agency of Canada, 2019). The need to involve CPS is often determined after suspected neglect or maltreatment towards a child (Child, Youth and Family Services Act, 2017).

In Ontario, between the three years of 2012 and 2015, a total of 592 mothers had their newborn infants apprehended by child welfare authorities (BORN, 2016). These newborn infant apprehensions take place in the hospital shortly after birth. CPSs are made aware of the pregnancy/birth by one of three processes.

First, CPSs are most often notified by healthcare providers during a mother's pregnancy (Child and Family Services Act, 1990; Ontario Ministry of Children and Youth Services, 2007; Healthy Babies Healthy Children Protocol, 2012). In Canada, CPS cannot intervene during pregnancy but they do try and engage parents in services. For example, CPS does suggest enrolling pregnant women "who are considered to be more likely than others to take actions that will put their unborn child at risk" in parenting programs that intend to inform mothers on how to care for their child (Richard, 2009, p.3). If services are refused by the expectant mother, the process of initiating a 'birth alert' will commence (Richard, 2009). In these cases, hospitals are asked to notify the child protection agency when the mother presents for childbirth (Richard, 2009). When birth alerts are flagged, mothers are often, but not always, aware that CPS will become involved at the time of birth (Child and Family Services Act, 1990; Everitt et al., 2015). Recently, in Ontario, the provincial government has condemned the practice of birth alerts as it has been reported to disproportionately affect racialized and marginalized mothers and families (Children, Community and Social Services, 2020). Historically, birth alerts have caused fear in pregnant women, deterring them from seeking prenatal care and parenting supports. Ending the use of birth alerts serves to improve outcomes for families and children by shifting focus to prevention and early intervention. With eliminating birth alerts, the provincial government aims to promote collaboration between the child welfare system, hospitals, service and community-based providers. Ultimately, it is unclear at this time if the practice is widespread across the Canada.

A second process that can lead to newborn infant apprehension begins at the time of childbirth, when providers in the hospital (most often a social worker, nurse, physician) notify CPS of their concerns regarding the safety of a newborn infant (Child Youth and Family

Services Act, 2017). Mothers living with multiple intersectionalities, such as racialized, living in poverty, living with addiction, family violence or homelessness are more likely to be reported to CPS by providers (Kenny, 2017). Not all reported concerns of mothers during pregnancy and childbirth will lead to newborn infant apprehension. However, if the safety of a newborn infant remains a concern at the time of birth, and no safety interventions are available to sufficiently mitigate the conditions, apprehension and placement of the newborn infant by CPS is the final safety intervention available (Ontario Ministry of Children and Youth Services, 2007).

Lastly, the third process that can lead to newborn infant apprehension occurs when pregnant women already have an active file with CPS, or have experienced a prior newborn infant apprehension. These mothers will be automatically 'flagged' by CPS when pregnant, resulting in a mandatory assessment for parental capacity with their newborn infant after delivering their newborn infant in the hospital (Wall-Wieler et al., 2018c).

After newborn infant apprehension occurs, protection and support services are often offered to mothers with other children in the home, "these services include counseling, guidance, support, education, and emergency shelter services" (Wall-Wieler et al., 2017a, p.171). However, for mothers with no other children in their care, limited resources are available (Wall-Wieler et al., 2017). Therefore, mothers may be left with having to find alternative supports.

This inadequate support system, combined with the societal stigma and shame experienced by mothers deepens their feelings of mistrust in the systems and people within their environments and communities, causing fear and isolation (Mason et al., 2019). These social barriers prevent mothers from accessing health and social supports, perpetuating even greater vulnerabilities and inequities in health (Pelkonen et al., 1998; Barkin et al., 2003; Dilworth, 2006; Little et al., 2007; Mill et al., 2010; Wells, 2011 Kenny et al., 2015; Kenny, 2017; Mason

et al., 2019). Without accessing supports at the appropriate time, mothers become at increased risk of developing poor health and social conditions, such as mental illness, substance use, and poverty (Wall -Wieler et al. et al., 2017).

An example of a poor health outcome that contributes to mothers' suffering following apprehension is complicated grief. Classified by the American Psychiatric Association (2013) as a form of psychiatric 'illness,' complicated grief occurs when grief lasts greater than 12 months and interferes with an individual's ability to attend to their activities of daily life. If complicated grief is left unsupported, it may deteriorate the long-term well-being of individuals, resulting in an inability to maintain their quality of life (American Psychiatric Association, 2013). Parental loss of a child is considered to have the greatest risk for and prevalence of complicated grief (Kersting & Wagner, 2012). Overall, the term complicated grief is most prevalent in the literature pertaining to the outcomes in mothers associated with newborn infant apprehension (Janzen & Melrose, 2017).

**Purpose of Study**

Various studies have identified characteristics, experiences and outcomes in mothers associated with older child apprehension; however, not much attention has been given to the support mechanisms and nursing care of women during the intrapartum and postpartum period when newborn infant apprehension is considered unavoidable by CPS. Although research has identified that mothers grieve the absence of their apprehended older child(ren) (Raskin, 1992; McKegney, 2003; Novac et al., 2006; Kenny et al., 2015; Kenny, 2017), the characteristics and factors that influence their grief experiences following apprehension have not been well described. The purpose of this study is to describe mothers' experiences of having their newborn infant apprehended at birth and develop further understanding of their grief. The use of Doka's

(1989) disenfranchised grief as a theoretical lens for this inquiry gives attention to how the social context influences mothers' grief experiences. The findings of this proposed study will inform the development of nursing interventions to more effectively support mothers facing newborn infant apprehension.

**Research Questions**

This study was guided by the following research questions: (1) How do mothers describe the experience of having their newborn infant apprehended by child protection services at birth? and (2) What do these descriptions reveal about mothers' grief? The findings of this thesis will contribute to our understanding of: (1) the impact of newborn infant apprehension on mothers' well-being, (2) how mothers' well-being is influenced by experiences of grief, and (3) the nursing role in supporting mothers during newborn apprehension.

**Outline of Chapters**

This thesis is composed of five chapters. This first chapter has introduced why the phenomenon of mothers experiencing newborn infant apprehension requires attention and the relevance of this problem to perinatal nursing practice. In Chapter 2 the literature review presents the existing knowledge of this phenomenon, in turn, providing a foundation of understanding why newborn infant and older child apprehensions occur and the inequities in care that exist for mothers affected by apprehension. Chapter 3 begins by describing the epistemological, ontological, and methodological orientations of this study. Chapter 3 also presents the theoretical framework used to help guide this study, the Disenfranchised Grief Framework (Doka, 1989), and highlights the methodological design used to guide the study: Interpretive Description (Thorne, 2016). Next, Chapter 4 presents the findings of the experiences of mothers who have experienced newborn infant apprehension in hospital. The experiences of nine mothers were

described and included mothers' feelings during pregnancy, at the time of newborn infant apprehension in hospital, and how their experiences of apprehension has affected their lives. Finally, in Chapter 5, I discuss the research findings and how they relate to the theoretical framework and extant literature presented in Chapter 2. I answer the research questions posed in Chapter 1 by providing an interpretation of the study's findings. Chapter 5 finishes by highlighting the strengths and limitations of this study as well as suggests the implications this study has to inform practice, education, and research.

## Chapter 2: Literature review

In this chapter I review the literature exploring newborn infant apprehensions and experiences of mothers. In the first section of this chapter, I synthesize the literature in five sections: (1) factors associated with newborn infant apprehension, (2) health outcomes of mothers after experiencing newborn infant apprehension, (3) mothers' experiences of newborn infant apprehension (4) the role of intrapartum and postpartum nurses for mothers affected by newborn infant apprehension, and (5) the social context of mothers affected by newborn infant apprehension.

### Factors Associated with Newborn Infant Apprehension

Most of the literature examining factors associated with newborn infant and older child apprehension aims to identify predictors that increase the likelihood of apprehension. Predictive research models help identify people at risk of an outcome but most often do not provide targets of intervention (Schooling & Jones, 2018). Most of the literature has focused on the characteristics of mothers that predict older child (versus newborn infant) apprehension in the United States (Minnes et al., 2008; Grant et al., 2011; Grant et al., 2014), Canada (Wall-Wieler et al., 2017a; Wall-Wieler et al., 2018a; Wall-Wieler et al., 2018b**)** and the United Kingdom (Gilchrist & Taylor, 2009). Currently, only a few Canadian studies have focused on examining the predictors of newborn infant apprehension (Brown et al., 2018; Wall-Wieler et al., 2018c).

Focusing on the literature concerning newborn infant apprehension, Wall-Wieler et al. (2018c) conducted a population-based retrospective cohort study using administrative data to identify factors that predict which women are at risk for newborn infant apprehension in Manitoba, Canada. Substance use in mothers was described as "one of the biggest predictors to the involvement with child protective services" (p.5). Other predictors strongly associated with

newborn infant apprehension include: mothers in the care of CPS when giving birth to their first child, schizophrenia, developmental disability, and ‘inadequate’ prenatal care (Wall-Wieler et al., 2018c). Additional predictors include mothers with low education, unemployment, ‘high risk’ lifestyles (e.g., involved in sex work), intimate partner violence, and receiving social welfare benefits (Wall-Wieler et al., 2018c). Despite being a predictive model of research, Wall-Wieler et al. (2018c) suggested an explanation as to why the described characteristics in mothers predicted newborn infant apprehension at birth. The authors noted how the ideological perspective of CPS may influence which characteristics in mothers have greater likelihood of causing the outcome of newborn infant apprehension; for example, providers may perceive "the cycle of involvement with CPS starts with adolescent motherhood (deemed as bad), and the only way to break the cycle is to take that child into care" (p.4). Children of adolescent mothers are described in the literature to be at greater risk of abuse and neglect (Canadian Institute of Child Health, 2000; Ordolis, 2007). Wall-Weiler et al. (2018c) critiqued the perspective that removing a newborn infant from adolescent mothers' care ends the cycle of involvement with CPS. For example, when examining older child apprehension among Indigenous adolescent mothers, Indigenous children raised in the state's care have a higher likelihood of having their own children apprehended from their care (Canadian Institute of Child Health, 2000; Ordolis, 2007). Removing Indigenous children from their mothers not only leads to greater social, political, and economic disadvantage, but also condemns a new generation of Indigenous children into the child welfare system, perpetuating the continuing cycles of marginalization and abuse exemplified by the residential school systems that remove children from First Nations, Inuit and Métis families, communities, and cultures (NWA, 2015). Therefore, Wall-Wieler et al. (2018c) suggested that rather than assessing individual mothers’ capabilities to parent successfully, the

western middle-class values held by CPS may exert a profound influence in predicting the outcome of newborn infant apprehension.

Another population-based study of women in Ontario compared the risk of newborn infant custody loss between women with intellectual or developmental disabilities (IDD) and those without IDD (Brown et al., 2018). Their findings contributed evidence of IDD as a predictor of newborn infant custody loss. Furthermore, among women with IDD, those with psychotic disorder, receiving social assistance, and had fewer prenatal care visits with a healthcare provider were at even higher risk of newborn infant custody loss (Brown et al., 2018). Other studies that have focused more broadly on identifying predictors of child custody loss mirror the findings presented in the research identifying predictors of newborn infant apprehension. For example, living in poverty, living with psychiatric disorders or intellectual/developmental disabilities, substance use before or during pregnancy, having a history of criminal activity (been in prison), and living with another drug user were listed predictors that have been associated with older child apprehension (Gilchrist & Taylor, 2009; Grant et al., 2011).

There are two important limitations of this body of literature. First, although researchers have considered variables that are thought to be potential risk factors for newborn infant apprehension, other predictive variables may exist that remain unaccounted for. Secondly, although the studies predicted who is at risk of newborn apprehension, they do not explain why certain characteristics place a population at risk. Therefore, it is important to question the meaning of the findings from predictive studies. For example, a variable identified as a predictor may or may not cause newborn infant apprehension. While the identification of predictors of newborn infant apprehension may identify specific populations for preventive interventions,

these studies fall short of identifying how to effectively intervene to prevent newborn infant apprehension (Schooling & Jones, 2018).

Overall, in Canada, Indigenous women are over-represented in having their newborn infants apprehended at birth, producing a distressingly high rate of Canadian Indigenous children in government care (Ordolis, 2007; Denison, 2012; NWA, 2015). Due to a long history of racism causing political and social disadvantage, Indigenous women in Canada live with higher rates of poverty, homelessness and increased exposure to illegal substances when compared to non-Indigenous or Caucasian women (Denison, 2012; Kenny, 2017; Wall-Wieler et al., 2018b). Research conducted by Kenny (2017) explained that, in Manitoba specifically, the total number of Indigenous children in care has "nearly doubled over the past decade and is among the highest in the world" (p.305). Similarly, Wall-Wieler et al. (2018b) examined racial inequities regarding the removal of children from their families living in Manitoba and determined that from among 10,000 children in foster care, nearly 90% were Indigenous children. With more Indigenous children entering the state's care or into culturally inappropriate foster homes, the disruption of Indigenous parenting traditions is perpetuated (Kenny, 2017; Wall-Wieler et al., 2018b). Given Canada's long history of colonization and systematic apprehension of Indigenous children, it is not surprising that Indigenous women fear the thought of having their newborn infants apprehended at birth. Consequently, many Indigenous women fear accessing healthcare services (Denison, 2012; NWA, 2015; Sharma et al., 2016; Kenny et al., 2015).

### Health Outcomes of Mothers after Experiencing Newborn Infant Apprehension

The following section summarizes the research examining health outcomes of mothers after experiencing newborn infant apprehension. The four main outcomes reported in the literature are: complicated grief, mental illness, substance use, and subsequent pregnancies.

### *Complicated Grief*

An identified health outcome among mothers who have experienced older child apprehensions is the development of a chronic, unresolved grief (Raskin, 1992; De Simon, 1996; Kellington, 2002; McKegney, 2003; Novac et al., 2006; Robertson & Kinsella, 2014; Kenny et al., 2015). Complicated grief (CG) is a psychiatric diagnosis, defined as an extension of a grief response where the symptomology associated with grief becomes disruptive, pervasive, or longer-lasting than 'normal' (American Psychiatric Association, 2013). The conceptualization of CG builds upon Bowlby's attachment theory (Naomi & Simon, 2013). Attachment theory posits that individuals rely on building close relationships to provide themselves with a sense of emotional security and safety (Bowlby, 1980). Therefore, when a close relationship becomes severed, especially in a sudden, violent, or traumatic way with little to no available supports provided, CG is likely to occur (Shear et al., 2012). CG can manifest in individuals grieving for any reason and is not limited to those experiencing death and bereavement (Shear et al., 2012). Symptoms of CG typically include a marked difficulty accepting loss, experiencing disbelief or emotional numbness, distress when reminiscing memories, experiencing bitterness or anger, and excessive avoidance to the reminders of their loss (i.e., places or situations associated with the loss) (American Psychiatric Association, 2013). Additionally, individuals diagnosed with CG can face experiencing a disruption to their identity. This includes: difficulty trusting other individuals, feeling alone or detached from others, feeling that life is meaningless or empty without the deceased, confusion about one's role in life, and difficulty or reluctance to pursue interest (American Psychiatric Association, 2013). Overall, the risk of developing complicated grief has been described when parents experience losing a child through death or custody loss (Kersting & Wagner, 2012; Zetumer et al., 2014; Janzen & Melrose, 2017).

Although mothers affected by newborn infant and older child apprehension experience symptoms suggestive of a CG response (e.g., blaming themselves, a disinclination to engage in activities, and ruminations of their apprehension experience), it can be argued that these are normal human reactions to such a traumatic experience. According to the results presented by Wall-Wieler et al. (2017) in a population-based study using administrative data from Manitoba, Canada between the years of 1988 and 2011, mothers who lost custody of a child to foster care experienced significantly higher rates of depression, substance use, physician visits for mental illness, and prescribed psychotropic medications compared to mothers surviving the death of a child. The authors suggested the disproportionate rates of mental health concerns among mothers affected by child custody loss reflects the lack of social support and social acknowledgment of mothers' grief (Wall-Wieler et al., 2017). Ultimately, a gap in understanding mothers' grief experiences has led to the medicalization of mothers' grief. "Turning grief into a pathology means treating with medications," which ultimately leaves the grief experiences of mothers affected by newborn infant and older child apprehension decontextualized, making it impossible to understand why these mothers are experiencing profound grief (Granek, 2015, p. 263). Pathologizing grief as psychiatric disorders has led to medicalized interventions, including therapy and prescription medications (Granek, 2015). However, for mothers affected by newborn infant or older child apprehension, accessing therapy to support their grief experiences may be quite difficult as there is a lack of available and accessible resources. Ultimately, with little access to therapy, mothers affected by apprehension are often diagnosed with psychiatric diagnoses and prescribed psychotropic medications **(**Kenny, 2017; Wall-Wieler et al., 2017**;** Wall-Wieler et al., 2017a; Wall-Wieler et al., 2018; Wall-Wieler et al., 2018b).

The notion of pathologizing grief is due to the pervasive Western ideology that grief must be attended to and resolved in a timely manner so individuals "can get back to the job of living full, productive lives as soon as possible" (Granek, 2015, p.258). The idea that grief disrupts lives has transformed the concept from being a normal, multi-faceted response into a social construct governed by normative constraints (Granek, 2015). This ideology of grief has permeated into healthcare settings as well as research where providers have normalized the concept of grief into a medical and psychiatric pathology (Granek, 2015); this is especially seen when grieving extends beyond a certain period of time, such as when grieving takes longer than six months (American Psychiatric Association, 2013). For mothers affected by older child apprehension, the literature has focused attention on mothers 'not dealing' with the acute symptoms associated with grief, which may, over time, evolve into a chronic, unresolved grief (Raskin, 1992; De Simon, 1996; Kellington, 2002; McKegney, 2003; Novac et al., 2006; Robertson & Kinsella, 2014; Kenny et al., 2015). However, rather than focusing on mothers' 'not dealing' with their grief and suggesting their reactions become disorderly, the literature should give attention to the conditions that push mothers away from attending to their acute symptoms of grief. Additionally, the literature should appreciate the individualistic nature of grief, where grief can manifest in various ways and should not need to be resolved within a specific timeframe to be considered normal.

### *Mental Illness*

For mothers whose newborn infant or older child is apprehended, being separated from their child may increase mothers' risk of developing or exacerbating mental illness, especially within the postpartum period (Wall-Wieler et al., 2018b). With little support offered to mothers

affected by apprehension in terms of their mental well-being, the literature highlights the rising mortality rates related to suicide within this population (Wall-Wieler et al., 2018).

Depression and anxiety are common outcomes that occur after childbirth, affecting 10 to 15% of mothers in developed countries (Lanes et al., 2011). Generally, postpartum depression and anxiety have been linked to hormonal changes, history of depression, psychosocial stressors and demands of parenting (Wall-Wieler et al., 2018b). Mothers who experience the apprehension of their newborn infant or older child face many of these stressors (i.e., poverty, mental illness, substance use), and face managing stressors alongside their apprehension experience with little support (Wall-Wieler et al., 2018b; Wall-Wieler et al., 2018c). Not supporting mothers after experiencing apprehension can worsen their health and social conditions (Wall-Wieler et al., 2017). Moreover, mental illness, substance use, and poverty are often described in the literature as conditions that prevent the reunification of mother and child from occurring (Wall-Wieler et al., 2017).

Wall-Wieler et al. (2018b) conducted the first retrospective cohort study using linkable administrative data within Manitoba, Canada between the years of 1995 and 2012. The authors compared mothers who had their first child placed in care with CPS at birth, mothers who received services by CPS yet retained custody of their first child, and mothers who were not involved with CPS. The research findings demonstrated mothers with mental illness are more likely to have a child placed in care, and mothers with pre-existing mental illness are more likely to experience postpartum depression and anxiety. Additionally, Wall-Wieler et al. (2018b) reported mothers who faced instability yet were able to retain custody of their newborn infant after birth reduced their likelihood of postpartum mental illness when compared to mothers who also faced instability yet experienced newborn infant apprehension. Moreover, for mothers who

experienced newborn infant apprehension at birth, the research findings demonstrated a significantly higher rate of antidepressant use when compared to mothers who retained custody as well as to those never involved with CPS (Wall-Wieler et al., 2018b).

A noteworthy finding raised in the literature about older child apprehension was the prevalence of suicide amongst women who had their child apprehended (Wall-Wieler, 2017a; Wall- Wieler et al., 2018). Using similar data presented in Wall-Wieler et al. (2018b), Wall-Wieler et al. (2017a) conducted a cohort study using linkable administrative data in Manitoba, Canada between the years of 1992 and 2015. The authors explored how mothers losing custody of their child have higher risk of death due to suicide when compared to mothers who remained unified with their child. The findings explained that when compared to their biological sisters who did not have a child taken into care, or to mothers who received services from CPS but did not have a child taken into care, death by suicide was greater among mothers whose child was taken into care by CPS [aIRR=4.46 [95% CI, 1.39-14.33] and ARR=3.45 [95% CI, 1.61-7.40], respectively (Wall-Wieler et al., 2017a). In another retrospective matched cohort study conducted by Wall-Wieler et al., (2018), data obtained from the Swedish national registers between the years of 1990 and 2012 described how the mortality rates of mothers who were separated from their child are considered avoidable and preventable, developing the argument that death caused by newborn infant and older child apprehension should be considered as a public health concern.

### *Substance Use*

A common health outcome linked to mothers who have experienced newborn infant or older child apprehension is the triggered use or exacerbation of substance use, and the impacts prolonged substance use has on mothers' health status (Gilchrist & Taylor, 2009; Grant et al.,

2011; Grant et al., 2014; Wall-Wieler et al., 2017; Wall-Wieler et al., 2018c). Wall-Wieler et al. (2017) conducted a population-based longitudinal cohort study, using the data previously collected in the studies Wall-Wieler (2017a) and (2018b). The authors compared mothers' substance use, depression, anxiety and psychotropic treatments for mental illness two years before and after experiencing custody loss of their child. The results included increase in substance use disorder by 97% (95% CI 74% to 123%), increase in depression by 19% (95% CI 10% to 29%), increase in anxiety by 36% (95% CI 23% to 50%) and an increase to all prescription medications by 42% (95% CI 33% to 53%). The population of mothers were also compared two years before and after custody loss to mothers without CPS involvement. The findings concluded that for many of the mothers who did not retain custody of their child, relative to mothers who did retain custody, the adjusted relative rates for substance use disorder increased from 3.77 before custody loss to 5.95 after loss occurred ($p<0.001$) (Wall-Wieler et al., 2017). The authors mentioned that despite the two groups of mothers "being very different in characteristics and health histories before the child was taken into care, these differences increased after the child was taken" (p.1148).

***Subsequent Pregnancies***

Women who lose custody are two times more likely to have a subsequent pregnancy ($p<.005$) (Grant et al., 2011; Grant et al., 2014). Some researchers' interpretations of the high rates of subsequent pregnancies among this population, suggest that mothers may have a subsequent child to avoid 'addressing' their grief (Raskin ,1992; Novac et al., 2006; Grant et al., 2011; Grant et al., 2014), or to 'replace' their lost child (Raskin, 1992). Some studies have even suggested that having a subsequent pregnancy may provide short-term solace to mothers by

replacing their grief symptoms associated with the loss of their first child with feelings of hope and happiness of having the next child (Raskin, 1992; Novac et al., 2006).

In extant literature, having a subsequent pregnancy after experiencing older child apprehension may cause some mothers to 'hold back' emotionally from their subsequent newborn infant in utero until the perceived period of threat to apprehension has passed (Raskin, 1992; Lewis, 2006). For example, holding back emotionally from their subsequent newborn infant in utero has been described by mothers who use substances and have experienced older child apprehension (Raskin, 1992; Grant et al., 2011; Grant et al., 2014). Mothers with histories of substance use have been described as those at risk of causing greater harm to their subsequent newborn infants when compared to mothers who do not use substances, as the odds of mothers using substances increases more than three-fold if an index child was apprehended from their mother's care ($p<.001$) (Grant et al., 2011; Grant et al., 2014). Unfortunately, when mothers cope with the apprehension of their newborn through the use of substances, including during their subsequent pregnancies, they are likely to be viewed as those whose problems "become repeated rather than resolved" (Broadhurst et al., 2015, p. 2256; Canfield et al., 2017). In turn, this sub-population of mothers are at risk of having their subsequent newborn infant apprehended, placing them in a position to be re-traumatized (Raskin, 1992; Canfield et al., 2017).

Based on the literature focusing on subsequent pregnancies within this population of mothers, it is important to question the dominant narrative. To describe this population of mothers as those who develop *risky behaviours* (such as *replacing* their lost child with a subsequent pregnancy) suggests a tone that mothers who become pregnant after experiencing an initial apprehension are those who, despite being told during their first pregnancy that they were unfit to parent a child effectively, will continue to act against the social norm and continue living

with *maladaptive coping behaviours.* Additionally*,* describing mothers as those who need support to change their *risky* behaviour into healthy 'coping strategies' assumes that this population of mothers has options. Mothers facing newborn infant or older child apprehension are disproportionately individuals positioned within the margins of society; in turn, they are positioned lowest in terms of social hierarchy and receive limited opportunities for support (Hatzenbuehler et al., 2013). Rather than blaming mothers for their behaviours, research should focus on the conditions that have led mothers to experience newborn infant or older child apprehension and their subsequent pregnancies.

Overall, describing mothers as risky or as those with maladaptive coping strategies leads to the unsubstantiated generalization that this population of mothers are unable to care for their children safely which, in turn, contributes to their continued oppression. Therefore, it is crucial to consider researchers' epistemological stance when generating knowledge and question the extent to which a researcher's attitude can shape the conclusions drawn from their research. For example, suppose the researcher agrees that mothers choosing to have a second child after experiencing an initial apprehension perpetuates cycles of involvement with CPS. Conducting research with this bias may solidify the impression that mothers affected by apprehension are *the problem* causing the vicious cycle they live within. Overall, there is a gap in the current state of research examining subsequent pregnancies amongst this population of mothers, specifically the mothers' perspectives for desiring another child after experiencing an initial apprehension. Therefore, a critical stance is required to investigate the meaning of subsequent pregnancies to mothers affected by an initial newborn infant or older child apprehension.

**Mothers' Experiences of Older Child Apprehension**

At this point, much of the literature I have discussed in this literature review has focused on mothers' characteristics that predict the outcome of newborn infant and older child apprehension. I will now describe the literature that has been created through a critical stance or qualitative approach, which aim to understand the experiences of mothers affected older child apprehension (Raskin, 1992; McKegney, 2003, Novac et al., 2006; Allison, 2011, Wells, 2011; Kundra and Alexander, 2009; Janzen & Melrose, 2013; Denison et al., 2014; Robertson & Kinsella, 2014; Kenny et al., 2015; Janzen & Melrose, 2017; Kenny, 2017; Kenny & Barrington, 2018; Broadhurst & Mason, 2019). Concerning newborn infant apprehensions, to date, only one qualitative study has explored the phenomenon through midwives' perspectives (Everitt et al., 2015). This next section will review the literature of what is known regarding the experiences of mothers. I synthesize and describe the literature in three sections: (1) traumatizing experience, (2) altered maternal identity and (3) stigma and avoidance to healthcare services.

