Change your thoughts and you change your world - Norman Vincent Pearle
THE MEANING OF NURSES’ EXPERIENCES CARING FOR FAMILIES WHERE MOTHERS AND INFANTS ARE ADDICTED TO SUBSTANCES

by

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Dedication

I would like to dedicate this work to my Grandmother, Phyllis Hill. Without her unconditional love and support, I would not be the person I am today.

Thank you Grandma.
Abstract

This phenomenological study explored nurses’ meaning of caring for families where mothers and infants are addicted to substances. There is an absence of literature indicating how nurses’ experiences caring for mothers with substance misuse issues. The literature does suggest that individuals with mental health issues, specifically substance misuse issues, face negative stigmatizing attitudes when interacting with the healthcare system and nurses.

Using written descriptions submitted via email, nurses’ experiences were analyzed-synthesized using Giorgi’s (2009) descriptive phenomenological method to produce a phenomenological description of the everyday experience. Descriptions were viewed through the disciplinary lens of Doane and Varcoe’s (2005) family nursing as relational inquiry.

The findings of this research have the potential to transform our understanding of what it means for nurses to care for families where mothers and infants are addicted to substances and what is important for nurses to know when caring for families with substance misuse issues.
Acknowledgments

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Chapter I: Introduction to the Topic

This chapter introduces the meaning of nurses’ experiences caring for families where mothers and infants are addicted to substances. I chose this topic after having multiple experiences within the neonatal intensive care unit (NICU) that I considered particularly troublesome and incongruent with my perception of appropriate nursing care as these experiences were nurse-centered rather than patient-centered. The judgmental tone of the following personal experience was written deliberately to allow the reader to understand some of what women who misuse substances experience when entering the NICU. Following this personal experience, the chapter continues with a description of the NICU environment and how challenging a setting it can be for parents. I will then explore the topic of mothers who misuse substances and strategies that have been suggested to ensure they seek appropriate care during pregnancy and the early post-partum period, a challenging time in all women’s lives.

My Experience

“That was labour and delivery, we’ve got another methadone baby coming” announced Joan* (* all names have been changed) as she hung up the phone. I watched the other nurses sigh with exasperation. Mumblings of “I wonder who it is this time” quietly filled the NICU. I went to help set up the incubator and waited for our admission to arrive. After the infant was settled, a U-bag was attached to obtain the first void for urinalysis and drug screen as the majority of our patients’ mothers involved in methadone treatment had polydrug misuse issues (Abdel-Latif, Bajuk, Lui, & Oei, 2007; Bandstra, Morrow, Mansoor, & Accornero, 2010; Burns, Mattick, & Cook, 2006; Dowdell,
Fenwick, Bartu, & Sharp, 2009; Jambert-Gray, Lucas, & Hall, 2009; Miles, Francis, & Chapman, 2010; Morton & Konrad, 2009; Wright & Walker, 2007). I took the Neonatal Abstinence Syndrome (NAS) scoring scale and placed it at the bedside. Neonatal Abstinence Syndrome was first described by Dr. Loretta Finnegan in 1975 (Kelly et al., 2011). Infant withdrawal from exposure to opiates in utero is characterized by central nervous system hyperirritability, gastrointestinal hyperirritability, respiratory distress, and autonomic signs that might include yawning, sneezing, mottling, and fever that could progress to convulsions and/or dehydration (Bandstra et al., 2012; Burns et al., 2006; Kelly et al., 2011). According to Patrick et al. (2012) rates of NAS diagnosis have increased over three-fold between 2000 and 2009. I stared at the little girl in the incubator. She was adorable; she had a full head of dark hair and appeared large for our patients, as she was 38 weeks gestation. Many infants admitted to NICU were less than 32 weeks gestation and the size difference was more than noticeable. She lay resting peacefully, but we all knew this would be changing over the next few hours.

