



The Children's Corner: Perspectives on Supportive Care

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Neonatal Abstinence Syndrome

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More than 5% of women use illicit drugs during their pregnancies (Substance Abuse and Mental Health Services Administration, 2012), and 49% to 94% of infants exposed to opioids in utero experience neonatal abstinence syndrome (NAS) (Maguire, Webb, Passmore, & Cline, 2012). NAS is a condition that affects the central and autonomic nervous systems, as well as the gastrointestinal tract, causing seizures, irritability, vomiting, diarrhea, and many other issues (Atwood et al., 2016, Hudak & Tan, 2012). It can be challenging providing high-quality medical and psychosocial care to these high-risk infants and their mothers (Cleveland & Bonugli, 2014) due to social stigmas surrounding substance abuse. In fact, women are typically judged more harshly for using illicit drugs than men because they are the bearers and primary caretakers of children (Wiechelt, 2008). Knowing the many difficulties that children born with NAS and their mothers face, it is important to consider strategies to better support these families and thereby promote improved outcomes for both mother and baby.

NAS is a growing healthcare issue. Incidence has quintupled in the United States in the past decade (Atwood et al., 2016), increasing the estimated cost of care from \$190 million to \$720 million annually (Patrick et al., 2012). Therefore, additional education for both parents and healthcare providers about NAS is imperative. Substance use during pregnancy is a complex issue that is often accompanied by comorbidities, including poverty, domestic violence, depression, and other mental illnesses (Cleveland & Gill, 2013). In a recent study, nurses expressed concern over a lack of sufficient education regarding substance addictions and mental health, stating that it created a barrier to providing optimal care (Cleveland & Bonugli, 2014). Like nurses, parents also desired additional education. Few families felt they received adequate education regarding what to expect during hospitalization, the emotional toll it would take to watch their newborn experience withdrawal symptoms due to opioid dependence, and the challenge mothers would face when balancing their own post-natal medical needs with the needs of their newborn

child (Atwood et al., 2016). Antenatal/preadmission education sessions could not only educate families on what to expect, but would also serve as an opportunity for members of the healthcare team to interact with these parents, providing initial support and starting to create rapport (Fraser, Barnes, Biggs, & Kain, 2007).

According to a study by Fraser et al. (2007), the largest area of concern for mothers surrounded patient/family/nurse communication. Mothers of infants with NAS desire to be more involved in the child's care; however, many mothers felt "out of the loop" and that they were not involved in creating or delivering the care plan for their baby (Fraser et al., 2007). Mothers often believed things were being done to their child they did not understand, and they were unsure why it was happening. For example, many mothers felt they did not receive adequate explanation of assessments, making these assessments seem like mysterious and seemingly subjective evaluations of their child (Cleveland & Gill, 2013). It is particularly difficult for mothers to be involved in caring for their child when they do not understand what is happening.

Fears about the mother/child bond, such as "what if he feels that one of [the nurses] is his mother or something?" and "I don't want for him to think 'oh this is mommy [the nurse]' like he would see her or have her scent more than mine," have also been shared by mothers of babies with NAS (Cleveland & Gill, 2013, p. 203). Although many aspects of care must be done by a trained nurse, there are also many tasks that the mother could help perform to promote the development of attachment. Thus, it is important for nurses to support mothers in fully establishing their role as mother by including them in such tasks when possible, or coaching mothers on ways they can contribute to their child's care in meaningful ways.

There were also concerns about the delivery of communication and feeling judged. All mothers who participated in one study (Cleveland & Gill, 2013) reported feeling judged regarding their drug use history and felt staff were unable to look beyond it to recognize their positive qualities or strengths. At times, some mothers felt alienated from their baby in the NICU, but there was no other option for visiting their child. One woman explained it as follows:

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So I would go in and – you just feel that ugly feeling – that weight on your shoulders – because it's so unwelcoming from the nurses. I think they don't want us to come. They would rather just take care of [the baby] and not have to deal with us (Cleveland & Gill, 2013, p. 203).

These feelings can create a potentially negative cycle in which the mother feels judged and unwelcome, leading her to be less present, which then may lead to additional judgment or communication difficulties with staff.

The American Nurses Association's (2012) Code of Ethics states that nurses are to practice in a way that respects the dignity of all individuals "unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems" (p. 3). We, as humans, often have implicit biases. Harvard University experts have studied implicit social cognition for nearly 20 years, helping educate the public about our thoughts, feelings, and biases beyond our conscious awareness (Harvard University, n.d.). These implicit biases may surround race, ethnicity, gender, weight, and age, among other factors. The same can go for opinions about families based on the nature of conditions. One nurse reflected on this, saying, "We talk about judgement, and yeah, we do (judge them). We don't mean to, but you just do" (Fraser et al., 2007, p. 1368). Although it might be unintentional, negative consequences can result. One mother shared this belief that judgement may be unintentional yet highlighted the impact, saying, "[the nurses] would be rolling their eyes. I don't think they tried to do it intentionally for me to see, but I did see them. It made me feel ugly" (Cleveland & Gill, 2013, p. 203). Therefore, it is important to have awareness of such biases and be intentional in ways to ameliorate the concerns from mothers' past experiences. Working with the hospital's psychosocial team may help nurses gain a better understanding of the challenges the family is facing to better empathize and provide for their needs.

One mother shared what she would tell nurses in the future about working with infants with NAS and their mothers. She said:

I would just tell [the nurses] to take it easy [on the mother]. You know, after being addicted, I realized that this is really a disease. There are some who abuse, but if you're using while you're pregnant, you have a problem; a big problem... and you need help. You obviously don't care about yourself, about anything except the drug. Make it a little bit easier on that mother if she's showing initiative... if she's taking the time to be there. If she loves her child, you can see it and you can feel it. If it's obvious that she's there for the baby then embrace it; make it easier. You don't know what her circumstances are. You don't know what she's been through or how hard her life has been. You don't know what she was feeling when she was pregnant... if she was being abused, if she was poor. Whatever the reason, she was using while she was pregnant... you just don't know. So, try to make it easier for her (Cleveland & Bonugli, 2014, p. 323).

In addition to balancing social expectations and minimizing biases, various more concrete things can be done to help patients with NAS and their mothers. Establishing consistency in staffing schedules can help decrease family stress. Consistent staffing reduces the number of times mothers need to share their story and enables a sense of comfort and trust to be established between mothers and

nurses. Such continuity of care can also minimize the chance of patient information being lost in the staffing handover transition.

In addition to consistent staffing of nurses, collaboration with social work, physical therapy services, and child life teams are important. They can provide family support, connect mothers to helpful resources, help all individuals involved understand and cope with the experience, and provide appropriate levels of developmental stimulation for the infant. Volunteer programs can also be incorporated to support mothers and nurses. Using volunteers to spend time holding/cuddling the infant maintains the attention to the infant while giving the mother and nursing staff time to focus on plans of care, discuss needs and concerns, and build trusting relationships (Fraser et al., 2007).

Although many pregnant women do not seek treatment for substance abuse for fear of losing custody of their baby, the development of a strong bond with the baby after birth can be a significant motivator for starting or maintaining treatment for substance abuse (Cleveland & Gill, 2013). Nurses working with babies with NAS and their families are in a unique position to impact this mother/child bond. By educating oneself about substance use and mental health, being supportive, controlling biases, and providing clear communication, nurses can not only care for the baby's needs, but they can also help foster this relationship, potentially driving positive behavioral changes and improving long-term outcomes for the mother/child dyad. ■

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