### *Traumatizing Experiences*

Experiencing newborn infant or older child apprehension has been described in the literature as a traumatic life event (McKegney, 2003, Wells, 2011; Denison et al., 2014; Robertson & Kinsella, 2014; Everitt et al., 2015; Kenny et al., 2015; Kenny, 2017; Broadhurst & Mason, 2019). At times, mothers are made aware that newborn infant apprehension at birth will likely occur, but there are situations when the timing of newborn infant apprehension is not disclosed to mothers until CPS arrives at the hospital (Everitt et al., 2015). Research has described that when the separation of mother and child is unexpected and involuntary, mental health concerns may arise, specifically post-traumatic stress disorder (Novac et al., 2006; Allison, 2011; Janzen & Melrose, 2013; Robertson & Kinsella, 2014; Kenny et al., 2015; Janzen & Melrose, 2017; Kenny, 2017). Research by Everitt et al. (2015), investigating the experiences

of midwives who supported mothers affected by newborn infant apprehension, explained typical reactions of mothers after apprehension took place during the postpartum period; midwives used words such as “crying, distressed, defeated, shock, fear, anger and aggression” to describe the reactions of mothers after apprehension occurred (p. 98). Everitt et al. (2015) discussed how the impact of trauma a mother endures after newborn infant apprehension greatly influenced their grief experiences, with the most common outcome being a mother “losing hope” to live (p. 98).

Moreover, a narrative analysis conducted by Kenny et al. (2015), exploring the experiences of mothers affected by older child apprehension, presented how mothers’ traumatic experiences remained unresolved over time. The authors suggested that mothers affected by older child apprehension experience “an everyday violence,” characterized by immense distress when mothers are faced by reminders that trigger remembering their traumatic apprehension experiences (p. 1160). Additionally, the authors noted that the trauma caused by the experience of older child apprehension was linked to increasing mothers’ likelihood to re-initiate or intensify their drug use. The authors noticed most mothers shared a similar goal, to forget their suffering. In turn, mothers would use alcohol and drugs to numb themselves and detach from their memories as they wanted immediate sedation from their pain. As quoted by participant Heather from Kenny et al. (2015):

Like I tell you if it weren’t for beer, I’d be dead. You know you just have like a bunch of beers and watch TV and then it’s bedtime and then it’s tomorrow, right? But if I had to sit alone in my head with the aftermath without that ability to escape and that distraction of a TV show, um, it would have been beyond my capacity to deal (p. 1162).

Kenny et al. (2015) posited the focus on mothers' substance use may obscure the recognition of more pressing social issues that increases the likelihood for newborn infant

apprehension, this includes poverty, single motherhood, intimate partner violence, health issues, and the impacts of cumulative trauma histories (Kenny et al., 2015). Like Kenny et al. (2015), I challenge how existing research predominantly focuses on identifying the characteristics of mothers that lead to newborn infant apprehension. There is a need to re-focus our attention on examining how systemic factors contribute to the apprehension of newborn infants from their mothers.

### *Altered Maternal Identity*

Studies have identified that after experiencing older child apprehension, mothers are at risk of having their identity as a mother altered and totalized (being viewed through an all-or-nothing lens) (Janzen & Melrose, 2013; Memarnia et al., 2015; Janzen & Melrose, 2017; Kenny, 2017; Kenny & Barrington, 2018; Broadhurst & Mason, 2019). A pervasively toxic social discourse described in the literature is how most mothers attributed being a ‘good’ person to being a ‘good’ mother (Wall-Wieler et al., 2018). Therefore, when mothers experience older child apprehension, this leaves them questioning their identity and overall value to society (Kenny & Barrington, 2018).

Memarnia et al. (2015) explored the experiences of mothers whose older child or children were taken into care or adopted. The researchers found that older child(ren) taken into care or adopted profoundly impacted mothers' sense of identity, including their identity as mothers and as a person (Mermarnia et al., 2015). Loss of identity left mothers feeling a loss of meaning to their lives causing mothers to contemplate that their "life was not worth living" (p. 307). Broadhurst and Mason (2019) who studied older child custody loss and mothers' experiences, echoed the significance of the loss of meaning in mothers' lives. The authors found loss of meaning could be amplified by the cumulative consequences that arise following custody loss,

such as in the drastic shifts that occur in mothers' everyday experiences when they are denied from actively participating in a mothering role. For example, for mothers, their children represented their life, routines and identity, and provided structure and purpose in their lives (Kenny & Barrington, 2018; Broadhurst & Mason, 2019). As custody loss abruptly changes mothers' lifestyles, it undermines mothers in their sense of personal control leaving them shattered in their lifeworld (Wells, 2011; Kenny et al., 2015; Kenny & Barrington, 2018).

Moreover, mothers are left with very little support to help them navigate the shifts to their power and agency, forcing them to endure their experiences in isolation (Broadhurst & Mason, 2019). For example, following custody loss, mothers are placed with restrictions on visiting their child (Broadhurst & Mason, 2019). Therefore, if their child is placed to live with a mothers' family member or with the respective father, mothers will experience being excluded from accessing these previously known social networks when they require care and support (Broadhurst & Mason, 2019). Mothers also face being excluded from participating in informal networks within their communities following custody loss (Broadhurst & Mason, 2019). Mothers are often re-casted into lower social positions due to the stigma surrounding child custody loss (Broadhurst & Mason, 2019). To avoid the stigmatizing behaviours from their communities, mothers may end up concealing their experiences of custody loss, in turn further isolating them from accessing sources of support (Broadhurst & Mason, 2019). Ultimately, from the cumulative consequences following custody loss, as mothers' struggle by themselves with the existential dread to the loss of meaning in their lives, they are pushed to an increased likelihood of contemplating or completing suicide (Mermarnia et al., 2015; Broadhurst & Mason, 2019).

A notable finding that was discussed by Janzen and Melrose (2013) was the difference between re-conceptualizing and re-negotiating maternal identity in mothers affected by child

custody loss. Janzen and Melrose (2013) expanded understanding to the ambiguity of what it means to be a 'good' mother through the perspective of recovering mothers who have lost custody of their older child. The authors explained mothers faced utmost distress as they are forced to re-conceptualize their maternal identity, as socially they are told they are not mothers to their child. By bringing a voice to mothers' experiences, the authors illuminated how mothers affected by custody loss are mothers and do not need to lose their maternal identity, instead it is their *role* of being a mother (i.e., *how* they mother) that requires re-negotiation (Janzen & Melrose, 2017). Mermarnia et al. (2015) echoed the discussion for mothers to be supported in re-negotiating their maternal identity after experiencing child custody loss. However, the authors noted how difficult re-negotiation might be due to the internal struggle mothers experience when reconciling being a mother but not a parent while also facing the stigma surrounding child custody loss, where society offers little validation or guidance to support mothers through the process of re-negotiation.

### *Stigma and Avoidance of Health Services*

Stigma is a well-documented barrier that interferes with individuals' engagement in healthcare services across a range of health conditions (Strangl et al., 2019). Goffman (1963) described stigma as the vehicle that enables *varieties of discrimination* causing an individual or group to be denied *social acceptance*, limiting them from opportunities and experiencing social inequalities. Critiquing this definition as vague and too individually focused, Link & Phelan (2001) re-defined stigma to include the co-occurrence of labeling, stereotyping, separation, status loss, and discrimination. They also described that stigma can only occur when power is being exercised (Link & Phelan, 2001). Stigma has typically been examined in the literature at the individual level, focusing either on the individuals experiencing or perpetuating stigma (Strangl

et al., 2019). However, this focus has led to the creation of interventions at the individual level; what is left unacknowledged is the social (e.g. cultural and gender norms) and system (e.g. legal and health policy) pathways that lead to stigma (Strangl et al., 2019).

Stigmatizing experiences during pregnancy, apprehension and postpartum contribute to the distrust mothers affected by newborn infant or older child apprehension have towards accessing healthcare services (Pelkonen et al., 1998; Kellington, 2002; Dilworth, 2006; Novac et al., 2006; Little et al., 2007; Kundra & Alexander, 2009; Mill et al., 2010). Mothers avoid services to protect and preserve their dignity from the detrimental effects healthcare providers' stigmatizing behaviours can have on mothers' well-being. (Novac et al., 2006; Kenny et al., 2015; Kenny, 2017). Avoiding healthcare services leaves this population of mothers at significant risk of developing long-term adverse outcomes and poorer health compared to those who do access services (Novac et al., 2006; Kenny et al., 2015; Kenny, 2017). Rebuilding mothers' trust to access healthcare services requires more than creating interventions that focus on the individual relationship between mother and provider. Interventions must include addressing the structures and conditions that have enabled stigmatizing behaviours in healthcare settings to exist towards mothers.

Kenny et al. (2015) highlighted how the fear of older child apprehension in combination with healthcare providers' stigmatizing behaviours (e.g. actions that judge, blame, shame) can significantly influence mothers' actions. They found that although mothers appreciated and understood how drug use interfered with parenting practices, mothers' motivation to reach out for help was interrupted by the fear of losing custody due to the dominant misconception that mothers who use drugs during pregnancy will not be safe and competent mothers (Kenney et al., 2015).

A Toronto Star article by reporter Cruickshank (2017) suggests the degree to which fear of newborn infant apprehension impacts women's use of healthcare services. Cruickshank (2017) estimated that approximately 300 babies are born to homeless women in Toronto annually, yet only about eight births to homeless women were reported during 2016. This gap between the number of estimated births and recorded births to homeless women suggests that women are so fearful of newborn infant apprehension that they avoid giving birth in hospitals. Fearing to access hospitals during childbirth may result in adverse health outcomes for both mother and child, including complications during labor and delivery resulting in death (Dilworth, 2006; Novac et al., 2006; Baskin, 2007; Little et al., 2007; Kenny et al., 2015; Sharma et al., 2016; Kenny, 2017).

Mothers affected by newborn infant apprehension are pushed further into developing distrust towards healthcare services as they often do not receive equitable follow-up care (Kundra & Alexander, 2009; Kenny et al., 2015; Kenny, 2017). For example, mothers who have a plan to ensure their newborn's safety and consequently retain care of their newborn infants, are followed by CPS and receive ongoing routine follow- up from public health nurses after hospital discharge (Healthy Babies Healthy Children Protocol, 2012). However, in Ontario, only some women who lose their newborn infants to apprehension are offered a visit by a public health nurse (that is often refused), and ongoing visits take place only if there is a plan in place to return the newborn infant to the mother's care. The lack of supports provided to mothers post-apprehension reflects how these women are not considered for immediate care and intervention (Novac et al., 2006; Little et al., 2007; Kenny et al., 2015, Kenny, 2017). As a result, mothers may develop an internalized shame, believing that they are unworthy of care, causing them to avoid seeking help later in life for their health-related needs (Wells, 2011; Kenny et al., 2015;

Sheway, 2017). Ultimately, stigma alongside a lack of equitable care, contributes to mothers' avoidance of healthcare services, resulting in a plethora of adverse long-term outcomes.

**The Role of Intrapartum and Postpartum Nurses**

Healthcare personnel, including nurses, contribute to the discrimination and social injustices inherent in the newborn infant and older child apprehension apparatus. Examples of healthcare providers' discriminatory behaviours directed towards mothers experiencing newborn infant or child apprehension include: overt blame as in "she doesn't deserve to raise a baby"; disregard where one provider asks "…how could such a terrible mother have any feelings about losing her baby"; and overemphasis on the baby at the expense of the mother, by suggesting that the mother "…get clean so that you can get [her] baby back" (Raskin 1992, p. 151). These statements are evidence of the negative attitudes pervasive within healthcare settings. Mothers who have experienced stigma and lack of support from healthcare providers are inevitably left feeling unguided and ostracized by society (Kenny et al., 2015; Kenny 2017; Kenny & Barrington, 2018).

Perinatal nurses working in birthing and postpartum settings are directly involved in the care of mothers when apprehension occurs at or shortly after birth (American Academy of Pediatrics, 2012; AWHONN, 2009; Perinatal Nursing Standards, 2018; Public Health Agency of Canada, 2018). Often, nurses are informed about the immanency of newborn infant apprehension before mothers. As perinatal nurses provide care to all mothers during the postpartum period, they are often present when newborn infant apprehension occurs. From the current state of research, there is a gap in understanding regarding the nurses' role during the process of newborn infant apprehension at birth in the hospital. Despite the amount of literature concerning evidence-based nursing practices regarding health promotion for mothers' wellbeing, bereavement care for

perinatal death, and ethical standards of practice, the recommended nursing care for mothers experiencing newborn infant apprehension is sparse (CNA, 2004; Kearvell & Grant, 2008; American Academy of Pediatrics, 2012; Philips, 2013; Guardino & Schetter, 2014; Ghadery-Sefat et al., 2016). Presently, there is a plethora of evidence-based best practices delineating what care is required for mothers who lose their newborn infants via perinatal death (American Academy of Pediatrics, 2012; Aziz et al., 2001; Aerde, 2001; Bartella & Aerde, 2003; Perinatal Nursing Standards, 2018; Public Health Agency of Canada, 2018); however, a lack of literature exists to inform the recommended interventions for mothers affected by newborn infant apprehension.

Little research exists exploring the experiences of nurses in newborn infant and older child apprehension. From the body of literature described in this chapter, there are recommendations for practice to support mothers following apprehension. Foremost, recommendations emphasized the need to destigmatize mothers affected by apprehension. Doing so, may alleviate the collateral consequences apprehension can have on mothers' well-being. Most of the research' recommendations were not limited to informing nursing care. The recommendations intend to inform both health and social services to promote a philosophy and care system that cooperatively addresses the needs of mothers, children and the whole family.

**Mother-Newborn Attachment**

Research exploring the theory of attachment suggests that for several months after birth, the mother and the baby remain a single "psychobiological organism" (Phillips, 2013). If the newborn infant is separated from their mother during at birth, the infant is likely to experience physical and psychological withdrawal due to the lack of their mother's sensory stimuli (Bowlby, 1969; Spinner, 1978; Bowlby, 1995). Attachment theory focuses primarily on the long-term

adverse outcomes for the child (Bowlby, 1969; Bowlby, 1995), however, mothers in these circumstances are also affected (Spinner, 1978; Kearvell & Grant, 2008; Benoit, 2004; Ghadery-Sefat et al., 2016). When mothers are separated from their newborn infants, a range of psychological disturbances like depression, anxiety, sleep disturbances, altered appetite, personality changes, fear and doubt and loss of self-confidence can occur (Kearvell & Grant, 2008; Benoit, 2004; Kenny et al., 2015; Ghadery-Sefat et al., 2016; Kenny, 2017). In addition, strong feelings of rejection and regret may be felt by a mother as she may feel that she has 'failed' in relation to society's standards of a mother and has 'destroyed' her child by surrendering (Veenstra, 2015; Kenny et al., 2015; Kenny et al., 2017).

Whenever possible, mothers and newborn infants should be placed together. When mothers are actively involved in the bonding process with their children, this not only promotes maternal physiologic stability, but also mental wellbeing (Kearvell & Grant, 2008; Benoit, 2004; Ghadery-Sefat et al., 2016). Research conducted by Wall-Wieler et al. (2018) identified that being a mother is a protective factor against suicide. Despite literature highlighting the significance the maternal-newborn attachment has for both mother and child's long-term health, there is a lack of research concerning which best-practices ought to be considered when the maternal-newborn attachment cannot be applied, specifically in cases of newborn infant apprehension.

**The Social Context of Mothers Affected by Newborn Infant Apprehension**

The following section will draw closer attention to the social context by highlighting the historical structures (i.e., ideologies related to 'good' and 'bad' mothering) and societal stigma that influence mothers' experiences. It is my aim to highlight what mothers require in terms of

support to reduce the prevalence of adverse outcomes related to experiences of newborn infant apprehension.

When a group of individuals are negatively labeled, they are positioned lower in terms of social hierarchy, and thus easily considered insignificant (Hatzenbuehler et al., 2013). Women vulnerable to newborn infant apprehension are often considered 'bad' mothers and face societal adversity and stigmatizing attitudes from families, communities, and organizations (Ladd- Taylor & Umansky, 1998; Kundra & Alexander, 2009; Kenny et al., 2015; Kenny, 2017). Mothers who fall outside of society's expectations as to what a 'good' mother are considered as 'bad' mothers (Hays, 1996; hooks, 2009; Kennedy, 2012). To comprehend what it means to be a 'good' or 'bad' mother, it is important to understand the historical and cultural contexts which influence the social construction of 'mothering.'

Dichotomies of *good* and *bad* serve to establish standards and norms within society (Hays, 1996; Veenstra, 2015). These standards have been socially constructed and become prescriptive ideologies of how individuals should act (Veenstra, 2015). When individuals act in ways that are incongruent with the 'good' standards, they become subject to multiple forms of stigma, resulting in oppression and ostracization by society (Hatzenbuehler et al., 2013).

Historically, in Western culture, 'good' mothering has been associated with the ideologies of "white, middle-class, heterosexual mothers, who are self-sacrificing and child centered" (Veenstra, 2015, p.39). Over time, Western society's illustration of a 'good' mother eventually became an embedded social construct (hooks, 2009). Women who do not meet this definition of the 'good' mother are systematically devalued and viewed as less competent mothers (Wells, 2011; Kenny et al., 2015; Veenstra, 2015; Kenny, 2017).

Women living in poverty are disproportionately represented or perceived as being ‘bad’ mothers (Ladd- Taylor & Umansky, 1998; hooks, 2009; Romagnoli & Wall, 2012; Kenny et al., 2015; Kenny, 2017). Romagnoli and Wall (2012) sought out to understand the experiences of young, low-income mothers, who were required to attend parenting classes, as they were perceived as at-risk of providing unsafe child care. Due to state-driven interventions aiming to improve child outcomes, young and low-income mothers are targeted as a particular at-risk group from delivering 'proper' modes of child-rearing, such as intensive mothering practices. Intensive mothering, a state-driven ideology, centres solely on children's needs, including a child's physical, emotional, psychological, and cognitive needs. Intensive mothering is promoted in Western society as the ideal form of parenting and demands that mothers provide time, energy, and economic security to their child. Mothers that struggle to attain both material and personal resources are limited from providing an intensive mothering approach. In turn, they are socially displaced and considered 'risky' mothers. Romagnoli & Wall (2012) described how low-income mothers who do not follow the dominant social expectation of intensive mothering had a greater likelihood of being labeled as a 'bad' mother. Low-income mothers who tried to associate with an intensive mothering approach found themselves struggling to fulfill societal expectations. Mothers would have to go to great lengths to find creative ways to obtain and afford the resources needed. Overall, the authors highlighted that despite low-income mothers "being with, playing with and reading to their children," these mothers remained more likely to be characterized as ‘unsafe,’ as they do not hold the generally accepted societal values and norms of the middle-class mothering (p.279).

Moreover, there is the perpetuated belief that women living with mental illness and addictions are 'bad' mothers. Historically, mothers with mental illness have been categorized as

potentially dangerous and therefore unfit to parent effectively, especially when considering drug use; mothers who use drugs are 'inadequate parents' who will neglect their children (Kundra & Alexander, 2009; Wells, 2011; Kenny et al., 2015, p. 1158; Kenny, 2017; Wall-Wieler et al. 2018c; Kenny & Barrington, 2018). Kundra and Alexander (2009) examined the parental rights of parents living with mental illness and the use of the Americans with Disabilities Act as a legal defense and identified that parents are seen as incapable of parenting, and are almost three times more likely to have their children apprehended when compared to non-mentally ill parents. The article highlighted how court systems in America focus on parenting capacity assessments through an assessment of parents' disability rather than parents' parenting behaviours and their ability to keep their children safe (Kundra & Alexander, 2009). Unfortunately, the findings suggest that for mentally ill parents, it's not a question regarding "*if* a child should be taken from a mentally ill parent, but *when*" (Kundra & Alexander, 2009, p.143). However, Kundra and Alexander (2009) explained that when the appropriate supports are in place for mentally ill parents at appropriate times, effective parenting can be reached. Wall-Wieler et al. (2018a) echoed the discussion found in Kundra and Alexander (2009) by identifying how women with mental illness and developmental disabilities have been historically typologized as being unfit to parent; the authors critique this notion by noting how "many mothers with mental illness have been linked to successful parenting and care for their children when provided with appropriate supports and services" (p.5). Unfortunately, research has identified that mothers affected by newborn infant or older child apprehension are subjected to a plethora of stigmatizing attitudes by healthcare professionals, causing a lack of available and accessible services post-apprehension (Wells, 2011; Kenny et al., 2015; Kenny, 2017; Wall-Wieler et al., 2018a; Wall-Wieler et al., 2018c).

### Summary of the Literature Review

Overall, this literature review provides a foundation for understanding the current state of knowledge pertaining to the well-being of mothers after experiencing newborn infant or older child apprehension. The literature primarily focuses on identifying the factors associated with mothers at-risk of apprehension. In comparison, very little research has been conducted regarding the associated health outcomes or interventions that can better support mothers affected by apprehension. Next, I describe the current state of research exploring the experiences of mothers affected by older child apprehension. Through the review of this literature, mothers are denied their right to grieve the loss of newborn infant apprehension; in turn, mothers experience trauma, an altered maternal identity, and stigma causing avoidance to healthcare services. Clearly, intrapartum and postpartum nurses are well positioned to support mothers affected by newborn infant apprehension during pregnancy, birth, apprehension and follow-up care, yet little research exists describing nurses' roles during and following apprehension. There is a need for research to inform our understanding of how nurses can best provide support, especially concerning mothers' grief experiences. Finally, this chapter describes how mothers' social context influences the likelihood for newborn infant and older child apprehension. In this section, I intend to remind readers to move beyond framings that have suggested mothers' lifestyles and choices are the reasons why apprehension occurs and recognize the influences Western society's historical and cultural ideologies have in causing newborn infant and older child apprehension.

# Chapter 3: Methodology

The purpose of this study is to describe mothers' experiences of having their newborn infant apprehended at birth and develop further understanding of their grief. The research questions are:

1. How do mothers describe the experience of having their newborn infant apprehended by child protection services at birth?
2. What do these descriptions reveal about mothers' grief?

In this chapter, I will describe the research paradigm, my disciplinary perspective and the theoretical framework selected to guide this study, in addition to the study design and the methods used to address the research questions.

## Paradigm

This study was informed by the constructivist paradigm. Constructivism encourages the uncovering of truth through considering multiple lenses of perception (Lincoln & Guba, 1985; Appleton & King, 1997). The paradigm acknowledges that an individual's background, culture, and embedded worldview shape their perceptions, creating multiple realities and truths when considering a phenomenon (Guba & Lincoln, 1994; Appleton & King, 1997). Using a constructivist approach, I investigated the experiences of mothers who had their newborn infant apprehended at birth. Through this paradigmatic lens, I collaborated with the participants to create a rich understanding of these experiences.

Using the constructivist paradigm, a unique ontological, epistemological and methodological structure was used to inform the study. Constructivism's ontological position accepts a relativist reality, therefore supporting the notion that reality is socially constructed and

based on individual or societal values, commitments, and beliefs (Guba & Lincoln, 1994; Appleton & King, 1997). Epistemologically, constructivism views the investigator and the object of investigation as linked, such that who we are and how we understand the world is a central part of how we understand ourselves, others, and the world. It looks at the theory of knowledge and challenges the average individual to understand it and then to step back and understand how we acquire knowledge (Guba & Lincoln, 1994; Appleton & King, 1997). Lastly, methodologically, evidence within this paradigm is collected through subjective experience, typically obtained through interviews or observation (Guba & Lincoln, 1994; Appleton & King, 1997).

Investigating the world using the constructivist paradigm allows researchers to look at a phenomenon or problem from different viewpoints, therefore encouraging flexibility in thinking and reasoning skills when drawing conclusions (Guba & Lincoln, 1994; Appleton & King, 1997; Cohen & Crabtree, 2006). Knowledge obtained is not considered a fixed reality but a construction of reality that is contextually bound to the environment where it was experienced (Guba & Lincoln, 1994; Appleton & King, 1997). With respect to this thesis, all the participants had experienced newborn infant apprehension at birth in the hospital, in Ontario, Canada. The knowledge co-created with the participants' interviews cannot be considered fixed, as each participants' subjective experiences are unique and were likely influenced by various conditions (e.g. gender, race, culture, time) (Guba & Lincoln, 1994). With differences between the participants' subjective experiences, I employed the design method of interpretive description to help identify patterns in the data.

**Design**

This qualitative study used an interpretive description design as the method to develop understanding of mothers' experiences (Matua & Van Der Wal, 2015). I explored, analyzed, and described mothers' experiences of having their newborn infant apprehended at birth, in the hospital. The design helped guide the identification of themes and patterns among individualistic perspectives, and an interpretation of experiences (Thorne, 2016). The findings have implications for how nurses can respond and better support mothers affected by newborn infant apprehension.

Interpretive description (ID) was created in response to the growing needs in developing nursing research, as it not only can generate new insights that shape new inquiries but also produce meaningful logic that is translatable into nursing practice (Hunt, 2009; Thorne, 2016). Nursing science is different from other sciences, as it is never solely theoretical and it sets out with the objective of directly influencing practice (Thorne et al., 1997). Unlike other descriptive approaches, ID builds on the assumption that nurses are not usually satisfied with description alone and prefer to explore meanings and explanations that can lead to application in the clinical setting (Thorne et al., 2004). This methodology aids researchers in constructing an interpretive explanation through informed questioning and reflective and critical examination with the intent to guide and inform practice in some way (Thorne et al., 2004).

Interpretive description is utilized to answer questions of naturalistic inquiry as it examines a phenomenon while considering both subjective perspectives and variations between individuals (Hunt, 2009). The methodology supports the notion that knowledge and understanding are co-constructed between researcher and participant; when the two interact, they influence one another and their understanding (Hunt, 2009).

Another aspect of interpretive description is scaffolding the study (Thorne, 2016). Thorne (2016) describes scaffolding the study as an acknowledgment of the researchers' theoretical and

practical foreknowledge. By acknowledging their positioning, researchers reveal how their assumptions, values and beliefs may influence the direction of the inquiry (Thorne, 2016). Thorne (2016) describes two components that are necessary to scaffold a study, a literature review and a theoretical forestructure. In Chapter 2, I presented the literature review, evaluating the current state of the literature concerning newborn infant and older child apprehension. The theoretical forestructure of a study refers to the researchers' reflection of their epistemological, disciplinary and theoretical perspectives. In the preceding section, I described my epistemological stance as constructivism. In the following section (situating the researcher) I account for my disciplinary perspective as a registered nurse. I begin by acknowledging that I approached this research project with a priori knowledge from my experience of witnessing and caring for a mother and her grief following apprehension. Following this section, I introduce the theoretical framework that I selected to help guide this research, the Disenfranchised Grief Framework (Doka, 1989). By applying a theoretical framework, I recognize how my practice experience has directed my attention to the need for ethical nursing care when responding to grief.

**Situating the Researcher**

According to Thorne (2016), there are many questions that researchers must ask themselves. Specifically, Thorne (2016) suggested that researchers reflect on "who they are, what they are trying to represent and what they are trying to accomplish" (p.54). To do so, the researcher requires understanding of their position intellectually and socially, as well as understanding what personal assumptions, values, and beliefs they have before entering the research project (Thorne, 2016). There are two critical elements which need to be considered to answer the above questions: the disciplinary social and personal orientation a researcher will take

into the study to provide a lens and foundation as to how the topic will be understood and the background knowledge and justified belief previously understood regarding the research topic (Thorne, 2016).

Interpretive description builds on the belief that "going in blind" can hinder the scientific growth of knowledge for nurses (Thorne et al., 1997). There are other methodologies that encourage bracketing of preconceptions, however this is not recommended in interpretive description (Thorne et al., 2004). It is suggested that the background knowledge of the researcher (whether learned through research or clinical experience) should be used to form the foundation for new investigation (Thorne et al., 1997).

My interest in this issue arose from my experience as a registered nurse on a child and youth mental health inpatient unit where I worked alongside many teenagers who had complicated acute mental health and concurrent disorders. During my experience on the unit, I received a patient who, at the time, was pregnant and experiencing homelessness; she was admitted for symptom management of her depression and anxiety. As her primary nurse, I grew very close and built a strong rapport with her. The patient eventually disclosed her fears of potentially having her newborn infant apprehended at birth due to her life circumstances. Ultimately, as the inpatient unit is for acute mental health needs, the young woman was discharged before delivery. I thought I would never meet her again, when one day she was re-admitted to the unit, this time for using a variety of methamphetamines after having had her newborn infant apprehended at birth. With the absence of her newborn infant resulting in her relapse into substances, I felt our healthcare system had done a dis-service in protecting her. Looking back, when counseling her on the second admission, I remember how distant she was to any form of support, rehabilitation, and care compared to the first admission. Over time, the

patient became open to treatment and conversations and one day, when attempting to unpack the grief associated with her apprehension experience, I noticed how difficult it was to provide support as a nurse. I felt unaware of how I could support the loss in meaning she felt for her life following her apprehension experience. From that moment, I understood a different, more tailored approach to support grief was required for her.

**Theoretical Framework**

For this thesis, I used the Disenfranchised Grief (DG) Framework created by Doka (1989) as a lens to help understand the grief experiences of mothers affected by newborn infant apprehension. The DG Framework was created to highlight how individuals may experience being stripped of their "right to grieve" certain losses, specifically losses that occur outside of society's normative discourses (Doka, 2002, p.6). The intention of creating the DG framework was to illuminate that grief should not be socially regulated, giving way for all grief experiences to be recognized, accepted and understood (Doka, 1989). Overtime, researchers have critiqued the original DG framework (such as the framework's binary assumption that grief is either enfranchised or disenfranchised), which has led to a reconfiguration of the framework, as seen in the edited collection of the DG framework (Doka, 2002).

Doka (1989) posits that when a loss occurs which conflicts with what is typically socially understood or accepted, the individual experiencing the loss is at risk of having their grief disenfranchised by society. Doka (1989) suggests that historically within each society and culture, individuals are governed by certain social norms. These social norms occur in society through their constant recurrence and representation. Eventually, they become unconsciously internalized by society, resulting in *rule structures*, which act in a prescriptive way to influence the values and practices of individuals (Doka, 1989). Doka (1989) suggests rule structures

control how individuals feel, think, and behave with respect to grieving. Over time, these structures make up "informal expected behaviours" also known as "laws" in a society which govern which losses to grieve, how one grieves them, who legitimately can grieve a loss, and how others should respond with sympathy and support (Doka, 2002, p.9).

Minority groups face a considerable risk of experiencing disenfranchised grief due to the socio-cultural attitudes that continue to exist, projecting stigma toward these populations (Reid, 2014). The loss, though perceived significant to the individual, is deemed illegitimate by society's standards, and as such, often leaves minority groups grieving with little to no social support (Doka, 1989; Doka, 2002). For example, due to the stigma that exists regarding losing a partner to HIV or AIDS, gay and bisexual men have described feeling forced to conceal their emotions when faced with the death of their partner and loss in their relationship (Bristowe et al., 2016). As gay and bisexual men fear the impact their bereavement may have on their social support networks and their careers, this fear of discrimination prevents them from seeking the care and support they need and deserve (Bristowe et al., 2016). Unable to access support, men who have lost their same-sex partner to HIV or AIDS are often pushed to social isolation, in turn, forced to manage additional stressors while also silently mourning their bereaved partner (Bristowe et al., 2016).

Doka (1989) identifies three types of grievers most at risk of experiencing disenfranchised grief: individuals whose relationships are socially unrecognized, individuals whose loss is unacknowledged, and those who are thought to be unable to feel a loss (Doka, 1989; Doka, 2002). Doka (1989) explains when grief transpires outside of a kin-based relationship, the relationship may be perceived as socially insignificant, leaving the individuals experiencing grief to be at a higher risk of having their grief left unacknowledged. Moreover, Doka (1989)

described grievers who are thought not to be legitimate grievers, such as those who are perceived by society to be unable to feel loss, are also at risk of having their grief disenfranchised.

Applying this typology, mothers who have had their newborn infant apprehended from their care are at high risk of experiencing grief that is disenfranchised by society (McKegney, 2003; Kenny et al., 2015). A few studies have examined the concept of disenfranchised grief with respect to mothers' grief after newborn infant apprehension (McKegney, 2003; Kenny et al., 2015; Janzen & Melrose, 2016). Research describes that although a kin-based relationship exists in these circumstances, mothers may not receive sympathy or be given the socially accorded right to be seen or labeled as a mother (McKegney, 2003; Kenny et al., 2015; Janzen & Melrose, 2013). Society's lack of recognition that a relationship exists between the mother and her newborn infant results in stripping the title of 'mother' from these mothers, causing a disenfranchised grief.

Mothers who have experienced newborn infant apprehension are not considered as a 'mother' as they fall outside of society's expectations of what comprises a 'good' mother (Ladd-Taylor & Umansky, 1998; Hays, 2009; hooks, 2009). The construction of the 'good' mother reflects ideologies of Western society, describing intensive mothering as the socially appropriate standard to child rearing (Veenstra, 2015). Intensive mothering has three key tenants, including expecting that women continue to be the primary, central caregiver of children, mothers provide time, money and energy on their children, and asserts the notion that children and the work of mothering is separate from professional paid work, in turn outside of the scope of market valuation (O'Brien Hallstein, 2006). There is a common presupposition that women who lose custody are 'bad' mothers, due to dysfunctional attachment or a lack of parental bond with their child due to their high-risk lifestyles, e.g., living in homelessness or with substance use (Ladd-

Taylor & Umansky, 1998, McKegney, 2003; Wells, 2011; Kenny et al., 2015; Kenny, 2017; Wall-Wieler et al., 2018c). Sensationalized and vilified within the media as "pariahs," society accuses mothers of losing their child to apprehension because of their lifestyle choices (e.g., addiction) (Kenny et al., 2015, p. 1158; Kenny, 2017). Based on the social presumption that it is the wrongdoings of mothers that lead them to newborn infant apprehension, they are viewed publicly as not being worthy or deserving "the right to grieve" (Doka, 2002, p.6). Therefore, despite the kin-ties between mothers and their apprehended children, societal expectations of mothers lead to doubting their integrity and, in turn, the value of the relationship between mother and child (Wells, 2011; Kenny et al., 2015; Kenny, 2017; Wall-Wieler et al., 2018c).

In this thesis, the theoretical framework of disenfranchised grief (Doka, 1989), provides a lens to explore mothers' experiences of newborn infant apprehension (Chapter 4) and to reveal what mothers' descriptions reveal about their grief (Chapter 5). The framework informed the research process by guiding a review of the related literature concerning newborn infant apprehension, informing the research question by focusing on understanding how mothers think, feel and behave with respect to their grief experiences, and by identifying thematic statements when conducting the data analysis.

## Methods

### *Setting*

Participants for this research were mothers who were receiving pregnancy and parenting case management services at a community health centre (CHC) located in two sites in Toronto, Ontario. The CHC is an accredited, non-profit, community-based health and wellness service organization governed by a Board of Directors. The CHC provides primary care, counselling, and health promotion services to members of the community who are at risk and/or face barriers

to accessing high quality healthcare services and supports. Clients who access the CHC can receive services regardless of whether or not they have the public, provincial health insurance (Ontario Health Insurance Plan [OHIP]). Priority is given to those who are from marginalized populations, low-income, seniors, youth, homeless, those living with substance use and mental health issues, immigrants, and refugees.

The pregnancy and parenting case management program offered at the CHC is a free, individually tailored service which gives priority to pregnant women who are involved with CAS, refugees, and/or living within homelessness. The clientele includes pregnant mothers categorized as having 'high-risk pregnancies' based on their current living situations and low socio-economic status. The program includes mothers who have had their newborn infants and/or older children apprehended from their care. The pregnancy and parenting case management program in this CHC is one of the few programs that exist in the greater Toronto area supporting mothers through their personal journey; it offers individual and group counseling and assists with referrals to additional resources.

### *Sampling*

I used purposeful sampling as the sampling method to conduct this study. Purposeful sampling involves recruiting participants who have lived experience with the research phenomenon and therefore can contribute to our understanding (Creswell, 2013). From the multiple different forms of purposive sampling techniques used in qualitative research, I used a combination of convenience and maximum variation sampling methods (Patton, 2002; Creswell, 2013; Etikan, 2016). Convenience sampling is a non-probability sampling method where participants are sampled based on their convenient accessibility and proximity to the researcher (Jager et al., 2017).

Mothers were eligible to participate in this study if they met the following characteristics: (a) were registered in the pregnancy and parenting case management program at the CHC, (b) self-reported having had at least one of their newborn infants apprehended at birth in the hospital at some point during the previous 5 years, and (c) spoke English. The eligibility criteria were limited to those mothers who have had their newborn infants apprehended within the previous five years to ensure that the women's experiences reflect recent nursing, social work and child protection practices. The convenience sampling resulted in the recruitment of mothers who varied according to (a) the number of children they had, (b) the number of children that they had had apprehended and (c) ethnicity.

Maximum variation sampling seeks to include participants with a wide range of experiences of the phenomenon of interest. Given that Indigenous Peoples are disproportionately represented among mothers affected by newborn infant and older child apprehension, I wanted to ensure that we included at least one mother who self-identified as Indigenous. Therefore, I employed maximum variation sampling to expand the inclusion criteria to include an Indigenous mother who had indicated interest in participating.

According to Thorne (2016), in qualitative research, estimating an adequate sample size a priori is difficult. That being said, to approximate the number of needed participants for a study, researchers aim to evaluate sample size on an ongoing basis to identify when sufficient density of the data is achieved and no new insights are given by additional sources of data (Given, 2008; Hunt, 2009; Thorne, 2016). Generally, in qualitative studies, approximately 5-12 participants are used (Given, 2008).

***Recruitment***

Prospective participants were contacted by the counselor of the CHC's pregnancy and parenting case management program to determine their interest in learning more about participating in the study. I met with potentially interested mothers just before their next appointment at the CHC to explain the study. When a mother volunteered to participate, I reviewed and asked them to sign a consent form (Appendix A). Interviews took place at the CHC, at a time convenient for the participant, often just before or after their next appointment. Interviews took place in a private room. Given that I was inviting participants to describe potentially traumatic events, we anticipated that some of the participants may experience emotional distress. Therefore, it was arranged that the counselor remained on site and available during interviews to counsel participants if they felt distressed during the interview.

Confidentiality of participant information was diligently respected. All identifying information was anonymized during transcription by replacing names of people and places with fictional names or numerical codes. Only my thesis supervisor (Wendy Peterson) and I had access to the master list linking participants with codes. The master list, all recordings, transcripts, and other study documents are in Dr. Wendy Peterson's locked office at the School of Nursing, Faculty of Health Sciences, University of Ottawa. All data will be kept up to a maximum of five years after the first publication in a peer-reviewed journal, after which data will be destroyed appropriately.

***Data Collection***

Prior to each interview, I reviewed the consent form with participants (Appendix A). To assure participants' understanding, I went over the consent form in detail.

During data collection, I asked participants to complete a short demographic questionnaire that provided information necessary to describe the sample (Appendix B). Subsequently, I

conducted audio-recorded individual in-depth, semi-structured interviews. Semi-structured interviews allowed mothers to express themselves as openly and freely as possible. Questions were open-ended and broad in order to gain an overall picture of the phenomenon (Hunt, 2009; Thorne, 2016).

The interview guide (Appendix C) included questions that explored mothers' experiences of apprehension and their subsequent grief informed by the DG framework typology; for example, I asked questions that explored if mothers' experienced a lack of a recognized relationship to their newborn infant, a lack of acknowledgment to their grief experiences, and if they felt perceived as mothers who lacked an ability to feel their grief. The interview guide was used to ensure that the same topics were discussed at each interview; however, flexibility was employed to capture new topics that arose (Polkinghorne, 1989; Thomas & Pollio, 2002; Englander, 2012). This method allowed for the interview to remain conversational, as well as provide me with the means to probe unanticipated information and any emotional responses (Englander, 2012).

***Data Analysis***

I followed the data analysis procedure described by Thorne (2016), whereby data collection and analysis processes occur concurrently (Thorne, 2016). This means that the data collected during each interview informed subsequent data collection and analysis (Thorne, 2016). For example, to probe for more in-depth data about an idea raised in one interview, I would share the idea with a subsequent participant. To begin, I transcribed the digital recordings of the semi-structured interviews verbatim. My thesis supervisor and I then analyzed the interview data through an inductive reasoning approach. After reading each transcript, I conducted first level coding by looking for similarities within the data, assigning codes and

meeting with my thesis supervisor to discuss the coding. As the analysis progressed, I identified patterns among the codes and grouped them into themes, labeled with significant statements (e.g. "Not good enough") (Thorne, 2016, pg.6). I went beyond the initial theoretical scaffolding of the DG framework and allowed the analysis to take an inductive approach, achieving rigor according to the interpretive description method (Thorne, 2016). Based on our discussions of the data and specifically, the relationship between themes, I synthesized the themes into an interpretive description of the experiences of the individuals (textual and structural descriptions) (Thorne, 2016). Ultimately, this process of analysis lead to a co-constructed "tentative truth claim" that intended to "yield clinically applicable insight" (Thorne, 2016, p. 6).

***Potential Challenges***

Several challenges were considered before studying the mothers' experiences with the apprehension of their newborn infants. Due to the sensitivity of the topic, mothers were offered the opportunity to end the interview at any time they felt uncomfortable. Additionally, the participants' case manager remained at the CHC during and immediately after the interviews to offer support as needed.

***Trustworthiness***

As stated by Lincoln and Guba (1985), the criteria for assessing the trustworthiness of qualitative research are credibility, dependability, transferability, and neutrality/confirmability. To demonstrate the trustworthiness of the proposed study, a process that addressed the four factors was followed.

Credibility refers to the 'truth' of the findings and was established through my engagement with participants (Lincoln & Guba, 1985). As a mental health registered nurse, I am skilled in establishing therapeutic relationships with patients and their family members and have

experience in facilitating meaningful conversations to foster trust and comfort. My ability to develop trusting relationships with the participants contributed to the credibility of the study findings. My approach when conducting interviews included allowing mothers the freedom and space to express themselves rather than prescriptively following the interview guide. This flexibility also allowed for mothers to share considerable detail about their experiences.

Dependability means that the study decisions are sufficiently described so that it could be repeated (Lincoln & Guba, 1985). Dependability was met through meeting with my supervisor and committee members to discuss data analysis, as well as keeping an audit trail throughout the study. I kept detailed notes of decisions related to the research methods, such as any modifications made to the research questions, interview guide and changes in analysis, i.e. identifying new concepts while coding the data. This record of study decisions will clearly document how we arrived at the findings.

Transferability refers to how the research findings may be applicable to other contexts (Lincoln & Guba, 1985). I demonstrated transferability by providing a detailed description of the setting and participants. With this description, readers will be able to determine if the findings are transferable to their population of interest.

Lastly, in terms of confirmability/neutrality, this study is influenced by a naturalistic approach to inquiry (Lincoln & Guba, 1985) and I acknowledged that interpretation will occur within the analysis. However, an audit trail highlighting every step of the analysis process, such as coding, themes and data interpretation, was conducted. Doing so helped guarantee that the findings accurately portrayed the participant responses rather than portrayed the bias or personal motivation of the researcher.

**Ethical Considerations**

Ethical aspects of the study that were considered prior to participant recruitment included: obtaining informed consent; privacy; minimizing potential physical, emotional or social risks; and confidentiality. Participants were provided with consent forms that described the purpose of the study, confidentiality, and the potential for risks (Appendix A).

***Informed consent***

Informed consent indicates that the study participants not only agree to participate in the research project, but also understand the research and its risks (Satyanarayana-Rao, 2008). Informed consent was obtained prior to each interview. I verbally reviewed the main points of the consent form and confirmed participants' understanding of their role in the study. If participants were agreeable to signing the consent form, an interview date and time were scheduled.

At the beginning of each interview, I reminded participants that they could leave the study at any time, without giving a reason. However, none of the participants withdrew from participating in the study; in fact, each participant described feeling empowered by sharing their experience as their aim was to help inform practice and change the way in which mothers affected by newborn infant apprehension are treated.

***Confidentiality***

My ethical duty, as a researcher, is to maintain confidentiality by protecting participants' personal information from disclosure, modification, loss or theft (Kaiser, 2010). Confidentiality of participants' identities was ensured by: using pseudonyms to replace names of people and places in the interview transcripts; removing any identifying information from direct quotes that are used in publications of the findings; and having all electronic study documents kept on a password protected laptop. After publishing the study findings, all electronic and paper study

documents will be kept in Dr. Wendy Peterson's locked office at the School of Nursing, University of Ottawa for five years.

### *Minimizing Potential Physical, Emotional or Social Risks*

Given the sensitive nature of the interviews, it is important to highlight the courage it took for each participant to share their experience of newborn infant apprehension. Every participant was open to sharing her story, allowing for a breadth of raw emotions to be expressed throughout each interview. Many of the mothers became quite emotional while recounting their experiences, with a few mothers requiring my support and subsequently the support of the case manager immediately after their interview. I had anticipated the possibility of mothers becoming emotional while recounting their apprehension experiences. Therefore, I had designed a protocol for minimizing the impact of emotional and psychological distress. The protocol explained that I would provide the initial therapeutic support; however, to ensure the mothers' well-being, the case manager was available at the CHC post-interview to mitigate safety concerns, minimize re-traumatization, and provide support and comfort.

Furthermore, there was the possibility that after their interviews, participants may have felt distressed for trusting yet another healthcare provider. I remained in close contact with the case manager at the CHC after completing the interviews for this study, encouraging the case manager to let me know if mothers felt uncomfortable for sharing their experiences. Based on this follow-up, participants never expressed any regret.

## Summary of Methodology

This study is rooted within the constructivist paradigm. I employed an interpretive description design to study the phenomenon of mothers' experiences of newborn infant

apprehension; interpretive description allowed for consideration of mothers' subjective perspectives and the variation of their experiences.

Based on my review of the literature, I put forward that mothers who have had their newborn infant apprehended at birth are at risk of being denied the right to grieve their loss. Therefore, I used the theoretical framework of disenfranchised grief, to inform this exploration of mothers' grief experiences after having their newborn infants apprehended from their care.

# Chapter 4: Findings

This chapter presents the findings from the interpretive description study designed to answer two research questions:

1. How do mothers describe the experience of having their newborn infant apprehended by child protection services at birth?
2. What do these descriptions reveal about mothers' grief?

This chapter presents the four themes that collectively describe the mothers' experiences of newborn infant apprehension and their grief experiences. The first section of this findings chapter presents a description of the sample of mothers. The second section presents the findings of the qualitative thematic analysis. The four themes are: (1) Not good enough, (2) I am a mother, I have rights, (3) I live every day like I'm grieving, and (4) Hope in the face of adversity.

## Participant Characteristics

The study participants were a diverse sample of nine mothers with varied experiences of newborn infant apprehension at birth (Table 1). Eight of the participants had experienced newborn infant apprehension one or two times over the previous five years. The ninth participant's most recent experience with newborn infant apprehension was over five years ago but within the last 10 years. This participant was included because of her numerous experiences with the phenomenon of newborn infant apprehension. She described becoming pregnant "almost every year starting at age 16," and experiencing a total of seven newborn infant apprehensions. In addition to newborn infant apprehensions, five participants had also experienced apprehension of their older children.

Collectively, the nine participants had a total of 35 children, with 30 of the children having been apprehended. Of these 30 children, 20 were newborn infants apprehended at birth, and ten

were apprehended during childhood. Five children had always remained in their mothers' custody.

At the time of the interviews, only two of the 20 newborn infants apprehended at birth had been returned to their mothers' custody. One mother (Dakota) had regained custody after four months and the other mother (Mary) after three years. The remaining seven participants had either occasional visits with their newborn infants as permitted by the children's guardians or were prohibited from any contact with their child.

Another variation in the participants' experiences was with whom their newborn infants and children were placed post-apprehension. From the 30 children who were either apprehended at birth or later during childhood, seven were placed in the care of maternal grandmothers or extended family members, whereas seven were placed in the care of their birth father or fathers' family members. The remaining 16 children became crown wards (legal responsibility of the Ontario government), and were placed in the province's foster care system and ultimately placed for open- or closed- adoption.

When asked why apprehension at birth had occurred, most of the mothers were uncertain of the reason(s). However, the participants believed that the following reasons contributed to their newborn infants being apprehended: young maternal age, substance use prior to or during pregnancy, past history of mental illness, living in homelessness A common reason, given by seven of the mothers, was living with intimate partner violence either prior to or during their pregnancy. Participants described their own (n=5) or the birth fathers' (n=2) childhood involvement with CPS as another factor that increased the likelihood of apprehension.

**Table 1: Characteristics of participants (N=9)**

| **Characteristic** | **N** | **Mean (range)** |
|---|---|---|
| Age at time of interview | | 32 years (28-37 years) |
| Self-identified ethnic or cultural background<br>First Nations<br>White<br>Black/Caribbean<br>South Asian<br>Filipino | <br>2<br>4<br>1<br>1<br>1 | |
| Experienced 1 newborn infant apprehension | 3 | |
| Experienced multiple newborn infant/ older child apprehensions | 6 | |
| Has experienced intimate partner violence | 7 | |
| Maternal involvement with child protection services during their childhood / youth | 5 | |

Participants' descriptions of the process of newborn infant apprehension also varied. However, similarities did exist based on whether it was their first birth or a second (or greater) birth after having already had a newborn apprehended. When giving birth to their first child, notice of newborn infant apprehension was not explicitly given to mothers ahead of time. Although some mothers described fearing or anticipating that apprehension of their newborn infant was possible based on interactions with CAS during their pregnancy or their high risk living conditions (e. g., living in homelessness, substance use, intimate partner violence), most of the study participants were not notified about their newborn infants' apprehension until after birth. Conversely, mothers who had experienced a prior newborn infant or older child apprehension were told by CPS during pregnancy that their subsequent newborn infant(s) would also be apprehended. In some cases, these mothers were 'flagged' by CPS, meaning that the agency requested that hospitals notify them when a specific mother is admitted for childbirth. This prompted hospitals to place a 'birth alert' on the mothers' charts indicating the need to send a notification of the birth to CPS. Some participants who gave birth on a weekend or on a statutory holiday described being prohibited from spending one-on-one time with their newborn infant until a social worker was present to discuss the process of apprehension; for some mothers, this meant waiting 24-72 hours until they were able to hold their newborn infant. When mothers were notified of newborn infant apprehension, they were told either by a social worker from the hospital or CPS.

**Overview of Themes**

This section presents the four themes that describe the mothers' experiences of newborn infant apprehension (Figure 1). The first theme described the healthcare and social service

providers' stigmatizing behaviours that mothers experienced throughout their prenatal, apprehension and postpartum periods. Mothers perceived that providers viewed them as "not good enough," which in turn pushed the participants to doubt the integrity of health and social service providers. Theme two, "I am a mother, I have rights" described mothers' need for equitable prenatal, birth, postpartum and post-apprehension care. Theme three, "I live every day like I'm grieving," describes how the participants' grief experiences after newborn infant apprehension had a long-lasting impact on their lives. The chapter will end with the fourth theme "hope in the face of adversity," which presented how mothers maintained some hope alongside to the magnitude of adversity they faced throughout their apprehension experience(s).

*Figure 1:* Themes and Subthemes


**Theme One: "Not Good Enough"**

The theme "not good enough" reflected the participants' perceptions regarding how they were considered by service providers, particularly nurses and social workers. Despite mothers' efforts to improve their circumstances, they described being continuously perceived as not good enough as mothers. Through the perceived judgment of providers, mothers described how their

parenting behaviours were never considered sufficient. This theme includes four subthemes: "feeling judged," "jumping through hoops," "watching over my shoulder," and "mistrust."

### *Feeling Judged*

Throughout each interview, mothers spoke about being regarded as a disgrace by providers. The experience of being negatively judged caused most of the participants' great harm, especially concerning their self-worth. All the participants felt they were perceived as unworthy and not good enough to be a mother when engaging with providers. Mothers recounted many examples of experiencing providers' judgmental attitudes over time, describing examples of such interactions throughout their pregnancy, childbirth, newborn infant apprehension, and post-apprehension experiences.

A few of the participants shared how they felt judged by providers during their pregnancy. For example, Cheyenne, who was living in homelessness at the time she was pregnant, expressed feeling as if she was provided with less supportive care during her prenatal appointments compared to mothers living with stable housing. She stated feeling that nurses "looked at [her] like [she] was just from the street." She went on to explain how the judgmental looks made her feel "like a nobody," as if she was categorized automatically as a person who "didn't deserve to have [her] baby in [her] care... like [she] didn't know how to parent." Similarly, Elizabeth felt judged by nurses during her pregnancy. This mother was living with severe mental illness and described seeking help at an emergency department for support regarding the obstetrical complications that presented during her pregnancy. When recounting her experience, she described overhearing nurses mutter "oh it's you again" and then "push [her] aside and treat others." She explained feeling confused as she was attempting to access "a service that is made to help people." With this assumption in mind, she believed that she "would be treated as a

normal person." She described how typical it was for a nurse to "take one look at [her] and judge [her] as if something's totally wrong with her." She went on to describe that, based on these previous interactions, when she experienced judgmental providers now, she would "get so angry and just leave" due to the lack of respect.

Judgment from nurses was also predominant in the participants' interviews when recounting their hospital experiences. For example, Ann repeatedly stated throughout her interview that she was "treated like shit" by nurses, specifically nurses in hospital settings. Ann, a mother who had experienced multiple apprehensions at birth, described her experiences with nurses as typical of individuals living in low socioeconomic positions. She emphatically reiterated throughout her interview the negative attitudes that nurses held towards substance using individuals; some phrases included: "if you're a drug addict, then they don't care," "they thought I was a joke." Similarly, Mary described being categorized by the nurses as "a junkie." Although Mary was not actively using substances during her pregnancy, she described "feeling frowned upon" by nurses during the birth of her newborn infant. When interacting with nurses during the postpartum period, she felt that "when they looked at [her], [she could] feel their eyes burning a hole in [her]." Overall, most of the mothers felt they were considered as "the problem" and the primary reason as to why their newborn infants were apprehended at birth. Feeling judged in this way made the participants feel like 'bad,' or incompetent mothers or "a nobody." Eventually, feeling judged perpetuated fear in the mothers such that they became "scared in showing any sign of weakness," as doing so may be perceived by providers as being "not capable of being a mom." As expressed by Summer:

> When it comes down to nurses and how they made me feel and if I could have any trust in them, I just couldn't wait to leave the hospital after having [my child] apprehended… [to] not

> have to worry about people saying 'oh you're crying ha-ha' or for people to judge me. I feel like all the time I have to be a strong person and show no sign of weakness, tears, nothing. Because if I do, that shows people that I am not capable of being a mom.

Most of the mothers also shared experiencing nurses' judgmental attitudes after apprehension of their newborn infants. For example, Dakota described being judged right after experiencing apprehension. She emphasized how the nurse's body language, through avoiding direct eye contact with her, significantly affected her self-worth as she began believing that she was "garbage," someone who "deserved everything that happened to [her]." As Dakoata expressed:

> …the tone was very disgusted, it was like '*I'm better than you'* type of voice. She never looked me in the eye. She never looked me in the face. I literally felt like I was the worst person in the world. She made me feel worse than scum. I felt like a bacteria, like I was gross, like I was nothing. And it was just by these nurses.

Moreover, Summer recalls after giving birth she felt that she was "in a place where [she was] hated, on top of having no children." She described how some nurses "would snicker or sneer, comment under their breath, or suck their teeth" when around her. Additionally, after Summer experienced the apprehension of her newborn infant, the nurse stated to her,

> …well I guess this is what happens when you get with a guy who is a dead-beat father." The mother went on to describe the impact these attitudes had on her comfort level, where she "wanted to leave the hospital as soon as possible so [she] could go home and bawl [her] eyes out and be alone and not have to worry about people judging [her].

Throughout most of the interviews, mothers described how harmful these stigmatizing experiences were to their self-worth and to their trust of providers. Feeling stigmatized left many

of the participants shocked, as they had believed providers should be trusted and compassionate professionals. As expressed by Elizabeth, "When you go [to the hospital] you expect to be treated like any normal person…but the moment they can tell you have something 'mental' going on, they will put you aside, leave you and treat people who look well…" For Elizabeth, having providers treat her in such a way kept her questioning her differences; this was demonstrated during Elizabeth's narrative in which she began shaming herself.

> It makes it feel like, if only Jesus would take this problem away from me and make me normal. That's what I tell people always, 'I want to be normal.' I don't want a learning disability or mental illness anymore. And it's all because of the way [healthcare providers] look at me … as if something's totally wrong with me.

Dakota, a First Nations woman who had her newborn infant and three other children apprehended, explained how providers' stigmatizing behaviours caused her to feel so powerless that she felt "comparable to trash." This perceived stigma left her feeling worthless and as if she "deserved the abuse" that she was experiencing at that point in time. She explained:

> They assumed that I was guilty of the worst crime and treated me as such. Because of how the nurses, social workers, and doctors treated me, I stopped standing up for myself. How they spoke to me made me feel like I deserved the abuse. So, when my partner decided to [abuse me], I just gave in because I had no other choice… because I deserved the abuse. I just became someone who just accepted abuse… I just wanted to die.

Stigmatizing attitudes by healthcare and social service providers alongside the experience of apprehension consequently led Dakota to a sense of hopelessness. Dakota described living with intimate partner violence before pregnancy. Despite staying in a violent relationship, she explained how she was previously a woman who would "stand up for [her]self." Unfortunately,

after apprehension of her newborn infant and children, she described feeling that her self-worth had been destroyed to the extent that she began tolerating her partner's abuse. She explained:

> And from then, that's when the abuse escalated, not just forcing me to have sex, but also verbal abuse, emotional abuse, psychological abuse. And then, it escalated to hardcore physical abuse… And, since I lost all my other kids because I didn't control the situation, I felt like I deserved everything I got.

### *Jumping Through Hoops*

"Jumping through hoops" was a common idiom stated throughout most of the mothers' interviews, and described how the process of trying to retain custody of their newborns was made more difficult than it should be. Mothers used this phrase to refer to the unclear and never-ending tasks that providers required they accomplish prior to the birth or reunification with their newborn infant.

Throughout each interview, the participants described feeling distressed and confused by the mandatory tasks and the rules imposed on them by the system, specifically CPS. All the mothers described feeling like they had to do certain actions in order to have a chance to visit their child(ren). For example, Cheyenne spoke about the struggle of jumping through hoops as follows:

> I'd do one thing that they ask, then they'll want me to do another thing. Then I'll do it, and then they'll ask me to do another thing… I had to jump through millions of hoops, I've had to do a [name of parenting class] three times, I had to go to drop-in centres for kids where kids play. I had to, you know, do all this stuff to just show them that I can do this… It's like it's a constant thing with Children's Aid, they make you jump through this hoop and that hoop to

> the point where you get so stressed from jumping, that you feel just like you can't do it anymore.

Moreover, mothers described their obligation to be present for unscheduled drop-in visits as another example of jumping through hoops. For example, at times mothers were unable to attend an unscheduled visit as they were out doing errands or at work; however, they were required to "stop what they were doing and meet with [the provider]." Mothers recounted reluctantly abiding by these rules, as they feared that the social service providers would "use [their] absence against [them]" as evidence demonstrating their incapability to attend to the responsibilities associated with effective parenting.

Furthermore, most of the participants were obliged to not only attend, but to re-take a variety of programs and parenting classes; they were left confused as to what else they needed to learn to demonstrate their competence as mothers. In fact, a few mothers independently signed up for different treatment programs, such as addiction rehabilitation or programs that provided information for women living with intimate partner violence. However, regardless of their efforts in "trying to listen to what CAS had to say," mothers described being told their best "was not good enough." As Dakota experienced:

> I found my own programs to get into. And I signed myself up and started doing them while also trying to find other resources. After that happened, we had meetings with the workers… and, they were like 'it's too little too late, we are still apprehending.' 'We don't think it's enough.' They just kept saying it's great what we're doing but 'it's too little too late.'

Many mothers described trying their best to complete what was required of them, only to be told to complete another task. A few of the mothers explained how the constant requests eventually made them feel so stressed that they began giving up hope in their fight for their

child(ren). Ultimately, the experience of jumping through hoops led mothers to believe that providers must "want [mothers] to fail," as providers must have viewed mothers as perpetually not good enough to competently parent their child(ren).

***Watching Over My Shoulder***

Mothers described that their feeling "not good enough" also arose from living with the impression of having providers continually surveilling their every move. When spending time with any of their children, mothers described feeling as if social service providers scrutinized their every move, trying to find flaws in their actions and parenting styles. Feeling surveilled by providers led many of the participants to feel stressed and afraid as any misinterpretation about their parenting could be used as evidence that they were not good enough to mother their child(ren). As expressed by Cheyenne:

> I still have Children's Aid involved and I feel a little bit stressed. Feels like there is a monkey on my shoulder or people looking over my shoulder over everything that I do. I tried to prove to them that I can do this, and I've been trying for 2 years with [my current child] but it's very hard. I still get really stressed, sometimes I get frustrated because I feel like everything that I've done is not good enough…And I think that's what CAS wants, for people to give up, for mothers to give up, for mothers to admit that they can't do this.

A few of the participants described how feeling continuously watched over by social service providers led them to feel that the public may also scrutinize them as not good enough to competently parent their child(ren). For example, four participants described obsessively "checking for bruises or scratches on [their] child" to ensure that they would not be mistakenly blamed for injuring their child(ren).

Mary described feeling watched over when she was on a bus with her child who began to cry. While consoling her child on a bus, Mary realized that self-inflicted scars on her arms became exposed. She automatically assumed everyone on the bus could see her scars and therefore "would report her to CAS as an incompetent parent." Recounting another example of feeling constantly watched, the same participant explained that although she had been able to regain custody of her apprehended child, she felt as if her "neighbors must be confused as to how [she has] received a three-year old child into [her] care." She constantly felt that "they must know her child was apprehended and has now returned." Due to these thoughts, she ended up in a panicked state if her child "cries for more than 15 minutes," as she feared that her "neighbors will call CAS" and inform them of her inability to soothe her crying child.

A few of the participants explained how being surveilled by CPS has imprinted an immense fear and paranoia, where they question the trustworthiness of their immediate surroundings. Constantly feeling that people in their environments will report them to CPS ultimately left mothers feeling isolated. As explained by Raina:

> This is what they [healthcare and social service providers] don't understand, I'm always going to be looking over my shoulder because I'm always going to be afraid. The first thought out of my mouth every time I talk to someone [healthcare or social service providers] is 'are you going to call Children's Aid because I just told you this?' This is not a life any women or mother should live, but this is the life that they made me live now. I have no choice but to live this life.

Overall, mothers who had successfully regained custody of their newborn infant or were currently parenting a subsequent child described living their lives cautiously to avoid any form of misinterpretation to their parenting styles and child's safety, as one misinterpretation regarding

their parenting style could result in their child being re-apprehended. As explained by Dakota, "All it takes is one person to make a phone call to CAS, and I'd lose him."

***Mistrust***

Cumulatively, the perception of mothers being not good enough by providers led to mothers' mistrust. The following section will describe the mistrust that mothers developed towards healthcare and social support providers.

Most mothers perceived nurses as dishonest, as nurses were aware of the imminent nature of newborn infant apprehension yet concealed the truth from mothers. Ultimately, perceiving that nurses withheld information resulted in many participants developing the view that nurses could not be trusted. Mia described how she wished the nurses had been honest with her. She explained:

> [The nurses] could have told [CAS] they have a protocol or procedure. They could have not lied to me. They could have not allowed me [to] spend the little money I had to buy all these baby things, [just] to leave the hospital without a baby.

Mothers described that mistrust often developed after nurses were dishonest with them. A common example of provider dishonesty that mothers recounted was regarding the amount of time a mother could spend with her newborn infant. As Dakota's described:

> Honestly, I just wish they were honest. Because [postpartum nurses] said the baby was going to be able to be in the room with you until you leave the hospital. If there was no intention of that, they should have just given me a warning... I can't forgive them for that. I can't forgive them for what they did to [my child]. Treat me like whatever, I'm used to being treated like garbage, by even my own family, but don't do it to my child.

Likewise, during Raina's interview, she reflected upon the "false hope" social service providers instilled within her, leaving her to believe reunification of her newborn infant was possible.

> [Child protection services] said if I listened to them I'd get him back, and I did everything… they gave me false hope. Like who lets a child come to your house for visitations, and it's never going to happen. They lied. I'm never going to get over that they gave me false hope for ten months. If I had known, right from the get-go, then maybe right from the get-go I would have done what was best for him… and I wouldn't have gotten as attached…but they gave me false hope, and they got me attached, and it was nobody's fault but theirs.

Anger was evident during Raina's interview as she recounted her experiences with healthcare and social service providers. As explained by this mother, if only providers had explained that the outcome of apprehension was inevitable, she could have better prepared herself in developing realistic expectations, in turn, saving herself from greater heartache. Ultimately, for Raina, as she felt deceived, her distrust of all hospital-based providers grew after experiencing newborn infant apprehension. Raina explained:

> The minute they came in with the car seat, they ripped him off my chest…I have not been back to that hospital for seven years... Now I don't trust hospitals. I don't trust practitioners. I don't trust anybody… I could be dying and if you take me to a hospital I would rather die than have them take care of me because I don't trust anybody anymore.

Breaking trust led this participant to develop a generalized mistrust towards all healthcare services. Similarly, Mary explained how her experiences with nurses during newborn infant apprehension led to her mistrust towards all providers. As Mary expressed:

> …because of how everything turned out, I'd probably not want to talk to anybody. I'd be scared of all of them… and I guess it does kind of suck for someone who's really in it to help their clients, because as a client now I'm not going to give them my time of day.

Mary specifically blamed nurses for her growing mistrust of healthcare resources, as they were the individuals who "lied to [her]," causing her the most suffering. She explained that during her pregnancy, she was referred to a public health nurse for support. She hoped that by engaging with this resource she could demonstrate how determined she was to care for her unborn child. Unfortunately, after birth, her newborn infant was nevertheless apprehended. Mary continued to fight for custody after her loss. When her case went to court, the clinical documents written by the public health nurses were presented, and revealed how the nurses believed Mary was unfit to mother her child.

> I just felt like [nurses] were kind of two-faced. Like how they told you 'don't worry, this worker is really good, they'll connect you with…,' just to find out that they [would] submit these papers, like with paragraphs saying why I'm not or should not be parenting my child. And it came from all these public health nurses. In the beginning, they told me they were there to support me and help me, but in the end they were kind of writing about me, writing against me, to not have my child. (Mary)

Being lied to left Mary with very little trust in available resources, especially those referred by a healthcare provider. She explained, "If [a healthcare practitioner] referred me to [a resource], I'd go find my own. Anybody that is kind of connected to them, I would now stay clear from." Later in the interview, I asked if a change in a nurse's approach would be enough to help re-cultivate a trusting relationship. Unfortunately, for Mary, any kindness that was exhibited

by nurses from her experiences had turned out to be perceived to be a form of manipulation. She explained:

> You got to be fishy about those people now. To be honest, that's how they got me. They got me to feel comfortable, like where I would start talking and open up, but then behind closed doors they were all writing an article about me, about all my flaws, and things that I have done…

From Mary's experiences of nurses being dishonest, alongside the manipulative approaches used to gain her trust, she remained doubtful that she would access healthcare resources later in her life. She described, only "as a last resort," after all other avenues were exhausted, would she consider entering back into a hospital.

In summary, the theme "not good enough" highlighted mothers' perceptions of how healthcare and social service providers viewed them and how these experiences of being perceived as not good enough led to mothers' mistrust in providers. Due to mothers' experiences of providers' judgmental attitudes, stigmatizing behaviours and dishonesty, they were left largely unsupported. The participants who successfully regained custody of their newborn infants were left feeling continuously surveilled. Many of the participants described "never giving up" the fight to regain or maintain custody of their child(ren), even if it meant living with somebody "watching over [their] shoulders for the rest of [their lives]." However, being forced to abide by certain rules dictated by providers to regain custody of their apprehended newborn infant(s), mothers described developing mistrust in the integrity of providers and the healthcare system.

**Theme Two: "I Am a Mother, I Have Rights"**

The participants described feeling that they were stripped of their right to be treated as mothers. The emphatic nature with which the participants spoke revealed strong beliefs in their

right to be seen and treated as mothers despite not having a newborn infant to parent. Each mother described how healthcare and social service providers could have better supported their rights throughout their pregnancy, birth, apprehension, and postpartum experiences. Four sub-themes emerged regarding how mothers felt their maternal rights were ignored and how providers should uphold ethical practice and support their rights.

### *Give Me a Chance*

During the interviews, I asked what nurses could have done differently to support mothers during their hospital birth and postpartum experiences. Collectively, the participants described needing providers to "give [them] a chance." Foremost, they wanted providers to give them a chance by allowing them time to hold their newborn infants.

Most of the participants described being denied the opportunity to hold their newborn infants. Due to the lack of time spent with their newborn infants, mothers perceived they were never "given a chance" to act as mothers. As stated by Raina:

> You just pushed out this beautiful thing, they don't even give you a day to take him, [even] after you just gave birth. They can't even give you a day to hold him. They turn around and tell you that they are not only taking him from you, but [also that you will not] get the chance to take him home. You'll never get the chance to hold him at night.

Ann, a mother who acknowledged that she, at the time of her deliveries, was not fit to parent her children, was denied the chance to hold her children at birth. She shared how nurses could have, nevertheless, supported her rights as a mother.

> …if [the mother] has something [they] want to give to the baby, or [if they] want something from them… like cut a piece of their hair, [healthcare professionals] should be more respectful [to that request] … I had a stuffed animal that [I wanted to give to] one of my sons,

> and they didn't let me give it to him… that really hurt me. Like it's something of me, it smells of me … I don't know, because I was doing drugs and the toy was in my bags they probably thought it was holding drugs… but still they could have… I don't know… give them something… take a piece of their hair, something of the umbilical cord.

Permitting mothers to retain a memory of their newborn infant or to give something to their newborn infants was described as a way to foster the maternal-newborn connection – and therefore, give mothers a chance. Ann described how she "just wanted [her child] to have something of [her] ... have something memorable, like even the way [she] wrapped [her child] in the blanket." As she states, "okay take them away but let them keep the blanket you wrapped them up in so they have your scent… so that they have a piece of you." She explained that creating this moment would not only benefit the newborn infant, but also could have the potential to motivate mothers to continue fighting for reunification and to not give up hope. As Ann explained,

> [Retaining their rights as a mother could] keep the mother motivated. Like, your baby was just kicking in your belly, but now you can actually see it. Like, you can get [mothers] to want to be better for their daughter or son.

Most of the participants recounted a strong confidence in their ability to be "amazing mom(s)." They believed this view of themselves was validated through their experiences of mothering their subsequent child(ren). Successfully parenting their subsequent children led most of the participants to question why some providers were certain of their incompetence to parent their previous newborn infant(s). Mothers recalled that they should have been given a chance – especially when providers were attempting to assess their competency as a parent. As expressed

by Mary, “whether you’ve been a mom or not, [nobody] can tell [someone they] can’t parent if [they] never got the chance to.”

The participants hoped that by sharing their experiences, providers will recognize the mothers’ strength, as opposed to viewing them as unworthy and easily tossed aside. A common plea reiterated by many of the participants was to have providers work with them, rather than against them. As described by Raina:

> Before anybody, the doctors and nurses should have been on my side. They should have seen that this is a young woman who has been abused, neglected, and battered. That she can be a mother but we need to help her become a mother. And they never gave me that chance, they never gave me that chance to see who I am today … and now, my son will never get to experience what my daughter has got to experience.

A few of the mothers offered suggestions regarding how care providers should change their approach, by giving mothers a chance. Some recommendations were: to “not limit a person to their past experiences… [as] people can change and grow up”; and remember that “everybody’s different, and [that] we all grow differently, and people have different tolerances to pain and emotions.” A notable quote from Cheyenne was, “I can be a mother, I just need help.” Ultimately, mothers needed nurses to uphold ethical practice when providing care to mothers experiencing newborn infant apprehension, meaning that nurses need to treat mothers with dignity and provide them with the required support, rather than limit them to certain expectations. As stated by Mary:

> The way I look at it, people change. And if you have the right support or like village to help raise you and your child, you can easily accomplish things and succeed. And I felt like there wasn’t much of an option there. I understand being an addict and actively using, there is

consequences, but you can't just throw the person away and say there is no hope for you. I don't see it that way, I think everybody should have a chance.

***Let Me Have Choices***

All the participants described moments where they felt providers did not include mothers in decision-making and restricted mothers in their choices. For example, Leila described that after her newborn infant's apprehension, CPS explained that the way she displayed her emotions was a cause for concern regarding her ability to be an effective mother. Leila described *choosing* to take a withdrawn approach after experiencing newborn infant and older child apprehension so she could focus her energy and attention on regaining custody of her children. Leila expressed her frustration as follows:

> And as much as I want to hold the baby and things to be alright I had to disassociate myself away from that and stay focused. Like, what can I do tomorrow, to help me get my child back, right? But, they said that I was emotionally withdrawn… and I'm like okay?! So, if I cry, then you're going to tell me that I'm emotionally distressed but if I don't cry then I am emotionally withdrawn! Where do you want me to stand? Is this about you, and what you want and what you like and your opinion, or is this about me? Like, how are you telling me about my emotions, and why am I catering to what you want and trying to be in the middle?

According to Leila, she was labeled by CPS as a mother experiencing a dissociative disorder for not attending to the grief she experienced following her newborn infant and older child apprehensions. With being labeled as such, providers questioned Leila's ability to be a safe mother as she was considered unable to manage her emotions. As Leila described:

> I guess I do disassociate myself? I mean this word keeps coming up lately so I might as well use it. So, I do try to disassociate myself because I can't sit there and dwell on it, I'd rather be

> doing something productive. [Child protection services] are making it seem like it's a bad thing, that I need to focus on [my apprehension experiences] and go through the grieving classes and see why they see this as a negative thing. Like I understand that I have to face it, [but] how do they want me to face it? How else can I face it?

Most mothers described feeling excluded from decisions that were being made related to their future. Ultimately, as their voices were silenced, mothers felt their right to act autonomously was unsupported by providers. Mary shared how she was silenced and unsupported when engaging with CPS, leading her to bring several advocates to promote her voice and choices to be reunified to her apprehended newborn infant. Mary explained: "I built, instead of a village, I brought an army to every meeting with CAS. I would bring eight advocates from different organizations that I was attached to… I brought everyone with me." Mary emphasized the need for mothers at risk or facing apprehension to have "advocates," as most "mothers don't know [they] have rights."

Throughout each interview, mothers recounted examples of not being allowed to engage in decision-making and described having "no choice." Rather, they were expected to follow directions from healthcare and social service providers. Mothers often felt that if they did not follow the providers' directions, they would be at an even higher risk of losing permanent custody of their newborn infants as their noncompliance would be interpreted as being an incapable mother.

Furthermore, many mothers were not offered the choice to engage in skin-to-skin contact or breastfeeding their newborn infants if the birth occurred on a weekend. These mothers were told they must wait for approval by a social service provider to hold their child. Leila described feeling confused about not being allowed to hold her newborn infant: "…How are you telling me

to my face that skin-to-skin is important when my baby is over there and I can't even hold [him]."

Instead of being involved in decision-making, mothers described being required to act in accordance to the rules enforced by healthcare or social service providers; many of the mothers were given ultimatums. For example, two of the mothers described never wanting to give up the fight for their child, however, after being determined "not capable enough to parent her child," they were eventually forced to "choose between two options." The choices presented were to either give up their parental rights and have an open-adoption, or continue to fight for primary custody and face the risk of losing all their visiting rights and having their child placed in a closed-adoption. Eventually, both mothers 'chose' the former option as this provided them with the ability to, at a minimum, maintain a connection with their child. Ultimately, choosing this option resulted in the participants "never accepting" what had happened to them as they were never given an option that they perceived was in their best interest. One mother, explained still feeling "shame" for allowing her newborn infant to be adopted; this was depicted in her interview as she described living with constant guilt for giving up her parental rights and "not fighting harder" for her child. The residual feelings of guilt were also expressed by other mothers. Each participant described similar regrets for allowing somebody to force them to make a particular decision.

Despite the mostly negative experiences mothers had with providers regarding not being offered choices, a few of the participants described positive experiences with specific nurses who did engage mothers in decision-making. For example, Raina shared how one nurse clearly understood her needs and supported her decision-making. She stated "bless that nurse's soul," as this specific nurse "did what she could" to comfort the mother compared to the rest of the

hospital team members. Raina explained that after the apprehension of her newborn infant, she was told by the hospital team that she was not allowed to be left alone with her child,' she had to leave the hospital and her newborn infant would remain in the hospital for approximately four more days. Her newborn infant's stay was extended for further assessments and because the placement of the infant had not yet been determined. Raina described being infuriated that she was being discharged while her newborn infant would remain in the hospital. She went on to describe that 'there was one nurse who did what she could' by advocating on her behalf. Raina stated:

> [That one nurse got me] to stay in the room for four extra days. She made sure that food was covered, [as well as the] T.V and phone. [Additionally, she] made sure I was placed right across from the nursing station so that even though I could not have my child in [my] room, I could still see him.

Raina explained having that nurse supporting her choice to stay in the hospital ultimately gave her the hope needed to "move forward and live onward." She explained, "having those four days kept me alive and going. Those four days have told me every single day that one day that little boy will be in my arms again … and I think she knew that's what I needed." Raina's narrative conveyed a belief in the potential for nurses to better support mothers experiencing newborn infant apprehension.

### *Help Me Be Informed*

The importance of mothers needing to be better informed became increasingly apparent as I conducted more interviews. The lack of information given to mothers by providers directly impacted mothers' rights, specifically in terms of mothers having access to information regarding the plan of care. Many mothers described receiving insufficient information from

healthcare and social service providers, leaving them defenseless throughout the process of newborn infant apprehension and navigating the process of being reunified to their apprehended newborn infant.

All the participants noted that they were not certain of the primary reason(s) as to why their newborn infants were apprehended. Most mothers had some idea as to what may have led to the apprehension, that included: living with intimate partner violence, young maternal age or substance use. However, none of the mothers recalled being given a direct reason as to what they had done/not done or how they could have retained custody of their child. As expressed by Raina, the reason for apprehension of her newborn infant remains unclear to her:

> When I had my son, I didn't get… like… I got the reasoning in a way. When you're young… I am sorry to say, but when you are young, everyone is going to judge you, especially the doctors and the nurses. It doesn't matter, if you go in at 20, they are not happy but they will be fine because you're 20 years old. But if a woman goes in at 18 or younger, they look at us like we are whores, like we're sluts and at the end of the day that is not the case. Yes, some of us chose to get pregnant, but some of us do get raped! Some of us, you know, have other circumstances while we are pregnant and the hospital, the healthcare team, does not see that. They see this young girl pregnant about the give birth and say oh she's going to be miserable… The minute they saw an 18 year old that was pregnant with an abusive baby father, who has had abuse done to her whole life, and then the minute I decide to call and ask Children's Aid for help, I didn't say come take my child away I came to ask for help! They decided to take that as my weakness and say to me that I will never have a chance to parent.

Participants explained how they would have appreciated it if someone clearly had informed them about what was to be expected regarding newborn infant apprehension so they could have prepared accordingly. Similarly, Ann expressed the desire for clarity:

> If [nurses] know there is already a red flag out, and [the mother] doesn't know, give them support… [nurses could start out by saying], "after giving birth this is what is going to happen." Like, if they are not going to let the kid out, let [the mother] know.

In addition to needing to be informed regarding newborn infant apprehension, a few of the participants expressed the need for nurses or other healthcare professionals to explain why some of their lifestyle choices were harmful, especially for a newborn infant. Raina, a woman with a history of many abusive relationships, expressed that mothers at risk for newborn infant apprehension require more lifestyle coaching. In Raina's interview, she repeated the following statement;

> Looking back at it, I just wish someone had sat down and just explained to me what I know now. That [intimate partner] abuse is not good for a child. I wish they had explained to me what I know now, the signs to expect.

For Raina, informing her about the cycle of abuse could have supported her long-term well-being. Because of Raina's apprehension experience, she advocated for more support for women in abusive relationships and for education on how to remove oneself from the situation:

> Everybody says, 'Oh you want to choose the guy, okay,' but nobody realized the only reason I choose him is because I am an [South Asian] woman. When a [South Asian] woman has a man's baby we don't leave him! But I strongly blame healthcare practitioners because you know what, from the day they found out I was pregnant they should have started helping me then. When they saw that I was bringing my baby father to the ultrasound appointments and

they saw how he was treating me, they should have turned around and said, ‘Mister you need to go.’

In Raina's narrative, she described how her cultural background shaped her relationship expectations; if Raina leaves her child's father, she risked losing membership to her cultural community. Knowing the risks, Raina grew to tolerate her partner's abuse as she felt she had no other choice. Raina went on in her interview to also describe the abuse she faced during her childhood. Raina acknowledged how she had never really understood abuse was harmful to a child when abuse “was all [she's] known.” Therefore, Raina explained that if providers had known and could see that she was in an abusive relationship, why not help her out of it by explaining to her what intimate partner violence is and that she did not need to tolerate it.

Similarly, Dakota described how “one of the biggest things that helped” her in her journey to regain custody of her last child was taking a program that “pointed out what abuse looks like.” She stated that she “didn’t realize some of the things that [she] did towards [her] children was in fact abuse.” She described how individuals “tend to fall into the category of an abuser because that’s all [they have] learnt [from their life experience].” She stated, “It’s not that we are [an abuser], but it’s what we’ve learnt. So, we have to re-program ourselves to not do these things. It’s all about how you’ve been raised.” Dakota then described how she recognized abusive traits in herself based on what her “mother did it to [her].” Dakota suggested that to end cycles of violence, mothers needed to be informed about abuse and the ways in which it can be elicited, prevented and stopped.

***I Need Compassion***

For the participants, experiencing newborn infant apprehension was traumatic. Given the severity of trauma, the participants needed nurses to provide them with more compassionate

support. Mothers spoke about compassionate support as a skill that nurses should provide to help boost mothers' self-worth, especially after newborn infant apprehension. Some examples of the words that the mothers used to describe this compassion were: "show respect" [by] "being nice"; to "listen" and "give time for [a mother] to feel [her] emotions;" "be compassionate;" "be empathetic;" and lastly, "be understanding." Elizabeth explicitly states what she needed from providers after experiencing apprehension, "what we mothers want is just to feel loved."

Mia recounted an extreme example of a lack of compassionate care causing a traumatic experience following newborn infant apprehension at birth. She described how, while she was giving birth, a social service provider entered the labour and delivery room to reveal that Mia's newborn infant was to be apprehended. In the midst of giving birth and having her privacy violated, Mia became agitated and 'attacked' the provider. This behaviour resulted in Mia being placed in restraints for the remainder of her child's birth. She was devastated as to why providers felt it was appropriate to deliver the sensitive message of apprehension in this way, leaving her feeling undignified and victimized. Mia proceeded in her interview to explain what she believed should have happened:

> I think there should be a law saying if there is an apprehension at least wait till the birth is over. I'm not trying to hurt my child, I came to [the hospital to] make sure my child was born safely. They didn't need to restrain me [and] stand there with strangers watching me as I gave birth. They didn't have to do that. They made me feel like a monster.

While sharing her experience, Mia required a great amount of emotional support. She was very tearful when recounting her experience, demonstrating how traumatized she was from the experience. Despite being offered the option to end her interview, she chose to continue. She wanted to share as much of her experience as possible as she hoped describing her experience

may illuminate the lack of compassionate care experienced by mothers undergoing newborn infant apprehension. Ultimately, by sharing her experience, Mia hoped that changes to practice will be made and other women experiencing newborn infant apprehension will be provided with more compassionate care.

One of the participants acknowledged how some providers may have difficulty providing compassionate care to mothers as they have never had to live through the experience themselves. Regardless, she articulated her views by describing the need for providers to offer an empathetic approach when providing care:

> …They've never had a child ripped out of their care. They never gave birth where their child automatically went to CAS… You don't understand the hurt, the emotions, being stressed every day not knowing what your child is doing, feeding, sleeping, you don't know any of this… Sometimes it takes a lot of mothers down a bad road. We resort to drinking, smoking, drugs. Some of them, unfortunately, pass away because they can't take the stress and they can't handle it anymore because they don't have their child. [Providers] don't realize this. I wish they would think about the mother. They don't think about the consequences, like suicide, the mother could have, the drug use the mother can get into, the alcohol, the addictions, the, you know, getting mental health issues because their child is not with them. (Cheyenne)

During Summer's narrative, she remembered asking the nurses to listen to her express her feelings of grief. However, despite reaching out for assistance, she was left with very little support. As Summer explained:

> I told them, 'Listen I really need someone to talk to.' They would say, 'Don't worry, we will get you a psychiatrist soon.' I would say, 'I don't need a psychiatrist, I would just rather talk

> to you people, as we are working together until I leave.' They would say, 'That's not up to us, we will talk to the upstairs psych unit and see if they can bring someone down for you.' And I was like, 'Okay, I'd rather not, so I guess I won't talk to anyone then.'

Summer then provided insight regarding how nurses could provide compassion to mothers after newborn infant apprehension. Based on her experience, all she wished for was a nurse to sit down and talk to her, and to let her cry after experiencing the apprehension of her newborn infant. She stated:

> I need compassion, give me a hug and tell me it's going to be ok or things will eventually work out. Don't be so cold about it, because in the end, your job is to make sure that the mother is okay and how can you better assist her.

Despite the negative experiences Summer had when engaging with nurses, she went on to describe how the moments spent with a specific nurse positively influenced her outlook towards life. She shared her appreciation of one specific community health nurse, who she acknowledged as an essential key player in supporting her throughout her life, during her apprehension experiences. She began by explaining the historical context of her relationship with this nurse: "I've seen her this whole entire time, from [age] 16 all the way up, and she's been my rock." When the interviewer asked what distinguished [nurse's name] from other nurses, Summer described:

> She is really straight forward but she is also a very, very caring woman… She makes me want to be around her. [When I lost each one of my children], I would go to her and cry because I wouldn't know what else to do, and she'd say, 'come here,' and give me a hug… then she'd talk to [name of counsellor] and try to come up with a plan. She is just always helpful, I would say she is more helpful than the ones in the hospital.

In summary, the theme 'I am a mother, I have rights' highlights mothers' descriptions of the unethical practices of healthcare and social service workers that violated their rights. Mothers described needing providers to give them a chance to demonstrate that they can be safe and competent mothers. However, to support mothers in having a fair chance, the participants need providers to provide them with the essential information necessary to make informed choices regarding their health and their newborn infants' care. Ultimately, mothers have the right to be supported following their newborn infant apprehension experience. Mothers need providers to see that separation between mother and newborn infant at birth is a traumatic experience. Making an effort to authentically understand this experience can be the resource that mothers need from nurses.

### Theme Three: "I Live Every Day Like I'm Grieving"

Mothers characterized their grief as an experience of overwhelming emotions, beginning from the moment apprehension occurred to the present time. Their grief experiences included the subthemes: "feeling numb," "loss," and "never forgetting."

#### *Feeling Numb*

For all the participants, their grief experiences were dynamic and changed over time. However, most of the mothers described their initial reactions as feeling numb, meaning that they "were alive but felt dead" (Mia). As explained by Summer:

> The pain of losing my other two kids plus her now, I was numb. I was so numb and so done with crying. I was depressed, I was angry… There was no support. There was no support for the other ones, there was no support with this one – with nurses, or family, it didn't matter, I didn't care.

Feelings of numbness after newborn infant apprehension resulted in a few of the mothers using substances to cope. As explained by Summer:

> With my other pregnancies, I never did drugs, I never drank, I smoked cigarettes but that was about it… I was so numb and so done. I was crying, I was depressed, I was angry… I just [felt that I] needed drugs. I just wanted drugs. I just wanted to feel happy again.

Other mothers similarly described using drugs and alcohol to cope with the feelings of numbness, as expressed by Mia: "I was broken. I am still broken. I will never, ever recover from any of this. It has been a leading factor in my addictions. I tried to do programs [but] nothing helps…I'm very emotional. I'm very numb." However, for some other mothers, drugs and alcohol were used to intensify their feelings of numbness in order to avoid their grief. As explained by Raina, a mother who identified herself as an individual who used substances socially before pregnancy:

> My life went upside down. I had started doing more drugs to cope with the pain. I started drinking. There were times where I had come to **[**the clinic**]** completely drunk or high because I didn't want to cope anymore. The only days that I would be sober is if I knew I was visiting my son, and those were next to never.

Like Raina, Ann, who identified as a chronic substance user prior to pregnancy explained that her intensified usage of substances after apprehension was not a means to help her cope with her loss, but rather a means to intensify the numbness felt, as she "did not want to feel" her grief. She explained that she had always had a limited number of supports throughout her life and therefore had learned to "deal with [grief] by shoving it down," "numbing herself with drugs," and "not talking about it."

***Loss***

Despite experiencing newborn infant apprehension, most mothers did not speak of losing their newborn infant(s), rather mothers spoke about grieving the loss of their identity as a mother and purpose. The following section will elaborate on these losses.

A few mothers expressed how experiencing newborn infant apprehension eventually manifested as a loss to their maternal identity. As expressed by Leila, "I don't feel like a woman or a full mother because a part of a woman is being a mother. I don't feel whole to that certain degree because I don't have them."

Grief occurs when an individual experiences a loss of someone or something. The participants in this study not only experienced being stripped of their newborn infant but also lost their maternal identity. Without the daily responsibilities associated with mothering, a few of the participants were left questioning their identities. A few mothers expressed feeling divided: they identified as a mother as they had given birth to a child but also felt incomplete because they were without a child to parent. Their confusion often led to a loss of their sense of self, worsening their mental health and, in turn, grief experiences. As explained by Raina:

> I also have come to the point that the saddest pill to swallow is that I am his mom but I'm not. And I think that's the pill that hurts the most, is having to accept that I am his mom but I'm not. With that, I suffer from depression every single day.

Participants described acts of mothering despite having their newborn infants placed in the state's care or in an open or closed adoption. Some of the participants who had an open adoption or had their newborn infant placed with mothers' family members sent gifts or letters to retain a connection to their child(ren) and claim the space as mothers to their child(ren). As described by Raina:

> When I write to him I am supposed to be signing off as *birth mom* but I never do. I am always putting from *mom* underneath, because I don't care. That is my son, that is my pride, that is my blood.

Participants described how CPS and custodial parents created barriers to being known as mothers and how this caused them immense distress. For example, some mothers were only permitted to be known to their child as the "birthmother," "a friend of the father" or "a family friend." As expressed by Cheyenne:

> My first daughter, she doesn't know me as mom, she knows me by my name. The uncle will not tell her that I am mom. He tells her I am a friend of her dads… And now, you know, [she] will end up calling someone else *mom*, and that's what hurts the most.

Participants also spoke about experiencing overwhelming emotions that led them to feel they had "no purpose left" in life. They described the feelings of loss in life purpose as occurring during moments in time when they were unable to retain hope in themselves and their future. For a few of the mothers, losing purpose in life led to violence or physically harming themselves. As explained by Cheyenne, "I punched walls… I never really self-harmed myself [before], but I just punched things because I was so angry and didn't know what else to do to get that frustration out." A few participants who had a history of self-harm described how the intensity with which they harmed themselves increased after newborn infant apprehension. As expressed by Raina:

> I already used to cut myself and I did drugs, but it got worse. I started to cut harder and deeper… I made this one last cut and overdosed on pills. [I was brought to the hospital and] they tried everything – stitches, glue, the whole nine yards, but nothing was getting my arm together. They could see tissues, the white tissues. It got to the point where you did not only

see white tissues but also some of my veins. I was at that point where my arm was just open and they told me if I got even an inch deeper past the white tissues, I would be dead.

Most of the mothers had attempted to complete suicide at some point in time after apprehension of their newborn infant. As expressed by Mia, "After the birth [and apprehension], I overdosed and flat lined twice…I did it because I just didn't feel like there was any reason for me to keep going. Because that was the only thing that made sense."

***Never Forgetting***

The mothers report feeling "haunted" every day, as if they would "never recover" from their grief. For a few participants, the pain caused by apprehension would never be forgotten due to the reminders with which they lived daily. Raina shared "never forgetting" her apprehension experience as she was reminded every day while parenting her second child, who, as she described, resembled her apprehended son. As she stated:

The best way to say it to anybody or to explain it to a woman who is not a mother; you will never forget. You will never forget that pain. You can go to counselling, you can hide it, but that is the only pain that will never go away. And it makes it harder, every single day, raising a second child that looks exactly like her brother.

In summary, this third theme, "I live every day like I'm grieving" described how most mothers felt numb after their experience. To cope with their trauma, a few of the mothers attempted to remain numb by using alcohol or substances. Participants were left feeling lost and incomplete, and experienced loss, not only of their maternal identity but also in the purpose to live their lives. Ultimately, mothers expressed feeling haunted by their experiences, resulting in never forgetting their child(ren) or their apprehension experience.

**Theme Four: Hope in the Face of Adversity**

Participants described some feelings of hopefulness; hope was characterized as mothers' expressions of a future-oriented, positive outlook. Hopefulness was primarily voiced when they recalled the moments shortly after childbirth when they had spent time with their newborn infant(s). According to participants, having spent that time with their newborn infants positively impacted their apprehension experiences, and nurtured their sense of hope.

***Time with Newborn Infant Creates Hope***

Through the analysis of the participant interviews, it was apparent that mothers' hopefulness was linked to the moments spent with their newborn infants. In fact, many described the profound impact that time spent with their newborn infants had on giving them a future to look forward to despite not having custody of their child. For Raina, even spending just a short time with her newborn infant provided her with hope for her future and, consequently, the motivation to make positive changes to her life. She expressed:

> …those four days [in hospital my son] have kept me alive and going every single day… Those four days are the reason why I quit drugs, I quit drinking, I stopped cutting myself. They're the reason, he is the reason, [that] I am a mother today and I have my [daughter] at home. If it was not for [having that time with my son], I would not be the woman nor the mother that I am today.

Mia also acknowledged how the love that she felt for her newborn daughter had "changed [her life] for the better," and became the driving force in "getting sober." Furthermore, Dakota, a mother who had been reunified with one of her apprehended children by the time of the interview, accounted for the time spent with him as a newborn as having provided her with hope:

> I still go through my depression, it doesn't go anywhere… I can go down, but what brings me up is that [my son] looks up to me. He's a big mommas-boy. He loves with all his heart, and

you can tell that is what gives me strength to fight through all the depression. Knowing that one day my child will be an adult and hopefully I've done a good enough job where he can survive on his own, and make something of himself and has confidence in himself to be that… someone who cares for others, helps others, who doesn't judge somebody by how they act or how they look, to get to know a person before they make a judgment.

### *Ongoing Hope*

Most of the mothers described holding onto hope, whereby they believed that one day, they would be reconnected with their child(ren). As Summer recounted, "Something inside me told myself to keep myself alive because, in the end, suicide is not the answer. Because if I want to kill myself, then my other three kids [who were apprehended] don't get to find me."

A few of the mothers described to be reconnected to their child(ren) was dependent on them "acting in good faith" or holding a higher power responsible for bringing a child back to a mother. Other participants described "never giving up" in proving their ability to competently parent, as they hoped this would aid in reunifying them with their child(ren). Lastly, the remaining mothers described how "natural it is for any child who is placed in care to search for [their respective mother] later on in their lives." Regardless of the source of their hopefulness, it provided mothers with the strength to 'live onwards' and to 'make sure that they are alive and well for the day when their child re-appears in their lives.'

## Summary of Findings

Although the four themes described in this chapter are presented in a linear way, it is important to state that the themes are entwined with one another. Therefore, although this chapter ends on a somewhat positive note by describing how mothers retained some hope after

experiencing newborn infant apprehension, the grief caused by apprehension alongside memories of having their rights violated remains present, affecting their everyday lives.

The degree to which these traumatizing experiences affected mothers' well-being became apparent through the participant interviews. Participants experienced almost a complete lack of support from healthcare and social service providers throughout their pregnancy, birth, apprehension, and postpartum experiences. Participants described how providers' (including nurses) stigmatizing and dishonest behaviours led mothers to be labeled as not good enough to mother their newborn infants. Being judged as not good enough alongside the experiences of providers' dishonesty resulted in mothers' mistrust of providers and the healthcare and social support systems. The participants have highlighted their healthcare and social service experiences as harmful and inequitable, in turn, mothers explained how providers should have supported their rights as mothers. Mothers described continuing to live every day like they were grieving because they will never forget the experience of having their newborn infant(s) taken away from them. Although they did retain some hope regarding being reunited with their child(ren) or even meeting their adult children at some point in the future, their experiences of newborn infant apprehension were clearly traumatic, and had long-lasting implications for their health.

## Chapter 5: Discussion

The purpose of this study was to explore mothers' experiences of having their newborn infants apprehended from their care by child welfare authorities in the hospital. Secondly, the study focused on understanding the mothers' grief experiences. To guide the study's inquiry, I used a three-fold process informed by Thorne's (2016) interpretive description methodology, which included:

- my perspective as a mental health and community health nurse, specifically an experience that I had supporting a grieving mother after newborn infant apprehension occurred;
- the literature primarily focusing on older child apprehensions, demonstrating a gap in understanding of newborn infant apprehension and mothers' well-being; and
- applying the disenfranchised grief framework(ref) as a theoretical framework to help understand mothers' grief.

The two research questions for this study were:

(1) How do mothers describe the experience of having their newborn infant apprehended by child protection services at birth?

(2) What do these descriptions reveal about mothers' grief?

The first research question aimed to provide a descriptive account of the participants' experiences of having their newborn infants apprehended at birth. The second question aimed to describe how mothers experienced grief after newborn infant apprehension.

In this discussion chapter, I briefly summarize the themes described in the study findings and discuss how the findings relate to the existing literature. I organized the first part of this discussion chapter according to the two research questions that guided the study. Subsequently, I discuss the importance of the study's findings for nursing practice, including the imperative for

nurses to provide ethical care to mothers affected by newborn infant apprehension. Then, I will relate how nursing interventions in a different care context can be used to support mothers affected by newborn infant apprehension, specifically their grief. Next, I address the study's implications for education, policy, and research. Lastly, I describe the strengths and limitations of this study and offer a final reflection.

**Summary of Themes**

As illustrated within the findings (Chapter 4) of this study, four themes described the experiences of mothers affected by newborn infant apprehension. The first three themes, "not good enough," "I am a mother I have rights," and "I live every day like I am grieving" largely described mothers' experiences as traumatic, and draw attention to their stigmatizing interactions with healthcare providers, specifically nurses and social workers. The last theme, "hope in the face of adversity," demonstrated how, alongside to their traumatic experiences of apprehension, mothers do express hope that they will be reunited with their child(ren) later in life. In the following section I will give a broad overview of the findings presented in Chapter 4 related to the experiences of mothers affected by newborn infant apprehension.

The findings chapter begins by presenting the theme "not good enough," which described how mothers felt perceived by providers, particularly nurses and social workers, and included four sub-themes: "feeling judged," "jumping through hoops," "watching over my shoulder," and "mistrust." Mothers' *felt judged* through both the actions and inactions of providers. Some mothers believed providers' judgment was a result of mothers' 'lifestyle choices,' such as living with: lower socioeconomic status, homelessness, an abusive partner, drug use during pregnancy or mental illness. All the mothers described feeling they had to *jump through hoops* to prove their worth as a mother to providers if they wanted a chance to be reunified with their newborn

infant. For the few mothers who were successful in regaining custody, they described having to continuously *watch over their shoulders* due to their feelings of having their parenting abilities constantly surveilled by providers and others from their communities. With providers communicating doubt to the participants' parenting competence, mothers ultimately developed significant mistrust in providers and the healthcare and social support systems.

The theme "I am a mother, I have rights" in particular, reveals the unethical and inequitable treatment by the health and social support systems that mothers experienced during their pregnancy, childbirth, and post-partum periods. Four sub-themes present how mothers needed providers to treat them throughout their experiences: "give me a chance," "let me have choices," "help me be informed," and "I need compassion."

Next, the theme "I live every day like I am grieving" brought attention to mothers' grief experiences following newborn infant apprehension. The theme included three sub-themes: "feeling numb," "loss," and "never forgetting." Mothers described *feeling numb* after experiencing the apprehension of their newborn infant in the hospital. Mothers faced a lack of support from providers and their communities after experiencing apprehension, leaving them to 'cope' by themselves. For many of the participants, 'coping with the grief' included prolonging their emotional numbness by using drugs. For other mothers, the lack of support and expectation to 'cope' led them to contemplate or attempt to complete suicide. In their interviews, mothers described their experiences as a loss; not only did mothers experience physical separation from their newborn infant, but they also experienced losing a part of their identity as a mother and for some, their purpose in life. Overall, mothers described how they would *never forget* their apprehension experiences, and that their grief remains part of their everyday lives.

The last theme presented was “hope in the face of adversity,” with two sub-themes: ‘time with newborn creates hope’ and ‘ongoing hope.’ Ultimately, both sub-themes highlight the hope that mothers expressed despite experiencing such traumatic event. For the participants in this study, hope developed from the moments mothers spent with their newborn infants and when treated with dignity by a few nurses they encountered during their apprehension experiences.

**Discussion of Study Findings**

In the literature review (Chapter 2), I describe how most of the existing literature pertaining to the phenomenon of newborn infant and older child apprehension focuses on identifying characteristics of mothers that predict apprehension and mothers’ health outcomes following apprehension. Many of the predictive characteristics identified in the existing literature were reflected in this study’s participant sample, such as being racialized or using substances during pregnancy. Three participants were mothers of colour, and a further two participants self-identified as being First Nations. Additionally, most of the participants were either using substances or living with a partner who used substances during their pregnancy and/or described themselves as living within a violent relationship during pregnancy or at the time of apprehension. All nine participants were of a low socioeconomic status or homelessness; their average income was ‘$20,000 or less/year.’ Moreover, many of the health outcomes that affect mothers following apprehension that have been described in the literature were echoed by the participants in this study; this included worsening mental health, increasing likelihood for suicide and exacerbation of substance use.

Despite the similarities in the characteristics and health outcomes of mothers at risk of newborn infant and older child apprehension described in the literature and the participants in this study, this study expands beyond and offers a more in-depth understanding of their

apprehension experiences. The following sections will situate the findings from this interpretive description study within the existing literature. I will highlight this study's novel contributions to the understanding of the traumatic and stigmatizing nature of mothers' experiences with providers and systems. Additionally, I will discuss how mothers' experiences influence their grief. Unlike most of the existing research that over medicalizes mothers' grief, I advocate that supportive interventions be made available and accessible to support mothers' grief and their long-term well-being.

## Mothers' Experiences of Newborn Infant Apprehension

### *Experiencing Trauma*

Mothers' experiences of newborn infant apprehension were traumatic. Although participants did not use the word traumatic, trauma was apparent by the descriptions of mothers' experiences. For example, mothers emphasized how their newborn infants were 'ripped from their arms' or 'stripped' from their care. Trauma permeated throughout each theme presented in Chapter 4, primarily through the experiences mothers had with providers. Mothers described being: perceived as not good enough to be mothers, treated without respect for their rights, left to manage their grief experiences with little to no support, and denied the opportunity to spend time with their newborn infant immediately after birth. In addition to being mistreated by providers, the lack of information mothers received regarding newborn infant apprehension furthered their traumatic experiences. Being unaware or unsure that apprehension would occur at birth in the hospital resulted in some mothers experiencing forcible separation from their newborn infants.

Trauma is described as a lasting emotional response that often results from living through a distressing event (CAMH, 2020). Trauma has been identified as affecting an individual's sense of safety, sense of self, ability to regulate emotions, and navigate relationships (CAMH, 2020).

In turn, when trauma is left unsupported, individuals may experience shame, helplessness, powerlessness, and intense fear (CAMH, 2020). Immediate reactions in the aftermath of trauma are quite complicated and are affected by a person's own experiences, the accessibility of supports, their coping and life skills, and the responses of their family as well as the broader community in which they live (TIP, 2014). According to Treatment Improvement Protocol (2014), although traumatic reactions range in severity, ultimately, "the most acute responses are natural responses to manage trauma— they are not signs of psychopathology" (p. 60). Trauma can affect everyone differently, where some individuals may fit the criteria for a posttraumatic stress disorder, and others may exhibit resilient responses (TIP. 2014). Nonetheless, trauma can be subtle, insidious, and ultimately destructive to an individual's overall well-being (TIP, 2014).

A few of the participants in this study described never forgetting the pain experienced following newborn infant apprehension. These mothers also explained how specific circumstances in their everyday lives would remind them of their apprehended newborn infant, triggering the memory of their apprehension experience. Moreover, other participants described resilient responses following the trauma of newborn infant apprehension. Resilient responses after experiencing a traumatic event are marked by developing a sense of *hardiness*, or a shift in attitude and actions that help an individual transform their stressors into growth opportunities (Maddi. 2005; Maddie, 2013; Thomassen, 2018). For example, in this study, Leila described holding back from reacting emotionally to her apprehension experiences and "moving forward" in order to fight for her parental rights to regain custody of all her children. Rather than noticing Leila's determination and will, providers perceived her reactions as a lack of emotional attachment with her children. In turn, Leila was labeled as "dissociating"; in other words, Leila must be mentally unfit to parent her children safely. This example demonstrates that there is a

failure in recognizing that trauma can manifest in many ways, including resilient responses, by providers. Rather than pathologizing mothers' reactions, providers caring for mothers affected by newborn infant apprehension should acknowledge how their apprehension experiences are traumatic events. Through acknowledging trauma in mothers' experiences, we can approach mothers' reactions following apprehension as normal reactions to abnormal circumstances.

Despite research identifying older child apprehension as a traumatic event (McKegney, 2003, Wells, 2011; Denison et al., 2014; Robertson & Kinsella, 2014; Kenny et al., 2015; Kenny, 2017), most of the literature does not provide in-depth descriptions of the trauma mothers experience during newborn infant and older child apprehension. Instead, the focus is placed on the social and psychiatric concerns that are likely to occur in mothers following older child apprehension (Gilchrist & Taylor, 2009; Grant et al., 2011; Grant et al., 2014; Wall-Wieler et al., 2017a; Wall-Wieler et al., 2018; Wall-Wieler et al., 2018a; Wall-Wieler et al., 2018b). When reviewing literature regarding the involuntary separation between mothers and newborn infants, a plethora of adverse outcomes have been described; such as increasing the likelihood of drug and alcohol use, mental illness, psychotropic medication use, domestic violence, family breakdown, and institutionalization (Brown et al., 2018; Wall-Wieler et al., 2018c). Before focusing on the outcomes in mothers following newborn infant apprehension, attention should be placed on understanding mothers' trauma. This study's findings add to the current state of research concerning the phenomenon of newborn infant apprehension by portraying the complexity of trauma through mothers' perspectives, and contributing understanding about how trauma may manifest in mothers.

### *Experiences of Stigma*

Experiences of stigma were apparent throughout mothers' interviews. Despite the literature identifying the presence of stigma within mothers' apprehension experiences, there remains a lack of detail regarding the impact that stigma has on mothers' lives. This study highlights how stigma impacts mothers' identity and intersects with their experiences of grief after their newborn infants are apprehended at birth in the hospital. In this section, I will discuss the impact stigma can have on mothers' identity and then describe the ways in which stigma impacted the lives of the participants in this study.

To understand how stigma impacts mothers' identity following newborn infant apprehension, attention must be placed on the historically mediated structures that influence how society views morality versus immorality in terms of motherhood. Mothers affected by newborn infant and older child apprehension are typically conceptualized as 'bad' mothers leading to the idea of 'bad' people (Hays, 1996; hooks, 2009; Hays, 2009; Wells, 2011; Kenny et al., 2015; Kenny, 2017). Being labelled as 'bad' often leads to a lack of social acknowledgment for mothers experiencing apprehension, as it is considered that their newborn infant(s) will most likely be *better off* with an alternate parent (Hays, 1996; hooks, 2009; Hays, 2009; Wells, 2011; Kenny et al., 2015; Canfield et al., 2017; Kenny, 2017). Historically, 'bad' mothering has been closely linked to those who do not abide by the Western ideologies of mothering as the way to successfully parent a child. For example, mothers of colour who hold specific parenting traditions, yet deviate from the way upper-middle class mothers in Western society parent, may be typologized as 'bad' mothers (Hays, 1996; hooks, 2009; Hays, 2009; Abrams & Curran, 2011; Wells, 2011; Kenny et al., 2015; Kenny, 2017).

In Canada, Indigenous mothers remain disproportionately represented as those who experience newborn infant or older child apprehension, a tragic phenomenon recognized as The

Sixties Scoop and continuing today as "The Millennial Scoop" (Kenny, 2017, p. 305). The Sixties Scoop refers to the separation of newborn infants and children from their Indigenous families and their subsequent placement into Caucasian households. The era contributed to the perpetuation of colonialism, the act of one nation gaining political control over another for economic gain, which included the assimilation of different cultures to a Western ideology (Sinclair, 2007; Denison, 2012; Kenny, 2017; Wall-Wieler et al.,2018b). Ultimately, forcing the Indigenous population's assimilation was a result of racist views, where the dominant belief was that differing cultures did not meet the expectations and standards dictated by white supremacy. Due to the differences observed in their cultural heritage and traditions, Indigenous populations were categorized as those who were worrisome and unstable, especially regarding their ability to be effective citizens and to safely parent their children (Gilbert, 2007; Sinclair, 2007; Goodman et al., 2018).

For example, traditionally, Indigenous Peoples value nomadic lifestyles (Gilbert, 2007; Goodman et al., 2018). However, within Western culture, nomadic lifestyles are linked to disruption of family stability (Goodman et al., 2018). Wall-Wieler et al. (2017) noted "residential mobility" remains a current and significant predictor of the likelihood of newborn apprehensions among Indigenous mothers (p.1146). The Western belief that nomadic lifestyles lead to unstable and disruptive lives has normalized the separation of newborn infants or children from Indigenous mothers since removal of the children is perceived as 'a better alternative' for their long-term well-being. However, research examining the experiences of children who were taken out of their Indigenous households and assimilated into residential schools, has overwhelmingly discredited the toxic discourse that they are *better off* than being with their parents (National Collaborating Centre for Aboriginal Health, 2012). When Indigenous children were separated

from their families and forced into institutions, they were often subjected to harsh punishment and physical, psychological, and sexual abuse (National Collaborating Centre for Aboriginal Health, 2012). Additionally, the historical removal of newborn infants and older children from their Indigenous families has created a perpetual cycle of intergenerational trauma, which remains today affecting the health, social, economic, and political status of Indigenous populations (National Collaborating Centre for Aboriginal Health, 2012).

The overwhelming disregard that Indigenous populations have faced from colonial interventions, including the systematic removal of newborn infants and older children from their Indigenous families, has significantly impacted mothers' identities (Ignas, 1988; National Collaborating Centre for Aboriginal Health, 2012). Greenwood et al. (1995) conducted a qualitative study of Indigenous young mothers, and found that a high value was placed on mothers finding their identity by learning their Indigenous culture and sharing it with their children. Research highlights the power of motherhood for Indigenous mothers, as motherhood establishes terrains of camaraderie, protection and connecting within Indigenous communities (Downe, 2017). Additionally, when Indigenous mothers can draw upon their intergenerational motherline, this can provide a source of strength and inspiration extending intergenerational ties not only vertically but also laterally across cultural and geographic spaces of Indigenous populations (Downe, 2017). The complexity of loss that Indigenous mothers face when experiencing newborn infant or older child apprehension is traumatic; it leaves them 'losing layers' of their identity, and with immense grief extending over generations (Ignas, 1988; Downe, 2017).

Participants in this study provided numerous examples of health and social service providers' stigmatizing behaviours throughout their pregnancy, apprehension, and post-partum

experiences. Described by the theme "not good enough," mothers were perceived as incompetent to parent their child safely. Mothers experienced helplessness, powerlessness, and fear following their apprehension experiences, with little to no support from nurses and social workers. Mothers felt providers had labeled them as "the problem"; these stigmatizing experiences resulted in mothers perceiving that little space was available for them to be seen as capable mothers, especially when attempting to regain custody of their newborn infant.

The stigmatizing experiences of the mothers in this study reflect the findings described in the existing literature. The removal of a newborn infant or older child from mothers' care may not be seen by providers as a loss, but rather as saving a child from a bad situation (life with their mother) and a benefit to the children's long-term well-being and safety (Van Arragon, 2016). Despite this perception, evidence exists demonstrating that removing children from their parents' custody and home does little to positively influence children's cognitive and behavioral development (Berger et al., 2009). Therefore, the primary focus when CPS remove children from their family should be limited to the immediate concerns of child safety rather than initiating apprehension due to the stigmatizing perception that life with their mothers is, or potentially can be, problematic (Berger et al., 2009).

All nine of the participants in this study described how their identity as mothers was affected by the stigmatizing behaviours of healthcare and social support providers (as seen in the theme "I live every day like I am grieving"). Being stigmatized left mothers to internalize the projected shame, leaving them feeling guilty and regretful for not being the mother they hoped to be for their newborn infant. Research examining mothers affected by custody loss has portrayed how mothers are positioned in socially devalued categories (e.g.: homelessness, poverty or single motherhood) that produce pathologized and potentially damaging identities for these individuals

(Abrams & Curran, 2011). Link and Phelan (2001) explained how experiences of stigma can harm an individual's social and personal identity. These authors explained that individuals experience stigma when they are labeled and discriminated against – both components highlighting human differences. When an individual is perceived as different from the norm, division occurs, separating this individual from the rest of society and placing them in a lower social status. Socially outcast, the individual has fewer opportunities, creating disparities in health and affecting their long-term well-being. Additionally, being known only for their differences, these individuals become subject to being stereotyped; meaning, they become linked to a set of undesirable characteristics. Eventually, these stereotypes become social constructions or the shared assumptions that help society 'understand' an individual. These assumptions create relativist truths that further marginalize the individual facing stigma as they experience being restricted from understanding and expressing their authentic selves.

In addition to the harmful effect on mothers' identities, providers' stigmatizing attitudes contributed to mothers' mistrust of healthcare and social support systems. The development of mistrust towards the health and social care systems among women of childbearing age is a particular concern as it reduces the likelihood they will seek health promotion and social support services (e.g.: prenatal care) in the future. (Kenny et al., 2015; Bergen, 2020). Peterson et al. (2007) explored the perceptions adolescent mothers held when receiving inpatient post-partum nursing care. The researchers found when mothers felt rushed, judged or misunderstood by nurses, they would intentionally avoid interactions, or in some cases refuse further nursing care. Similarly, the mothers in this study described their interactions with most nurses before, during and after their apprehension experiences as uncomfortable. Most of the participants described feeling manipulated and lied to by nurses. Participants described how nurses would misuse their

position of trust to collect evidence against the participants' competency to parent. With nurses breaking mothers' trust, many of the participants recalled avoiding the hospital where they experienced newborn infant apprehension, even when they were in need of health care.

Healthcare providers can overtly or covertly express judgmental attitudes. The literature describes how healthcare providers, specifically nurses, covertly display stigma through their level of social distance – being the desired degree of space wanted between a member of one social status to another (Nordt et al., 2006; Ebrahimi et al., 2012). Nordt and colleagues (2006) compared social distance and discriminatory patterns between nurses and the general population. They found that both groups held the same degree of negative labeling, stereotypes, and desired separation towards marginalized populations, especially those diagnosed with severe mental illnesses. Tragically, this study mirrored the literature's findings and demonstrated that nurses contributed to harmful discrimination by avoiding or limiting their time with mothers when mothers would access care during their prenatal, intrapartum, and postpartum periods.

To date, most of the literature examining the phenomenon of newborn infant and older child apprehension has been contributed by researchers from the discipline of social work (McKegney, 2003; Allison, 2011; Wells, 2011; Kamara, 2015). Stigmatizing behaviours by social workers have been described as resulting from pre-existing biases and prejudices, especially when the circumstance of apprehension conflicts with a provider's ideologies (McKegney, 2003; Allison, 2011; Wall-Wieler et al., 2018a; Wall-Wieler et al., 2018c). Wells (2011) described the toxic views embedded in the CPS industry towards mothers affected by older child apprehension. Mothers at risk of experiencing apprehension are often labeled as abusive and neglectful towards their children, in turn, perceived as those who must struggle with abusive and neglectful traits, making them unable to act and think independently from their

immediate experiences. Viewing mothers as those who will continue cycles of abuse has led CPS providers to treat mothers with less supportive care than the standard of care delivered to mothers who remain unified to their newborn infants at birth (McKegney, 2003; Allison, 2011; Wells, 2011).

Systemic biases that exist in healthcare settings also contribute to the inequitable care mothers affected by apprehension receive, as the systems continue to allow prejudicial attitudes by providers to occur. Research exploring how nurses contribute to enacting stigma when delivering care has received far less attention in literature, specifically perinatal nursing (Halter, 2008; Recto et al., 2020). If the nursing profession is committed to reducing the stigma towards marginalized populations, it must start by addressing issues of stigma that exist overtly and covertly within its own ranks and expand its knowledge around stigmatizing processes. This requires critically questioning how historical and societal power structures transfer into healthcare settings and influences nursing practice.

### *Mothers' Experiences of Grief*

To date, there has only been one study that presents an understanding of the ongoing nature of mothers' grief experiences following older child apprehension (Janzen & Melrose, 2017). The remaining body of research exploring mothers' experiences gives attention to identifying the presence of grief and the consequences that grief has on mothers' lives (McKegney, 2003; Allison, 2011; Kenny et al., 2015; Janzen & Melrose, 2013; Everitt et al., 2015; Mermania et al., 2015; Janzen & Melrose, 2017; Kenny & Barrington, 2018; Broadhurst & Mason, 2019). Despite research identifying the presence of grief following apprehension, little research has set out to understand *how* mothers grieve.

To further explain mothers' grief experiences following apprehension, I will address how mothers experienced a disenfranchised grief following newborn infant apprehension. It was clear that when mothers were displaced from the title of mother or were restricted from enacting a mothering role, this worsened their grief experiences. Using the disenfranchised framework as a lens, I will describe the extent to which the framework helps understand mothers' grief experiences when forced to re-conceptualize their maternal identity. Following this section, I will continue to explore mothers' grief by discussing the collateral consequences that occur as mothers live their grief following newborn infant and older child apprehension.

**Disenfranchised Grief**. In Chapter 3 (Methodology), I presented the theoretical framework of this study, the disenfranchised grief (DG) framework. The DG framework focuses on how societal dogmas affect individuals experiencing non-traditional losses, as in the case of mothers' grief following newborn infant apprehensions (Doka, 1989; Doka, 2002). When an individual experiences a loss that deviates from what is socially recognized and understood, the individual's grief may not be openly acknowledged, publicly mourned, or socially supported (Doka, 1989; Doka, 2002). For example, when an individual dies, their immediate family circle is accorded the right to grieve by society, whereas the right to grieve for those with relationships to the deceased that fall outside of a defined family unit are not acknowledged to the same extent. Nevertheless, every individual should have the right to grieve, despite the perceived social significance of a relationship (Kim, 2019). Every individual should be free from judgment and restriction and allowed the space to feel, think, and behave in the ways in which they want after experiencing loss (Allison, 2011).

This study used the DG framework to help understand mothers' grief experiences. The findings from this study contribute to the existing evidence that mothers affected by newborn

infant apprehension experience disenfranchised grief for the loss (physical separation) of their newborn infant. However, in the following section, I will describe how this study has contributed to an in-depth understanding of how participants' experience of disenfranchised grief also extends to their loss of maternal identity.

Individuals are often deprived of their right to grieve when relationships are not socially recognized, such as those that fall outside of kinship (Doka, 2002). Interestingly, despite mothers affected by newborn infant apprehension holding a familial relationship to their newborn infant(s), they are perceived as those who will not actively 'mother' and are therefore stripped from being known as their newborns infants' mothers. Westernized motherhood is described as encompassing two dimensions, pregnancy and giving birth, and raising a child (Sacks, 2017). Because mothers affected by newborn infant apprehension do not take on the traditional roles and responsibilities associated with raising a child, society places distance between the relationship of mother and newborn infant (Wells, 2011; Kenny & Barrington, 2018).

This distance that society places between the relationship of mother and newborn infant is not limited to mothers experiencing apprehension but has also been described regarding mothers' experiences with pregnancy loss, including stillbirths, perinatal death, and miscarriages (Carolan & Wright, 2017; Wonch-Hill et al., 2017; Jordan et al., 2018). Due to the value placed on the social roles of motherhood, pregnancy loss severs the possibility for mothers to actively parent their newborn infant(s), leaving mothers excluded from identifying as a mother (Carolan & Wright, 2017; Wonch-Hill et al., 2017). For example, Jordan et al. (2018) conducted a qualitative study exploring mothers' experiences raising a single surviving twin. The authors described mothers' identity as a twin mom was left socially unrecognized the perception existed that "their child's' life was too brief to be worthy of acknowledgement" (p. 896). Like mothers affected by

newborn infant apprehension, mothers who experience pregnancy loss struggle to gain acceptance as mothers, leaving them unable to make sense of the absence of their newborn infant(s) (Carolan & Wright, 2017). Research suggests, "meaning-making is an essential piece of grief and loss resolution" for mothers who experience pregnancy loss (Carolan & Wright, 2017, p. 149). Therefore, when mothers suffer the absence of their newborn infant are offered little support, they experience social denial leading them to internalize the shame of others' disapproval. In turn, mothers' grief can grow in intensity, causing concern to their mental well-being (Robinson, 2001; Carolan & Wright, 2017; Wonch-Hill et al., 2017).

In the theme "I am a mother, I have rights," the sub-theme "give me a chance" portrayed how mothers needed nurses to see them as mothers. To see the participants as mothers meant nurses treated mothers sensitively, lending understanding that they had just given birth. Despite the apprehension, participants had created a life with a lasting, eternal connection and having this connection to their child recognized was meaningful for them. Nonetheless, most mothers were not given time to even hold their newborn infants. Not allowing mothers to hold their newborn infants can be interpreted as providers' lack of recognition of the profound relationship that exists between mother and newborn infant. As seen in the theme "I live every day like I am grieving," sub-theme "loss," mothers experienced a loss of identity, where they felt incomplete, or not "whole" , in terms of their maternal identity and potentially their identity as a woman. From the participant narratives, it was clear that mothers needed, at a minimum, to be recognized as mothers and given some time with their newborn infants. Doing so may be a key part of a trauma-informed approach that supports mothers in making meaning of the connection they have with their newborn infant and their identity as mothers.

A socially dominant misconception is that mothers affected by newborn infant apprehension do not care enough to be with their newborn infants, because if they did care, they would make the necessary changes in their habits or lifestyles to ensure the safety of their newborn infants (McNeese, 2016; Khazan, 2019; Lamb, 2020). If a provider perceives that a parent is posing a risk to their newborn infant's or child's safety, it is their duty to inform child protective services (Ontario Ministry of Children and Youth Services, 2017). Therefore, in the eyes of many providers, if a mother is perceived as putting herself first, over her newborn infants' well-being, she may be categorized as selfish and unsafe in terms of protecting a vulnerable child (McNeese, 2016; Khazan, 2019). Risk is inherent to life; therefore, it is essential to note that the providers' perception of newborn infants' safety is not a value-neutral assessment. The perception providers have regarding newborn infants' or children's safety is influenced by their personal biases and prejudices (Wells, 2011). Therefore, what is typically negated from providers' perceptions of mothers affected by newborn infant apprehension is the social, economic, and political disadvantages mothers face that leave them with few resources, forcing them to cope by themselves.

Mothers who use substances have been described as a sub-population of severely stigmatized mothers (Poole & Isaac, 2001; Abrams & Curran, 2011; Stone, 2015). As identities are socially constructed by the dynamic interplay of an individual's social context, society's stigmatizing attitudes towards substance-using mothers threaten a mother's self-concept, resulting in mothers developing a low self-image and self-esteem (Poole & Isaac, 2001; Abrams & Curran, 2011). Mothers' low self-esteem creates barriers to finding help for their substance use (Poole & Isaac, 2001; Stone, 2015). Poole and Isaac (2001) explored the experiences of 47 mothers accessing addictions services in British Columbia to identify barriers and supports

encountered at the point of entering care. Two-thirds of their participants identified with the statements of feeling ashamed about having a problem with alcohol or drugs and having others know, which, in turn, affected their willingness to seek out and access healthcare services (Poole & Issac, 2001). Mothers interviewed for this thesis who struggled with substance use before or during pregnancy echoed feelings described in the literature. Mothers described their treatment by providers, specifically nurses, as cruel when compared to the way mothers who did not use substances were treated. For example, Ann described that nurses must have felt she did not care to protect her newborn infant since she did not abstain from substances, as she was told, "This is what happens when a junkie has a kid." Following their apprehension experiences, each mother expressed internalizing shame and feeling isolated due to providers' stigmatizing behaviours. With little support, most mothers began to use substances as they felt they had no other way to cope other than finding a means to numb themselves from the pain of their newborn infants' absence. Numbing their pain through drugs could be interpreted as an example of how the mothers put their needs over their newborn infants' safety. However, mothers were pushed to cope in this way as they had no other avenue of support. Ultimately, being perceived as those who do not have the ability to feel their loss leaves mothers affected by newborn infant apprehension deprived of a maternal identity and grief *held* by others.

There is a gap in our understanding of how to support mothers' grief experiences following apprehension, especially with respect to their maternal identity. Application of the DG framework as a lens demonstrated how mothers who experience newborn infant apprehension experience being left unrecognized, unacknowledged, or held by others in terms of their maternal identity and grief. Overall, the cultural context of motherhood imposes a sense of "otherness" on mothers experiencing newborn infant apprehension (Carolan & Wright, 145). Additionally, the

societal perception that these mothers are ‘bad’ mothers who do not express emotions following apprehension leaves little space for mothers’ grief to be accepted by healthcare providers and systems. Mothers affected by newborn infant apprehension deserve to have their grief and maternal identity legitimized and supported by society. Leaving their experiences unacknowledged contributes significantly to affecting their everyday lives and long-term physical and mental well-being.

**Collateral consequences of Grief.** Research exploring the experiences of mothers affected by older child apprehension is limited to either identifying grief as a concern or describing the impacts of mothers' grief (McKegney, 2003, Wells, 2011; Denison et al., 2014; Kenny et al., 2015; Mermania et al., 2015; Kenny & Barrington, 2018; Broadhurst & Mason, 2019). Research exploring the impacts of mothers' grief did not explicitly discuss grief but rather implied it as part of the collateral consequences grief has on mothers' lives. This body of research described how grief intersected with mothers' anger, fear, and ability to reach their self-actualizing potential, influencing mothers to remain at a socioeconomic disadvantage.

Wells (2011) focused on a narrative analysis of one mother’s custody loss and reunification with her three children. Wells (2011) did not center on grief but rather revealed the mother’s anger that arose from western society’s ideology regarding motherhood. The mother that was interviewed in the study described how her emotional pain was attached to her inability to live a moral life. The mother had to reconstruct her maternal identity in order to live up to the moral expectations described by westernized motherhood throughout her entire experience of fighting for custody of her children. Wells (2011) explained the demands and cultural expectations described by westernized motherhood are not easily achievable for mothers living in disadvantaged social positions. The author posited that the child welfare system should consider

the psychological and social positions mothers affected by custody loss live with and the difficulty mothers would be faced with when attempting to regain custody of their child.

Denison et al. (2014) explored how older child apprehension impacted 11 Indigenous mothers. The authors did not describe grief, rather they focused on the fear Indigenous mothers experienced following apprehension. The findings of the study revealed the judgments providers displaced onto mothers during their apprehension experiences lead mothers to develop a fear of accessing healthcare services (Denison et al., 2014). The fear of being judged was historically situated in the study, where the researchers expanded on the social, economic, and political disadvantages many Indigenous mothers have faced in Canada. The authors reiterate how racist, sexist, and discriminatory government policies have been and continue to remain oppressive towards Indigenous women, and how this oppression influences fear in Indigenous mothers, preventing them from proactively accessing healthcare services.

Kenny and Barrington (2018) conducted a qualitative study exploring the social relationships and social supports following the removal of a child by child protective services among 19 mothers who used substances. The findings demonstrated mothers were severely disadvantaged in terms of having social networks following child removal. As mothers were stigmatized, they are left with a lack of acknowledgment to the trauma that follows with child custody loss, resulting in fewer supports made accessible and available. The findings suggested that experiencing fewer social supports can undermine mothers, especially in terms of their emotional and physical well-being, limiting them from their self-actualizing potential that is needed to support them in their fight to being reunified with their child (Kenny & Barrington, 2018).

Lastly, Broadhurst and Mason (2019) explored the perspectives of mothers who experienced child custody loss. The authors centered on describing how child removal could be conceptualized as a gateway to further adversities in mothers' lives, one example being mothers' grief following child removal restricting them to disadvantaged social positions. As mothers experience the absence of formal or informal supports following child removal, mothers may cope through harming themselves; this included socially harming themselves, where mothers would destroy their personal and intimate relationships. Ultimately, experiencing isolation from their pre-existing supports undermined mothers in their rehabilitation, leaving them to face greater structural vulnerabilities, such as civil disqualifications that restricted them to housing, employment, and welfare benefits.

While interviewing mothers who either were successful in being reunified to their apprehended newborn, or who were, at the time of interview, parenting a subsequent child, anger towards healthcare and social support systems was evident. Mothers who became reunified to their newborn infants were angry for all the years they lost being a mother to their child(ren). All mothers who were now parenting a child were angry for not having the freedom to enact their own parenting styles, as they were aware that they are being constantly surveilled and scrutinized for if they made any mistakes. All mothers interviewed were angry for never being given a chance to be the mother to their newborn infants, this included not being able to hold their newborn infants at birth.

Not being able to spend time with their newborn infants lead mothers to question the integrity of healthcare and social support systems, whereby mothers described developing mistrust to seek out resources later in their lives. Mothers did not directly express fear when describing mistrust towards healthcare and social support providers and systems but noted how

they would feel uncomfortable if required to use these services. Considering the self-actualizing potential of mothers in this study, it was clear that due to the stigmatizing attitudes projected by providers towards mothers during pregnancy, apprehension, and post-partum experiences, mothers struggled with their self-concept. Mothers experiencing apprehension were not just stripped from being the mother to their child(ren) but also stripped from the idea of being known as a mother, leaving them shattered to who they were as a person. In theme one, "not good enough," Dakota explained she had always viewed herself as a strong woman who always stood up for herself. Yet after experiencing stigmatizing attitudes by nurses following newborn infant apprehension, the mother described changing into a shadow of her former self, accepting and tolerating abuse. Each mother had their own experience following the change in their self-concept after experiencing newborn infant apprehension. However, one common theme that arose throughout each participant's experience was how the struggle of a mothers' self-concept led to thoughts and attempts of suicide. Ultimately, mothers faced living their grief by themselves. Most of the participants turned to substance use as a way to numb themselves and cope. As mothers feared to be judged by their community and social networks for having their newborn infant apprehended, mothers did isolate, as they wanted to be alone to create a safe space to feel their emotions.

### *Hope: Re-defining the Mother Role*

Mothers affected by newborn infant apprehension face many negative experiences, such as the stigmatizing attitudes of their health and social service providers, traumatic apprehension experiences, and a lack of social recognition and of their grief. However, in the theme "hope in the face of adversity," mothers in this study spoke of how time spent with their newborn infants, or with a few nurses, supported mothers in developing hope for their future. Mothers described

developing profound feelings when recounting the time spent with their newborn infants that extended from their pregnancy to birth experiences. For example, mothers feeling their newborn infants' first kick during pregnancy, hearing their newborn infants' heartbeat at ultrasound appointments, and, for some mothers, holding their newborn infant after giving birth. McMahon (1995) theorized in the book "*Engendering motherhood*" that maternal identity is a moral construction that is partially dependent on women's emotional investment in their children. It was clear that the participants in this study cultivated a maternal identity with the emotional investment they began developing with their newborn infants from their pregnancy and birth experiences.

When exploring the moments shared with nurses, the compassion provided by some nurses helped acknowledge mothers' mistrust of healthcare providers following apprehension. A few mothers shared examples of how nurses who advocated for them, delivered compassionate care, or offered their time, positively influenced mothers' perceptions of healthcare resources. For a few of the mothers who participated in this study, despite experiencing newborn infant apprehension in the previous five years, they continued to hold on to the positive moments spent with those few nurses during their birthing experience. As described by one mother (Raina), she gave credit to a specific nurse during her postpartum experience who acted as expected in providing the mother more time to stay in the hospital (regardless of not being able to be with, or hold her child), motivating the participant to stay alive. Overall, the role nurses can have when providing care to mothers can significantly influence their experiences. Nurses providing support immediately following apprehension can protect mothers from further harm, by inspiring mothers with the hope needed to help them continue to persevere.

For many mothers, motherhood is envisioned as one of the most rewarding experiences in life (Martell, 2001; Mercer, 2004; Abrams & Curran, 2011). Having a child changes a woman's view of her personal life and how she sees herself in a broader social context (Stenius et al., 2005). When a mother experiences newborn infant or older child apprehension, her identity as a mother is stripped away. In turn, she is socially pushed to re-negotiate her maternal identity with very little support (Janzen & Melrose, 2013). Few studies described the issues related to mothers' maternal identity in the context of newborn infant or older child apprehension (Wells, 2011; Kenny et al., 2015; Janzen & Melrose, 2013; Janzen & Melrose, 2017). A notable contribution from the study conducted by Janzen and Melrose (2013) is the critique of previous research that described mothers affected by older child custody loss as having to re-conceptualize their identities to subsequently fit within the context of motherhood. Janzen and Melrose (2013) suggested that mothers affected by older child custody loss are in fact mothers and do not need to lose or re-conceptualize their maternal identity, instead it is their *role* of being a mother (i.e., *how* they mother) that requires renegotiation.

In this study, the mothers were not prepared to detach themselves from their maternal identity, leaving them unable to appreciate being told by providers that they were not mothers rather birthmothers to their newborn infant(s). Mothers had a firm belief they were still mothers despite experiencing apprehension of their newborn infants; this kept their identities as mothers intact. Therefore, it was not their identity that was relinquished when their newborn infant's apprehension occurred, but a process of re-negotiating their role as a mother and what that role looked like despite not having a newborn infant to parent.

Mothers' confidence in knowing where they stood in terms of their maternal identity occurred with little to no support provided by the systems or people within their environments.

These findings suggested mothers did not allow the context of newborn infant apprehension to define the whole of their mothering and maternal identity. Abrams and Curran (2011) conducted a qualitative study examining the maternal identity among 19 low-income, mothers of colour with symptoms of postpartum depression. Like mothers affected by newborn infant apprehension, low-income mothers of colour also experienced stigma from society, creating a pervasive loss of self, characterized by a loss of autonomy and time, affecting their occupational identity, body image/ appearance, sexuality, and relationships (Abrams & Curran, 2011). The authors described despite facing stigmatizing attitudes, mothers were able to negotiate the conflicting versions of their maternal identities, as they "believed that their depression laid outside of their authentic and core inner selves" (p.383). The participants in this thesis mirrored the findings presented in the research of Abrams and Curran (2011), as they resisted adopting labels informed by the discourses of motherhood by asserting themselves as 'good' mothers who can be there for their children, especially if given support and the opportunity for a chance. Research described the phenomenon whereby individuals who do not fit into the discursively defined categories for identity (such as those outlined in the Western ideology of 'good' motherhood) can still engage their *self* in their *identity work* (Gubrium & Holstein, 2001). By doing so, the individual can transcend or contest social definitions, allowing them to negotiate, preserve and convey a positive sense of self (Gubrium & Holstein, 2001). Mothers in this thesis did engage in completing *identity work* on their own by claiming a space to be seen as mothers to their apprehended children. Nevertheless, identity is socially constructed (Abrams & Curran, 2011). Consequently, the lack of social support provided to mothers by the systems, providers, and people within their environments left mothers at risk to internalize notions of a failed maternal self.

## Implications for Nursing Practice

The following section will introduce the implications this study has for the profession of nursing. The section will begin with an ethics analysis of the roles and responsibilities nurses are expected to provide when delivering care. Next, I will draw on what we know of ethical nursing practice to help inform how nurses can take action and care for mothers at-risk or affected by newborn infant apprehension. Finally, the implications for nursing policy, research, and education will be described.

### *Ethic of Care*

The stigmatizing behaviours of nurses experienced by the mothers in this study left little space for mothers to feel recognized, acknowledged, and accepted as individuals who had just endured significant trauma and profound grief. Permitting stigmatizing behaviours affects the delivery of care and conflicts directly with nursing's ethical responsibilities (Martino Maze, 2005). Nurses are accountable to a code of ethics and for nursing decisions and actions regardless of personal preferences (Martino Maze, 2005; CNA, 2017). Canadian nursing standards require that nurses recognize that social, economic, and political factors influence nurses' actions when delivering care (CNA, 2017). When nurses remain attached to their biases and prejudices, this can act as a barrier to providing ethical, compassionate, and competent care (Wilson & Neville, 2008; CNA, 2017). Nurses must begin by recognizing the impact their values have and the power they hold within their positions when engaging in care with marginalized populations (Martino Maze, 2005; CNA, 2017). With an understanding of the self, nurses can lend awareness to the systemic disadvantages faced by vulnerable groups in society, such as mothers affected by newborn infant apprehension (CNA, 2017).

To deliver safe, competent, and ethical care, nurses must begin by recognizing the gaps within an individual's access to the social determinants of health and how they can significantly impact a person's health status. To prevent further illness and harm, nurses are responsible for delivering equitable care and advocating for social change to help create a just environment for all populations (CNA, 2017). Unfortunately, when relating the nursing profession's ethical mandate to this study's findings, it is apparent that mothers did not experience compassionate, ethical care. Instead, mothers described nurses as one of the primary contributors of stigma causing them great harm during their pregnancy, birthing, and apprehension experiences.

Nurses can play an essential role during a mother's apprehension experience since they are present throughout their pregnancy, birth, and postpartum periods. As far as we know, this thesis is the first known study to describe the ways the nursing profession can offer support to mothers experiencing newborn infant apprehension. The theme "I am a mother, I have rights" demonstrated the ways nurses can provide support to mothers. This theme was composed of four sub-themes, including: "give me a chance," "let me have choices," "help me be informed," and "I need compassion." When looking at the theme "I am a mother, I have rights" through the lens of the Canadian Nurses' Association Code of Ethics (2017), parallels exist between how mothers described improved nursing care and the core values that should characterize all nursing care.

The Canadian Nursing Association (2017) identifies seven core nursing values and ethics, the seven being, providing safe, compassionate and competent care, promoting health and well-being, respecting informed decision making, honouring dignity, maintaining privacy and confidentiality, promoting justice and being held accountable. Within every patient interaction, it is an expectation for nurses to abide by this ethical code of conduct (CNA, 2017). In the

following paragraphs, I will show how nurses have ethical responsibilities to protect mothers' rights, autonomy, dignity, and compassion to promote their health and prevent further illness.

**Maternal Rights.** In the theme "I am a mother, I have rights," the participants took the opportunity to voice how nurses need to support them despite their social positions and current circumstance of newborn infant apprehension. Ultimately, all mothers possess the right to be considered a valued member of society who is deserving to be treated equitably. Therefore, to uphold a mother's right, the participants described wanting nurses to care for them the same way they would care for a mother that leaves the hospital with her child. When explaining how nurses can treat them as mothers, most of the participants were simply asking nurses to practice according to their ethical responsibility to promote justice and safeguard mothers' rights to be treated with fairness during their apprehension experiences.

Permeated through each participant interview was how mothers affected by newborn infant apprehension were not allowed to spend time with their newborn infant after birth excluding them from cultivating a maternal-newborn connection. There is evidence to support the importance of the maternal-newborn connection (Bowlby, 1969; Fuller, 1990; Bowlby, 1995; hooks, 2009). All mothers, despite race, culture, sexual orientation, and social status, are to be provided the opportunity to cultivate an attachment to their children. This means providers, such as nurses, are to encourage keeping mothers and babies together after birth, as this promotes not only the health and well-being for the mother but also the child (Public Health Agency of Canada, 2020). Generally, giving mothers and newborn infants the opportunity to spend time together after birth has been linked to improvements in long-term psychological and physical functioning for both mother and child, including fostering the foundation for both mother and

infant to achieve future emotional, developmental, and social milestones (Bowlby, 1995; Kovalesky & Flagler, 1997; Crenshaw, 2014).

Despite the impending separation from their newborn infant, mothers affected by apprehension should not be denied the opportunity to nurture an attachment with their newborn infant. When considering the benefits of maternal-newborn connection in the context of perinatal death, fostering the bonds between parents and newborn infants has been shown to help develop post-traumatic growth as well as support maternal identity (Waugh, Kiemle & Slade, 2018). Recognizing that the context of perinatal death differs from newborn infant apprehension, I draw a parallel between the appropriate nursing actions in both contexts. Waugh et al. (2018) found mothers who experienced perinatal death and were encouraged to bond with their newborn infants through creating mementos (photographs, hand/footprints) recognized positive changes in their self-perception, relationships and life philosophy. Interestingly, in the theme "I am a mother, I have rights," sub-theme "give me a chance," participants shared how important it was to give and take something of their newborn infant following apprehension, as this could honour the existence of their relationship and keep them connected to one another. Ultimately, nurses did not allow mothers' requests to give their newborn infant toys following apprehension or have a keepsake of their newborn infants, such as keeping a piece of their umbilical cord or hair. Nonetheless, participants shared how if they and other mothers affected by apprehension were supported with receiving mementos or giving items to their newborn infants, it could potentially act as a source of strength and empower mothers by recognizing their role in producing life, in turn, inspiring hope in mothers.

**Autonomy**. In theme "I am a mother, I have rights," the sub-themes "let me have choices" and "help me be informed" demonstrates how mothers' required support from nurses to enact

their autonomy. To promote an individual's autonomy means to give authority back to the individual so they have the freedom to make decisions in accordance with their values, commitments, and beliefs (Hyland, 2002). Nurses have a professional and ethical obligation to recognize and incorporate the individual voice and needs of the patient into their health experience (Martino Maze 2005).

Introduced in the 1970s, the concept of shared decision-making became an essential component of promoting patient-centered care (Hansson & Froding, 2020). Shared decision-making, the act of including the patient in treatment decisions, replaced the outdated models of paternalistic care, which indicated providers, specifically physicians, knew better than the patient what was 'good' for them in terms of their health (Hansson & Froding, 2020). In turn, shared decision-making models shifted power back to the person by supplying the person with sufficient information to make informed choices regarding decisions in terms of their care (Hansson & Froding, 2020).

Concerning the participants in this study, mothers described never being included in the treatment decisions that were being made in terms of their health and their newborn infants' care. This was evident in each interview where mothers were not allowed the chance to hold their newborn infants after birth. Additionally, mothers described never being provided with adequate information throughout their birthing and apprehension experiences. As demonstrated through most of the participant narratives where mothers were not told that newborn infant apprehension would occur until after birth.

Mothers articulated how nurses could respect them by offering choices, and being transparent regarding the immanency of newborn infant apprehension. When interviewing the participants, I asked for the reason as to why their newborn infant was apprehended. Most of the

mothers could not identify an exact reason for apprehension, however, mothers did identify intimate partner violence as a possible reason as to why their newborn infants were apprehended from their care. The mothers' lack of understanding as to why their newborn infant was apprehended demonstrated that, at a minimum, they did not receive or comprehend the explanations for experiencing newborn infant apprehension by providers. The idea that intimate partner violence could contribute to newborn infant apprehension was assumed by the participants, as many recalled being told by CAS workers to leave their violent relationship during their pregnancy. The participants perceived that staying with their partners must have caused CAS workers to question their desire to create a safe environment for their newborn infant. However, for many of the mothers who did leave their violent partners, reunification with their newborn infants did not occur. In fact, some mothers described having left their partners and becoming a single mother was interpreted by CAS workers as placing themselves in an even more vulnerable position than if they had remained in the violent relationship.

Concerning mothers' choices, the participants described needing nurses to allow them the opportunity to engage in decisions to provide evidence-based practices, such as skin-to-skin contact and breastfeeding their newborn infants. These are evidence-based practices that should be offered to all mothers after giving birth, as described by the best practice guidelines for healthy mothers and healthy babies (Crenshaw, 2014; RNAO, 2018; Public Health Agency of Canada, 2020). Despite mothers being unable to continue to provide skin-to-skin contact and breastfeeding after apprehension, they should nevertheless be given the right to exercise their parental autonomy and engage in behaviours to promote the maternal-newborn connection, and are known to promote their long-term well-being by nurturing their maternal identity and fostering their hope. (Crenshaw, 2014; RNAO, 2018; Public Health Agency of Canada, 2020).

**Dignity**. Mothers affected by newborn infant apprehension are systematically disregarded in their dignity. In the theme "I am a mother I have rights," mothers' plead to be treated fairly and for providers to be open minded and give them the opportunity to be understood. However, following newborn infant apprehension at birth, the well-being of the participants were grossly ignored by the systems, providers, and people within their environments, creating a cumulative effect to mothers' trauma. With the state-driven ideology of 'good' mothering, priority is placed on child outcomes, which, in turn, has historically perpetuated the violent dismissal that mothers need interventions, support, and care following their apprehension experiences. CPS has enrolled in cementing the *good* versus *bad* mother ideology, asserting that child safety is the 'truth' worth recognizing in the circumstances of child removal. This ideology has become socially pervasive, influencing the ways in which healthcare providers and healthcare systems operate, whereby even the suspicion that a child may be unsafe overrules the idea of promoting health and justice for mothers. Consequently, mothers are treated less than human, where they are reduced to a vessel bringing a child into the world. Treating mothers as vessels for childbirth is akin to a dystopian society. For example, as seen in the novel "The Giver" (Lowry, 1993), a birthmothers' job is to give birth to children for the community, and having this job prohibits birthmothers from being a part of a family unit. Despite being categorized as a 'fiction' novel, it could be argued that this is the current reality that has been co-created by Western society for mothers affected by newborn infant and older child apprehension.

Mothers are excluded from being a part of a family following newborn infant apprehension. For three of the participants, their newborn infants were placed in the care of either the maternal grandmother or mothers' extended family members. In these circumstances, mothers were restricted from being a member of their family as conditions were placed regarding

when mothers could visit their child(ren). Moreover, for four of the participants, their newborn infants and (for one mother) older children, were placed in the care of their birth father or the father's family. Placing children in the care of the father left mothers alienated from being a part of their child's life. Recall, in the theme "I live every day like I am grieving," the sub-theme "loss" included how, for some mothers, they were not allowed to be known as the mother to their child. For Cheyenne, her daughter was placed in the care of the birth fathers' family members following newborn infant apprehension. Cheyenne was not allowed to be known as the mother to her child, rather she was introduced as "a friend of the father." For other mothers who had their newborn infants and older children placed in the care of the father, they described feeling controlled by the birth father, where they were limited from being able to be with or speak to their child(ren).

For the participants who had their newborn infant and older children placed in the care of their father, they described the reason for apprehension was related to intimate partner violence, where they were the victims of abuse. During their interviews, a few mothers were confused as to why they were being punished when comparing themselves to the birth fathers. Mothers described having to complete multiple parenting classes and programs to prove their parenting competency. In contrast, the perpetrators of abuse, the birth fathers, not only had custody of their child(ren), but were also not forced to jump through hoops and complete the same programs.

Cahn (2020) explained why the court system would decide to award child custody to a father when claims existed that a father was abusing a mother. The author explained that if a father alleged a mother was making false claims of abuse to alienate children from the father, the father had a greater likelihood of retaining custody of the child. Research confirming that parental alienation trumps the claim of abuse was demonstrated by Meier (2019). Meier (2019)

was the first to conduct a national study analyzing published court opinions made online between 2005 and 2014 and included a data set of 4,388 custody cases. The study's findings demonstrated that regardless of abuse claims when fathers alleged mothers were alienating a child from their father, the state granted fathers custody 44% of the time. However, if mothers claimed parental alienation by fathers, mothers were only granted custody 28% of the time. In turn, regardless of the abuse claim, if fathers claimed parental alienation, mothers were twice as likely to lose custody as when fathers did not claim alienation. If abuse against mothers were substantiated, mothers still lost custody in 13% of the cases, meaning fathers lost custody only 4% of the time when abuse was proven against them. Finally, the study revealed that in the circumstances where mothers claimed fathers had sexually abused the child, only one case (out of 51) credited the mother's claim. The author suggested that parental alienation supersedes abuse due to the power in the shared parenting ideology, which supports the notion that both parents require creating a relationship with their child to support healthy child development. In turn, when mothers claim abuse by fathers, their allegations become discredited and appear as if mothers are actively trying to reject the social norm that speaks to providing equal opportunity to both parents. In all, it appears the appropriate legal counsel for mothers fighting for custody of their child would be not to claim abuse against fathers, even if claims can be legitimized. Giving mothers this advice places them in an impossible position where they are forced to stay silent about the abuse they experience; otherwise, they risk being punished for their honesty.

To support mothers following their experiences of apprehension requires dismantling the social constructions that have created the norms dictating a healthy upbringing for a child. The ‘good’ mothering and shared parenting ideologies are similar as they direct attention to what is considered socially ‘right’ for a child’s well-being and choosing ignorance of mothers’ dignity.

Promoting dignity is an ethical value nurses are expected to attend to when delivering care across all populations. Ethical nursing practice pushes nurses to identify how broader societal issues influence health and well-being and then to promote social change in systems and societal structures to create greater equity for all (CNA, 2017). When nurses remain silent regarding mothers' experiences of apprehension they are complicit in anti-feminist agendas that continue to undermine women from being respected, impacting their privilege in society. Nurses must support mothers affected by apprehension by advocating for their realities to be heard, honoured, and validated as a truth that extends beyond relativism, requiring ongoing attention and consideration.

**Compassionate Care.** The most common statement observed throughout each of the participant interviews was the lack of compassion offered to them by nurses. The theme "I am a mother, I have rights," the sub-theme, "I need compassion," demonstrated how the care provided to mothers lacked sensitivity, understanding, concern and care. Foremost, mothers needed nurses to remember that regardless of their circumstances, they are human too, not the "nobody" that society has labeled them. Mothers emphasized they live every day traumatized by remembering their apprehension experience(s). Mothers expressed the need for nurses to act as an ally and support them through their suffering by spending time with them.

There is an expectation for nurses to provide compassionate care to all populations, despite their social positions (CNA, 2017). Compassionate nursing involves a commitment to act in response to suffering (CNA, 2017). Therefore, it is within a nurse's duty of care to show compassion, where compassion extends beyond an attitude and includes acting as social justice advocates, identifying the root causes of disparities between social groups in society, and supporting upstream interventions that can help populations achieve their full health potential

(National Collaborating Centre for Determinants of Health, 2014; CNA, 2017). Upstream approaches seek to reform the global forces that have perpetuated and reinforced structural inequities between populations (National Collaborating Centre for Determinants of Health, 2014). Historically, the healthcare system has placed emphasis on attending to individual lifestyle factors, which ultimately created "neglect of the conditions that structure and constrain individual choices" (Whitehead & Popay, 2010, p. 1235). In the context of mothers affected by newborn infant apprehension, to enact compassionate care, nurses must challenge their assumptions that the apprehension of a newborn infant or older child from its mother is a result of mothers' behaviours. Instead, nurses must recognize the influence of social, economic, and political structures (i.e., race, stigma, poverty, etc.), have on marginalized women, leaving them vulnerable to apprehension. Through the conscious effort in understanding how marginalized women are systematically disadvantaged, nurses can respond by advocating for women's parental rights throughout their pregnancy, birthing, and apprehension experiences.

**Health Promotion and Illness Prevention.** Health promotion is "the process of enabling people to increase control over, and to improve, their health" (Canadian Community Health Nursing, 2019, p.18). Nurses are accountable for enacting nursing care that promotes health and prevents illness amongst populations (CNA, 2017). However, according to the findings from this study, nurses often failed to promote participants' health. In fact, mothers described how they developed major mental health-related concerns after experiencing newborn infant apprehension with few available resources to support them in their grief. Each participant described either apast intention or attempt to complete suicide. Additionally, each of the participants described having no follow-up provided. Guidelines of the Registered Nurses Association of Ontario indicate that public health nurses should provide follow-up care for up to one year postpartum,

especially if a mother is flagged at-risk for depression before or during pregnancy (RNAO, 2018). With a lack of support provided to mothers following apprehension, growth in mortality rates related to suicide has occurred (Wall-Wieler et al., 2018). Therefore, this thesis raises the question - Are nurses truly protecting and promoting mothers' health after newborn infant apprehension takes place?

Wall-Wieler et al. (2018) found that mothers affected by newborn infant apprehension are at an increased likelihood for death caused by suicide. The authors suggest that due to the growing suicide rates, apprehension of a newborn infant or child should be considered a public health concern. The Office of National Statistics in the United Kingdom (2017) noted, "…deaths that could have been avoided through good-quality healthcare are considered amenable as these deaths could have been avoided by public health interventions," such as behavioral, environmental and lifestyle changes, or through support offered in restoring an individual's socioeconomic status (Wall-Wieler, 2018, p. 1092). On that premise, suicide of a mother affected by newborn infant apprehension is therefore considered as preventable and avoidable, as mothers' mortality rates have been linked to the lack of supportive interventions addressing their grief experiences (Wall-Wieler et al., 2017a); this includes, yet is not limited to, the internalized stigma, guilt, shame and loss of self-worth that occurs after experiencing newborn infant apprehension (Wall-Wieler et al., 2018a).

When nursing care fails to meet ethical or clinical standards it can be conceptualized as missed care (Kalisch, 2009). Missed care has been described "…as patient care that is omitted (either in part or in while), or delayed, in response to multiple demands and inadequate resources" (Kalisch, 2009, p.1510). Kalisch (2009) conducted a qualitative study that consisted of 25 focus groups that interviewed of 107 registered nurses, 15 licensed practical nurses, and 51

nursing assistants who worked on medical-surgical units. Kalisch (2009) identified several reasons that push nurses to miss care, this included: staffing shortages, the number of competing tasks that are required to be completed by a nurse by the end of their shift, poor use of existing resources, 'it's not my job' syndrome, ineffective delegation, habit and denial from investigating whether all tasks were completed. When examining the missed opportunities to care for mothers affected by newborn infant apprehension by nurses, it is not possible to conclude whether nurses working in the context of newborn infant apprehension experienced the reasons listed by Kalisch (2009). Little research has been conducted to understand the nurses' experiences when working with mothers affected by newborn apprehension. However, the findings of this study, suggest that nurses missed opportunities to provide compassionate, supportive care to mothers. For example, recall Summer's narrative:

I told them 'listen I really need someone to talk to.' They would say 'don't worry we will get you a psychiatrist soon.' I would say, 'I don't need a psychiatrist, I would just rather talk to you people, as we are working together until I leave.' They would say 'that's not up to us, we will talk to the upstairs psych unit and see if they can bring someone down for you.' And I was like, 'okay, I'd rather not, so I guess I won't talk to anyone then.'

Summer's experience was a shared reality amongst the participant sample. Despite seeking support, mothers were redirected to discuss their concerns to providers within another sub-specialty. In Summer's case, the nurse felt the grief experienced by the mother required psychiatric follow-up. Although a referral to a psychiatrist may be beneficial, it was not what Summer was requesting in the moment. Summer was simply asking for this nurse to consider that she had just experienced a traumatic event, and to then attend to her compassionately.

Kalisch (2009) describes *it's not my job syndrome* occurs when the task is seen by nurses as less of a nursing responsibility and rather the role of another interdisciplinary team member. With the competing priorities demanded by nurses during a given shift, nurses may feel the urge to delegate tasks to other members of the team (Kalisch, 2009). Unfortunately, when nurses delegate tasks to other members of the interdisciplinary team, *ineffective delegation* may occur, where the other team member may also perceive the same as the nurse and feel the role to support is not within their disciplinary scope yet more applicable to the nursing role (Kalisch, 2009). The conflicting perceptions result in a revolving cycle, leaving the patient untreated, and blame of responsibility cycling amongst team members (Kalisch, 2009).

Overall, nursing's role in caring for mothers affected by newborn infant apprehension is currently undefined. There is a lack of evidence or resources describing how intrapartum and postpartum nurses can offer support to mothers and newborn infants affected by apprehension in hospital-based settings. For nurses to address the gaps within a mother's health status and initiate sustainable upstream interventions to help mothers from re-entering cycles of violence, nurses must first acknowledge the lack of clarity in their role regarding newborn infant apprehensions and how a lack of clarity may lead to the phenomenon of missed nursing care. Therefore, I suggest that nurses take an active role in advocating for system-level and social change for mothers affected by newborn infant apprehension, attention must begin with developing policies that define the role of nurses in the context of newborn infant apprehension.

### *Inspiring Nursing Action for Newborn Infant Apprehension*

In the following section, I will describe how the nursing profession can better support the nursing care of mothers affected by newborn infant apprehension. I will begin by demonstrating the parallels between perinatal death (death occurring at 22 completed weeks of gestation up to

seven completed days of life) and newborn infant apprehension (WHO, 2021). Despite the contexts being vastly different, the support seen for parents affected by perinatal death can be used to inform supportive interventions, such as bereavement care, provided to mothers affected by newborn infant apprehension. Next, I will describe the concern related to the over-medicalization of mothers' grief and social conditions following apprehension and the need to transform care away from pathologizing grief towards the concept of ambiguous loss. Moreover, throughout this thesis, I emphasize the concerns related to stigmatizing behaviours amongst healthcare and social support providers when providing care to mothers affected by newborn infant apprehension. Therefore, I will conclude by calling attention to implementing health equitable frameworks, such as the harm reduction philosophy, whereby nurses can cultivate a dignity enhancing strategy to support mothers' long-term physical and psychological well-being.

**Perinatal loss.** Grief is an outcome for mothers after both perinatal death and newborn infant apprehension. Currently, there is a plethora of literature concerning mothers' grief experiences related to perinatal death; however, little research has described the grief experiences of mothers after newborn infant apprehension (Aerde, 2001; Aziz et al., 2001; Bartellas & Aerde, 2003 Arditti, Burton & Neeves-Bothelho, 2010; Association of Women's Health, 2009). With evidence-based research in perinatal nursing care disregarding newborn infant apprehensions at birth as a type of perinatal loss, nurses are left with a lack of guidance regarding the care of mothers affected by apprehension. There is an urgency for healthcare providers to reflect upon the difference between care standards regarding the support and bereavement interventions provided to mothers experiencing perinatal death versus newborn infant apprehension. The next section demonstrates the differences in care provided to mothers

experiencing perinatal death and newborn infant apprehension, to advocate for resources and supportive interventions for mothers affected by newborn infant apprehension.

**Bereavement Care.** It is essential that parents and families are offered, and have access to, appropriate support after experiencing apprehension, loss, or death of a newborn infant. Given the lack of recognition and awareness of mothers' grief experiences after newborn infant apprehension, little is known regarding bereavement strategies and supportive interventions that should be offered by nurses at the bedside or in the community. In examining the literature regarding ways in which nurses can provide bereavement support to individuals experiencing grief related to perinatal death and loss, a plethora of extant and current resources are available (Forrest et al., 1982; Gardner, 1999; Koopmans et al., 2013; Blood & Cacciatore, 2014; Hendson & Davies, 2018). When comparing the abundance of available resources for parents who experience perinatal death, the disenfranchisement of a mother's grief after newborn infant apprehension becomes even more apparent.

For many bereaved parents who experience perinatal death in hospital, the care delivered by healthcare providers has a significant effect on their responses to the death. Nursing research pertaining to bereavement care for perinatal death described various approaches that can begin at the bedside to promote parental health. These approaches include: "respecting and supporting parents spiritual and cultural beliefs, establishing trusting relationships with parents and their families, providing continuity of care throughout the perinatal period, giving parents privacy and unlimited time together in hospitals, listening to and encouraging parents' expressions of grief, providing information regarding their baby, encouraging other supportive persons (family members, friends, chaplains, funeral directors, and physicians) to be present, and continuing to communicate with bereaved families after their dismissal from hospital perinatal settings"

(Gardner, 1999, p.128). Koopmans et al. (2013) assessed the effectiveness of different types of bereavement support interventions for parents experiencing perinatal death and described three themes that were consistent in supporting parents; “for providers to offer deep respect for the individuality and diversity of grief, respect for the deceased child, and recognition of the healing power and resilience of the human spirits” (Koopman et al., 2013, p. 9). To promote resilience in bereaved parents after experiencing perinatal death, Blood and Cacciatore (2014) emphasized the importance of the roles of healthcare professionals in supporting parents when navigating their grief after perinatal death. Blood and Cacciatore (2014) described, as the utmost importance, healthcare professionals must convey respect for parents’ needs and acknowledge the significance of their loss when they have experienced perinatal death. Next, professionals should act empathetic, humble, consistent, and provide honest communication when engaging with parents during their crisis. Lastly, healthcare professionals can use creative approaches to help bereaved parents grieve, such as creating mementos, including plaster cast footprints, locks of hair, infant clothing worn in hospitals, and photographs of their baby.

When healthcare professionals support parents who experience perinatal death with compassionate and sensitive care in hospitals at the bedside, resilience in parents can develop, helping parents navigate their grief experiences (Koopmans et al., 2013). Based on the study findings reported in this thesis, it is unfortunate that the interventions described as the standard of care for parents experiencing perinatal death were described as the care that was missing by mothers interviewed for this study. For example, mothers shared how meaningful it could have been for them if allowed to keep, or give, mementos of their newborn infant after experiencing apprehension, such as pictures, locks of hair, or pieces of their newborn infants' umbilical cord. If mothers could not keep mementos of their newborn infant, they then asked for healthcare

providers to allow them to give their newborn infant items (clothes, blankets, or toys), as these items may hold the mother's scent. Mothers described their intention to give items to their newborn infants was to help their newborn infant not feel alone despite mothers' absence. Mothers questioned why they were excluded from fostering memories with their newborn infant following apprehension, especially when they noted that these interventions are best practices offered to parents who experience perinatal death.

**Supporting Ambiguous Loss.** Mothers affected by newborn infant apprehension experience disenfranchised grief, leaving them with little therapeutic and supportive interventions to share their experiences. Due to the intensity and chronicity of grief following apprehension, mothers' reactions are often framed as pathological, in turn, categorized as mental health disorders, such as anxiety, depression, and complicated grief (Janzen & Melrose, 2017). Mothers affected by apprehension should benefit from having their grief normalized as an expected feeling, as, of course, any mother would experience profound grief when faced with the traumatic event of being separated from their newborn infant after birth. The need to develop policy that guides nursing practice in the care of these mothers requires a shift from medicalizing mothers' grief to anticipating and supporting their ' grief.

Janzen and Melrose (2017) suggested that to prevent the medicalization of mothers' grief following child custody loss, grief should be viewed through a lens of *ambiguous loss.* Boss (2010) described two types of ambiguous loss. The first being when a person is physically present but psychologically absent. The second type, which I will relate to mothers affected by newborn infant apprehension, is when a person is physically absent but psychologically present.

Boss (2010) explained that when an individual experiences an ambiguous loss, there is no clear pathway to supporting grief. The author suggested when faced with ambiguous loss,

individuals will *freeze* in their grief process, limiting them from being able to move forward. In turn, individuals may experience reactions such as dysfunction within their relationships, difficulty making decisions, and confusion – all of which have also been described as symptoms in mental health disorders of grief, such as complicated grief (American Psychiatric Association, 2013). Despite the similarities between grief reactions and psychiatric disorders, Boss (2016) advocates limiting the degree to which grief is pathologized. When assessing for pathology, the author suggested pathology should be examined based on the types of loss, not types of grief (Janzen & Melrose, 2017; Knight & Gitterman, 2019). Doing so may allow the bereaved to build resilience by living their grief rather than seeking psychiatric intervention.

In this thesis, mothers affected by newborn infant apprehension experienced ambiguous loss as they grieve the physical absence of their child(ren) while holding hope that they will be reunited one day. Despite not being directly asked if they were diagnosed with mental health disorders, many mothers described being prescribed psychotropic medications, such as antidepressants, if they expressed their grief to a healthcare provider following newborn infant apprehension at birth in the hospital.

Traditionally, grief has been looked at as a condition requiring 'resolution.' Rather than attempting to 'resolve' mothers' grief, nurses should view mothers as facing an ambiguous loss and who require support to foster their resilience (Janzen & Melrose, 2017). The concept of resilience is elusive and has various interpretations, the most common being "the ability to rebound from challenges in everyday life" (McGuire, 2010, p. 120). However, to survive, recover and grow from adversity, an individual experiencing grief must be empowered (Kessler, 2019).

An example demonstrating how recovery is rooted through empowering an individuals' resilience can be seen within the culture of Indigenous populations. Indigenous populations value determination (McGuire, 2010). Therefore, despite the historical marginalization Indigenous people have faced, they recognize and are proud of their resilience. To promote Indigenous strength, the focus is placed on Indigenous populations' innate capacities and community strengths. In turn, rather than emphasizing explanations of failure and how Indigenous people must overcome their disadvantages, honour is given to the alternative perspective that acknowledges the search for Indigenous success (Durie, 2006; Valaskakis et al., 2009). Looking at mothers affected by apprehension through the lens of Indigenous resilience, interventions should not be focused on routinely requiring mothers to complete parenting classes that imply how mothers have 'failed' as 'good' mothers. Instead, to empower mothers, interventions are needed that help them search for success by recognizing their strengths.

Kessler (2019) added to the quintessential five stages of grief model created by Kubler-Ross (1969) by suggesting the sixth stage to grief, being the stage to find meaning. The author acknowledged that although for most, grief may lessen in intensity over time, it will never end. Therefore, rather than limiting the bereaved individual to resolve their grieving at the fifth stage of grief (i.e.: to accept their loss), space is given to the undeniable fact that grief is inherently ambiguous, making it free to take on any form without limits. Kessler (2019) suggested despite the type of loss, bereaved individuals often desire to make meaning from their experiences. When the bereaved are supported in finding meaning to their grief, they can transform grief into something powerful and empowering, all of which may reinvigorate strength and help them find the best in themselves and keep growing.

In an article by Knight and Gitterman (2019), practice interventions that can be implemented by providers towards those facing ambiguous losses were proposed. Interventions included how providers can help the bereaved find meaning for their ambiguous loss, such as re-orienting to a non-dualism perspective. The authors explained that attaining 'closure' from grief following an ambiguous loss is not realistic. Therefore, providers are encouraged to support the bereaved by recognizing how they can hold two opposing truths at the same time, such as accepting "that someone [they] love can be both absent and present at the same time" (Boss, 2010, p.141).

From the findings of this thesis, we have learned that the participants live their grief largely on their own, learning to live in-between dichotomous tensions that pushed and pulled them towards a state of self-discovery. Mothers described coming to terms with the fact that their grief exists, may never make sense, and may never end, yet they simultaneously experience hope for their future, specifically looking forward to the day they are reunited with their child(ren). Additionally, mothers resisted the idea that since they did not have their children to parent, they are not mothers. The hope mothers hold onto, and their will to preserve their maternal identity gave their lives meaning - to continue to fight for the return of their child(ren).

Supporting mothers to make meaning of their grief experiences may be the strength-based approach needed to help them have a chance to participate in their *identity work.* Allowing mothers to complete their *identity work* can help them heal, cope and grow in resilience, preserving a sense of self that can challenge the conditions that marginalize their grief experiences and lives. Ultimately, the concept of ambiguous loss can inform policy development regarding the nursing care of mothers affected by newborn infant apprehension. Nurses have a role in supporting mothers. Nurses can begin by acknowledging how opposing truths may

present during mothers' grief experiences and remind mothers how they have a choice to be undivided in their thoughts, feelings, and identity. When supporting mothers, the overarching goal is not to force an understanding, rather guide mothers to their strengths, including their capacity to mother their child. Supporting mothers in such a way can help foster their hope and sustain a future orientation to mothers' lives. Through implementing these direct practice interventions, the over-medicalization that currently occurs regarding mothers' grief can be replaced with social acknowledgment and support.

**Harm Reduction Approach**. Mothers affected by newborn infant apprehension experience facing systemic barriers that create greater disparities within their social determinants of health (McKegney, 2003; Allison, 2011; Wells, 2011; Janzen & Melrose, 2013; Kenny et al., 2015; Kenny, 2017). As mentioned, disparities that exist in mothers' access to the social determinants of health that predict the likelihood of newborn infant apprehension include mothers being: racialized, facing poverty (living in homelessness), and substance use. Based on findings from this study, additional gaps observed in mothers' access to the social determinants of health that increased mothers' vulnerability to newborn infant apprehension included chaotic childhood experiences and limited social supports. Living with a plethora of pre-existing gaps in their social determinants of health, mothers are left with little opportunity to break cycles of violence, such as living in homelessness or intimate partner violence.

Through this thesis's findings, a systemic barrier that significantly impacted mothers' health and bound them to their social conditions was the stigmatizing behaviours mothers faced within their communities, including healthcare and social support resources. Facing stigmatizing behaviours when accessing healthcare or social support resources led mothers to increased isolation and intensifying their mental illness and substance use. Ultimately, stigma harms

mothers, leaving them systematically disadvantaged in their health and social positions. When health and social positions become worse, mothers faced further disadvantages in their economic and political situations.

The philosophy of harm reduction posits that healthcare providers must advocate and intervene on upstream factors that push marginalized populations into greater vulnerability (CCHN, 2019, p. 19). Harm reduction appreciates that not everyone is ready or able to stop risky or illegal perceived behaviour, therefore through the development of policies, programs, and practices, adverse health, social, economic, and political consequences can be mitigated (NCHRC, 2020; Canadian Harm Reduction Network, 2020). Overall, a harm reduction approach that can protect mothers affected by newborn infant apprehension should aim to meet mothers where they are, "rather than making judgments about where they should be in terms of their health and lifestyle" (NCHRC, 2020). An approach the healthcare system can take to reduce the harm that occurs following apprehension is acknowledging how the separation between mother and newborn infants at birth is a socially unjust, unethical practice that stems from discriminatory ideologies.

Families in Recovery Combined Care Service (FIR Square) founded in British Colombia, Canada is the first single unit to care for women who use substances and their newborn infants exposed to substances utilizing a harm reduction framework (Nathoo et al., 2015). FIR Square's overarching goal is to reduce the harms associated with substance use and risky behaviours in mothers affected by newborn infant apprehension. The program mitigates harm among mothers by increasing the number of mothers seeking recovery treatment, increasing access to medical and community services, improving perinatal outcomes, and lastly, increasing the percentage of mothers who can safely retain custody of their newborn infants after birth (Nathoo et al., 2015).

With a multidisciplinary team, FIR Square provides a holistic treatment plan to care for mothers to build their confidence and understand the meaning of safe environments – for their home and the healthcare team (Nathoo et al., 2015). If a newborn infant is to be apprehended at birth, FIR Square's philosophy is to help stabilize and withdraw a mother from substances while keeping mothers and newborn infants together whenever possible, including in the antepartum and postpartum periods as well as during the transition between hospital and community (Nathoo et al., 2015). Abrahams et al. (2010) conducted a study examining 952 moms and babies at FIR Square and described that babies who were kept with their moms after birth (rather than separated) had fewer admissions to the neonatal intensive care unit, a shorter hospital stay, a greater likelihood to be breastfed while in the hospital, and were more likely to go home with their mothers. Ultimately, FIR Square recognizes that many mothers at risk for newborn infant apprehension have histories of being removed from their families at a young age or isolated from family and community support (Nathoo et al., 2015). Therefore, the program goal has been central in ending a multigenerational cycle of addiction, poverty, and child removal (Nathoo et al., 2015).

The FIR Square program is novel as it is one of Canada's first programs that has identified how problematic the phenomenon of apprehension occurring at birth is to mothers' health. Mothers affected by newborn infant apprehension need more supportive resources that advocate for retaining the connection between mothers and newborn infants after birth in the hospital to promote their long-term health and well-being. As suggested throughout this thesis, mothers affected by apprehension emphatically expressed wanting to be seen as mothers, which meant allowing mothers to foster the connection they have to their newborn infant after birth. Without providing them with this opportunity, the findings from this study suggests mothers were pushed

into greater vulnerability, leading to immense suffering, where mothers faced the disenfranchisement of their grief and maternal identity. Losing a sense of themselves, mothers in this study demonstrated developing immense despair that had the potential to result in suicide. The mortality rate among this population of mothers is, in fact, a public health concern as these deaths are preventable. Healthcare providers and healthcare systems should implement changes to current practice to reduce harm following apprehension at birth and intervene to support mothers by advocating and acknowledging the need for mothers to have the chance of experiencing the journey of motherhood.

**Recommendations for Nursing Policy.** There is a position for nurses and decision makers to create new or change existing policies regarding the nursing care of mothers affected by newborn infant apprehensions at birth. To this end, a review of the current practices for how newborn infant apprehensions occur in the hospital settings across Canada is recommended, with attention placed on describing the roles and responsibilities of the multi-disciplinary healthcare team, specifically nurses. I attempted to obtain policies on newborn infant apprehensions at birth in Toronto and Ottawa, Ontario; most hospitals did not have a policy in place. Through my search, I was able to find two hospital-based policies, one located in Vancouver, British Colombia and the other in Toronto, Ontario (Mount Sinai, n.d.; BC Womens Hospital, n.d.). The lack of policy in hospital settings for nursing care reflects the value society places on mothers' well-being following apprehension.

Mothers affected by apprehension have rights and deserve quality healthcare. To date, there is a paucity of research examining the care delivered by nurses during newborn infant apprehensions at birth. Based on the participants' stigmatizing experiences, I perceived the nursing care delivered to mothers affected by newborn infant apprehension rooted in historically-

mediated, discriminatory ideologies that blame mothers for apprehension. To explain why I perceived nursing care to mothers affected by apprehension as rooted in discriminatory practices, I will relate the care delivered to mothers in the same way nursing care has been provided to prison populations. I relate nursing care delivery between the two phenomena as both demonstrate how nurses can be enrolled to participate in delivering unethical practices.

Prison populations as a whole are overwhelmingly stigmatized by society, creating a deeply enculturated mistrust (Hudson & Wright, 2019). Through stigmatizing attitudes towards prison populations, a relationship of power exists when healthcare providers, including nurses, provide prisoners with care. If stigmatizing beliefs are held by nurses when delivering care to prison populations, nursing care has the potential to be interfered with, where prisoners are left receiving less quality of care when seeking supports for their health; this includes delayed diagnoses, withholding of treatment or analgesics, lack of accommodations (such as mobility aids), and substandard healthcare resources (Hudson & Wright, 2019, p. 344).

A concept within prison settings that has perpetuated the belief that prisoners deserve to be treated poorly is known as *penal harm* (Hudson & Wright, 2019). Penal harm is rooted in *tough-on-crime* sentencing policies where the institution intends to hold authority and sovereignty over the prisoner (Holmes & Federman, 2003; Hudson & Wright, 2019). The notion of penal harm influences nursing care provided to prisoners, as nurses align with the institutional goals of custody, control, and punishment to the prisoner rather than enacting ethical care. (Holmes & Federman, 2003; Hudson & Wright, 2019, p. 342).

Nurses working in prison settings are pushed to work under the institutional goals, even if they possess ethical expectations (Hudson & Wright, 2019). Typically, nurses are not given the appropriate resources to support prisoners, giving nurses little space to conduct themselves

ethically (Hudson & Wright, 2019). In turn, nurses are subjected to pervasive stigmatizing ideologies and controlled by the state to enact a specific type of care to prison populations (Holmes & Federman, 2003; Hudson & Wright, 2019). Over time, the factors that have shaped nursing in prison settings have lead nurses to become an extension of the states' intrinsic killing enterprise found in prison systems, as seen in the disturbingly and dispassionate nurse role found in the execution of prisoners facing capital punishment (Holmes & Federman, 2003).

Nurses working with mothers affected by newborn infant apprehension may face similar experiences to nurses working with prison populations as both patient populations are highly stigmatized and believed to require control through rehabilitation by the state in order to prosper as a contributing member in society. However, more research is required to understand the current standard in practice regarding nurses' care of mothers affected by apprehension to understand the constraints nurses face by the healthcare system when providing care.

### *Implications for Research*

This thesis has outlined several research gaps concerning the phenomenon of newborn infant apprehension occurring at birth in the hospital and mothers' health. However, more research is needed to further understand mothers' and their families' grief experiences following newborn infant apprehension and nurses' experiences when working with mothers affected by newborn apprehension.

Grief experiences of mothers are described in this thesis; however, attention is needed regarding how mothers' grief manifests following apprehension. As mentioned, only one other study has focused on the manifestation of grief associated with mothers affected by child custody loss (Janzen & Melrose, 2016). To date, understanding of fathers' and extended family members' (grandmothers, aunts, uncles, etc.) experiences of newborn apprehension are absent from the

literature, leaving them silenced and unrecognized as individuals affected by newborn infants' apprehension; it is imperative to include all the individuals who are affected by newborn infant apprehension in order to help support healthy individual and family development. Moreover, there is a lack of available literature concerning nurses' experiences of working with mothers affected by newborn infant apprehension. To date, no research examining nurses' experiences has been conducted. Research exploring other allied healthcare providers' experiences when working with mothers affected by newborn infant apprehension does exist, specifically midwives and social workers (Kellington, 2002; McKegney, 2003; Allison, 2011; Robertson & Kinsella, 2014; Everitt, Fenwick & Humner, 2015). As nurses are present throughout mothers' pregnancy, birth, apprehension, and postpartum experiences, they have a role in supporting mothers. Therefore, further research is required to understand nurses' feelings, attitudes, and behaviours when delivering care to mothers experiencing newborn infant apprehension. Gaining nurses' perspectives can inform practice concerning which supports nurses' need to provide safe, ethical, and competent care to mothers and shed light on the stigma that persists in nursing practice that leaves mothers affected by apprehension in vulnerable positions.

### *Implications for Education*

Mothers affected by newborn infant apprehension face profound trauma and require nurses to acknowledge their trauma when providing care throughout their perinatal experiences. The findings from this study suggest that nurses working in perinatal care settings would benefit from additional educational training being delivered earlier in undergraduate nursing programs, with attention centered on supporting mothers and family members experiencing a crisis. Using a trauma-informed approach to care, nurses can support mothers and their family members affected by apprehension.

Typically, if an individual experiences trauma or concerns related to mental health or substance use, they are referred for additional support to healthcare providers specializing within the field of mental health. However, when a newborn infant's apprehension occurs at birth in the hospital, mothers require immediate support. Nurses across all care contexts should be well informed regarding the ways to engage with individuals in crisis. Rather than limiting mothers' support following newborn infant apprehension to mental health nurses, perinatal nurses can adopt a trauma-informed approach to care when supporting mothers.

There is a lack of education regarding trauma-informed practices within care contexts that fall outside of mental healthcare. Therefore, nurses in perinatal care settings are not always prepared to foster therapeutic relationships and deliver therapeutic communication to populations who have faced or currently facing trauma (Abdolrahimi et al., 2017). Providing nurses with the opportunities to develop and practice clinical communication and relational skills may be a starting point to support nurses in various care contexts outside of the field of mental health to facilitate a trauma-informed approach to care (Abdolrahimi et al., 2017).

To date, most of the research examining newborn infant apprehension has focused on identifying predictors of newborn infant apprehension. Studies have concluded that being racialized, living in homelessness, and using substances are correlated with newborn infant apprehension. However, I appeal for future research to recognize the social conditions lead to mothers who are racialized, homeless or using substances to be viewed as inherently dangerous. Placing fault on mothers' behaviours discounts the systemic forces that influence mothers' lives, increasing their likelihood of experiencing newborn infant apprehension at birth. When acknowledging mothers’ histories in addition to the lack of recognition, and care they receive following apprehension, we can move towards understanding how these mothers are

systematically set up to remain disadvantaged. To continue to separate mothers and newborn infants at birth maintains the status quo of unethical practice in healthcare settings. Looking through a lens of social justice, mothers' experiences can be acknowledged and supported. Acknowledging the imperative for social justice to mothers' experience can encourage for more available and accessible resources that give mothers have the chance to be a mother and stay unified to their newborn infant. All providers must advocate for the end of newborn infant apprehensions at birth. I encourage nurses to contribute to ending discriminatory practices in healthcare settings, as it is within our ethical positions to act and advocate for social change collectively.

**Strengths and Limitations**

Interpretive description (ID) requires epistemological integrity by choosing a framework congruent with the research question, methods, and approach. This study achieved epistemological integrity through identifying and informing one out of the two research questions, methods, and analytic approaches with the Disenfranchised Grief (DG) framework. The DG framework helped inform the research question by focusing on understanding mothers' grief experiences following newborn infant apprehension. Additionally, the DG framework was used as a guide for this study's methods by informing the interview guide and data analysis.

A strength of this thesis was the number of participants recruited. Nine mothers who experienced newborn infant apprehension at birth in Ontario were recruited, giving an adequate sample size. After eight interviews, similar dimensions amongst mothers' experiences were observed and the data collected from the ninth participant validated the thematic analysis's preliminary insights.

The goal of qualitative research is not to be generalizable, but transferable. The sample of mothers recruited for this study facilitates the transferability of the findings given that the variation in demographic characteristics of the mothers mirrored the profile of mothers at risk or experiencing newborn infant and older child apprehension as described in the literature. However, I recruited mothers from an urban, metropolitan area, the findings may not represent or be transferable to mothers living in rural catchment areas.

Although the sample of participants included two Indigenous mothers, there is a need for future research to explore the experiences unique to this population given their disproportionate representation as those who experience newborn infant apprehension at birth. Although the findings from this thesis do not represent the experiences of all mothers affected by newborn infant apprehension, they do allow for a deeper understanding and provide new insights into the phenomenon of mothers' experiences following newborn infant apprehension at birth in the hospital setting.

Neutrality (also known as confirmability) acknowledges that interpretation will occur within the analysis of a qualitative research study. Depending on the researcher's degree of interpretation during data analysis, the study findings can be skewed to the investigator's biases. Over-interpreting the data can result in untrustworthy research, as the findings will not speak to the participant sample's true voices but rather the researcher's beliefs. To assure that the researcher's interpretations were trustworthy, the ID methodology suggests strategies to promote interpretive authority.

Achieving interpretive authority requires a rigorous data analytic process. This study enabled interpretive authority by using exemplary quotes as the primary way to describe the findings. Data analysis began by transcribing interviews verbatim, reading the transcripts

numerous times, creating field notes and memoirs after each interview, and reviewing the audio recordings. Line by line coding then commenced, which identified the main concepts using the direct descriptive account of the participant narratives. These concepts were allocated codes, clustered into groups, and iteratively given tentative labels. Eventually, the data formed themes and subthemes, which embodied the participant sample's language. Relationships and links between themes were then explored. An audit trail was kept of the analytical decisions to ensure clarity and transparency of the analysis process.

Another strategy used to assure interpretive authority during the analysis phase was by presenting the preliminary findings to thesis committee members and as a poster at two conferences. Committee meetings and poster presentations provided opportunities to reflect on the concepts and the meaning associated with the emerging themes. Next, as the study progressed I presented orally at the Canadian Association of Perinatal and Women's Health Nurses (CAPWHN) national conference, and at research rounds held by the School of Nursing, University of Ottawa. Orally presenting the thesis provided clarity about which concepts related to the emerged themes and were pertinent to highlight when completing this study's discussion.

This study's last strength was the honest descriptions of mothers' experiences following newborn infant apprehension. As a mental health nurse, my background provided me with the necessary skills to cultivate an environment for mothers to share their experiences. Being a mental health nurse, I understand the nuances that create an empowering discussion; this included reminding mothers that the interview was in their control and respectfully adjusting the interview guide if mothers voiced feeling uncomfortable. Additionally, I utilized therapeutic silence, pausing between questions to provide mothers the opportunity to feel their emotions.

Ultimately, creating an environment that honoured mothers to share their experiences allowed for depth and breadth to mothers' emotional experiences following newborn infant apprehension.

**Final Reflections**

While writing this thesis, my thinking about mothers' experiences of newborn infant apprehension developed. I began the study limited by the framing described in the literature, focusing on the predictors that contribute to newborn infant and older child apprehension. This body of literature described mothers of colour, engaging in substance use, experiencing intimate partner relationships, and living in homelessness as social conditions that increased the likelihood for apprehension of a newborn infant or older child to occur from mothers' care. Through conducting this research, I moved beyond this framing and focused on understanding the mothers' experiences. Both micro (individual) and macro (systemic) level barriers were described through the narratives of the participants, demonstrating the layers of resistance mothers faced when attempting to regain custody of their newborn infant(s). Despite these barriers, mothers held firm in their beliefs of themselves as competent mothers, giving them hope while still grieving the absence of their newborn infant(s).

Macdonald (2020) asserts that we currently live in a grief-denying world, where denying grief creates a host of adverse outcomes and creates a path for social isolation and loneliness for the bereaved (Breen et al., 2020). Grief has grown to become more pathologized as a mental health condition, leaving bereavement care bound to clinical and institutional care forms (Breen et al., 2020). Ultimately, to hold space for mothers affected by newborn infant apprehension, a shift is required where conversations about death and non-death losses need to occur outside of the medicalized and institutionalized setting and into community spaces (Breen et al., 2020). As grief reflects communities' values, shifting conversations about grief into community spaces

requires interdependence amongst individuals rather than leaving grief as an individual responsibility to overcome. For providers to work interdependently with mothers affected by newborn infant apprehension, they must begin by acknowledging the responsibility we, as a society, all have to one another and help develop the collective action needed to support mothers in relational spaces.

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## Appendix A: Consent Form – University of Ottawa

**Title of the study:** Apprehension of Newborn Infants by Child Protection Services: Experiences of Mothers

**Researchers:**

Natasha Parmar, RN
Master's Student (Nursing)
451 Smyth Road, RGN 3051
University of Ottawa

Wendy Peterson, RN, PhD
Associate Professor, School of Nursing
451 Smyth Road, RGN 1118F
University of Ottawa

**Invitation to Participate:** I am invited to participate in the abovementioned study conducted by Natasha Parmar and Wendy Peterson because I am (a) registered in the counselling program at the CHC, (b) self-report having had at least one of their newborns apprehended at birth in the hospital at some point during the past five years, and (c) speak English.

**Purpose of the Study:** The purpose of the study is to explore the experience of grief birth mothers endure after their newborn has been apprehended at birth.

**Participation:** My participation will consist of one interview with Natasha Parmar. The interview will last about one hour and will be recorded. During the interview I will be asked to describe my experience of having a newborn taken from my care by a child protection agency. The interview will be held in a private room at Community Health Centre in Toronto at a mutually convenient time.

**Risks:** My participation in this study may mean that I volunteer very personal information regarding my experience. Recalling my experience may cause me to feel emotionally unwell. I understand that I may stop the interview at any point and my case manager, Laura will be present at Community Health Centre to counsel me if needed.

**Benefits:** There is no direct benefit to me for participating in this study. However, my participation will help nurses to better support women who are at risk for losing custody of their newborn at birth.

**Confidentiality:** I have received assurance from Natasha Parmar that the information I will share will remain strictly confidential. I understand that the contents will be used only for research exploring the experiences of women who have lost their newborn at birth. Only Natasha Parmar, Wendy Peterson and the professional transcriber will have access to the interview recordings. After transcription, the recordings will only be stored on password protected computers at the School of Nursing, University of Ottawa.
I understand that the researcher, Natasha Parmar, is obliged by law to report serious concerns about the safety of a child. In the situation where the risk in safety to a child is expressed, I understand that confidentiality cannot be maintained and Natasha Parmar will seek the appropriate resources to report the concern.

**Anonymity** will be protected by removing any identifying information when the recording is transcribed. For example, names of people will be removed and replaced with a fictional name. A master list that matches my identity with a fictional name will be kept in Wendy Peterson's locked office at the School of Nursing, University of Ottawa, separate from the transcripts. I may be quoted in presentations and publications of the findings of this research however a fictional name will be used instead of my real name.

It is possible that the Community Health Centre will be acknowledged during presentations and publications. Also, Laura and other staff at Community Health Centre may know that I have agreed to participate in this research.

**Conservation of data:** The data collected (i.e.: audio recordings, transcripts, questionnaires and hard copy notes) will be kept in a secure manner in Wendy Peterson's office at the University of Ottawa for up to a maximum of five years after the first publication in a peer-reviewed journal. Research student, Natasha Parmar, and thesis supervisor, Wendy Peterson, will have access to the conserved data for up to five years, after which data will be destroyed appropriately.

**Compensation:** I will be provided with a 20-dollar grocery store gift card for participating in this study. If I choose to withdraw from the study, I will still receive this compensatory gift card.

**Voluntary Participation**: I am under no obligation to participate and if I choose to participate, I can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If I also aware that if I should not feel coerced or pressured into answering any questions outside of my comfort zone. I understand that if I withdraw from the study, this will not affect the care I am currently receiving at Community Health Centre. If I choose to withdraw, all data gathered until the time of my withdrawal will be used in the study unless I ask Natasha Parmar not to use it.

**Acceptance:** I, (Name of participant), agree to participate in the above research study conducted by Natasha Parmar RN, Masters student, School of Nursing, University of Ottawa, which research is under the supervision of Wendy Peterson RN, Associate Professor, School of Nursing, University of Ottawa.

If I have any questions about the study, I may contact Natasha Parmar or Wendy Peterson using the contact information at the beginning of this consent form.
If I have any questions regarding the ethical conduct of this study, I may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5
Tel.: (613) 562-5387
Email: ethics@uottawa.ca

There are two copies of the consent form, one of which is mine to keep.

Participant's signature: *(Signature)* Date: *(Date)*

Researcher's signature: *(Signature)* Date: *(Date)*

## Appendix B: Demographic Questionnaire

**What is your year of birth? _____**

**How do you describe your current partner status?**

No partner / single

Living with partner

Common-law

Married

Widowed

Divorced

Separated

Other: _____

**What is the highest level of education you have completed?**

Some secondary (high) school

Completed secondary (high) school

Some college, CEGEP or university

Completed a college or CEGEP diploma/certificate or university degree

Masters or doctoral degree

**What is your current employment situation?:**

Not currently employed

Part-time employment

Full-time employment

**Household income**

$20,000 or less / year

$21,000 - $40,000 / year

$41,000 - $60,000 / year

More than $60,000 / year

**How do you describe your ethnic or cultural background?** ***(Circle all that apply.)***

First Nations / North American Indian

Metis

Inuit

Black

White

Chinese

South Asian (e.g., East Indian, Pakistani, Sri Lankan)

Filipino

Latin American

Southeast Asian (e.g. Cambodian, Indonesian, Laotian, Vietnamese)

Arab

West Asian (e.g., Afghan, Iranian)

Japanese

Korean

Other – *please specify* _____

**How many children have you given birth to? _____**

**What year(s) was your child(ren) born? _____**

**How many children live with you now? _____**

**This research is about women's experiences having their newborn infant taken from them by a child protection agency.**

- **In what year did this happen to you? _____**
- **Was your newborn infant placed with:**
  - A family member
  - A foster parent / family
  - Do not know
  - Other: _____
- **How long was your newborn infant /child out of your care? _____**

## Appendix C: Interview Guide

Introduction: How would you like me to refer to your baby who was removed from your care

| Disenfranchised Grief | Questions | Probes |
|---|---|---|
| Lack of a recognized relationship | 1. Describe the emotions you had during your pregnancy<br>2. Tell me about your pregnancy with [name of child]<br>3. How were you treated by others when you were pregnant with [name of child]?<br>4. Tell me what you remember about the birth of your baby.<br>5. What happened when your baby was removed from your care? | 1.<br>a. How did you feel about your baby during your pregnancy?<br>2.<br>a. During prenatal care appointments<br>b. By healthcare providers?<br>3.<br>a. Who do you remember being with you during your labour and birth?<br>b. Tell me about the time that you spent with your baby<br>4. Tell me about how you found out that your baby may be removed from your care<br>5. Tell me about how you found out that your baby may be remove from your care. |
| Lack of ability to feel the loss | 6. How did you feel after your baby was removed from your care?<br>7. Did you feel recognized as the mother to your child after having given birth?<br>8. Tell me how this experience affected your life. | 6. Why did you feel that way? |
| Lack of acknowledgment of the loss | 9. How did the nurses in the hospital support your emotional needs (or not?<br>10. Tell me how you felt over the next few months. | 9.<br>a. How could nurses in the hospital help women going through this experience?<br>b. How could healthcare providers/ nurses help? |