The next morning when I arrived for my shift, I was greeted by an infant’s piercing screams of withdrawal. One could always recognize these cries that were frantic and desperate; no amount of cuddling or food could make them stop. Infants who were withdrawing clawed at their eyes and sweated profusely soaking the sheets of their bassinet or waterbed. Little Andrea* who had been admitted the evening before was in this condition. We had two other infants being treated for NAS, but they were not as symptomatic so Andrea had been given the waterbed bassinet. The waterbed bassinet looked like a regular bassinet except it had a hood to darken the area and reduce noise, and the mattress was a bladder that held water. The bladder was warmed and vibrated;
this had been found to soothe infants who were withdrawing (Osborn, Jeffery, & Cole, 2010).

During report, Shonda*, a nurse, relayed that Andrea had started crying at 04:00 and was found sweating profusely. She was transferred to the waterbed, which did not seem to be helping. Her mother, Chrystal*, a 21 year old woman with known substance misuse issues, had been admitted to the post-partum unit and had been in to see her baby once during the night. She initially voiced an interest in breastfeeding, but was unable to be located by the post-partum staff when called multiple times throughout the night to come to the NICU and feed Andrea. When she was finally located after coming in from having “a smoke” she told the nurses to give the baby formula. The staff had also started scoring Andrea for NAS as she had started to show signs of withdrawal. She received her first dose of morphine just before shift change.

We learned that this was Chrystal’s third baby; her other two children were living with Chrystal’s mother. Social workers were aware of the situation. Throughout report I noted the other nurses rolling their eyes and exchanging knowing glances. Andrea was not one of the babies I had been assigned. I had one of the other two infants who were withdrawing in my pod (the NICU is sectioned into groups of four beds, each section is called a pod). However, we all shared the responsibility of caring for these infants during breaks throughout the shift.

Bev*, who had been assigned Andrea, tried multiple times throughout the morning to invite Chrystal to come to the unit to feed and care for her baby. Around 12:30, Chrystal and her boyfriend came into the NICU. They did not make eye contact
with anyone and headed directly to Andrea’s pod. Andrea, who had just fallen asleep, was picked up by her mother and immediately began to cry.

At the same time, Chrystal had started talking loudly to Char*, another young woman who also had a NAS infant in the unit. As Bev had gone to lunch and I was covering her pod, I went over to introduce myself and ask if they needed anything. As I made my way over I heard Chrystal remark to Char that the nurses had been hassling her throughout the night. I introduced myself and asked if Chrystal needed anything. My offer was declined and as I went back to what I was doing I heard whispering and giggling. Chrystal decided that Andrea was hungry and loudly made the comment that the nurses “here [NICU] don’t do anything to help”. She set up Andrea’s father with the bottle while she continued to chat with Char. Andrea would not eat and I could see her father starting to get frustrated. Again, I went over to offer assistance. I told them that Andrea had just eaten and suggested she might want to sleep. Her parents put her back in the waterbed and tried their best to soothe her. They eventually abandoned this effort and decided to leave. Chrystal came to me and told me to let them know when Andrea was hungry and they would return to feed her. That was the last I saw of them for the rest of my shift although Bev had tried contacting Chrystal throughout the shift for Andrea’s feedings. Later in the afternoon, Andrea’s drug screen came back. It was positive for methadone, cocaine, and opioids.

As time went on Andrea progressed through her withdrawal and was weaned off morphine. Her parents continued to visit and the visits became more frequent. Andrea’s father seemed particularly distressed about the situation and did not appear to understand why Andrea was acting the way she was although we tried multiple times to explain the
situation. Andrea was his and Chrystal’s first child together, so he had not experienced the withdrawal of her previous two infants. Often when asked about coming to the unit to do more care, Chrystal said she could not come to the hospital because she had trouble finding “drives” to Moncton as she lived in one of the surrounding communities. Chrystal had been given a hostel room down the hall from the NICU, as were most of the mothers with NAS infants. This close proximity has been found to increase parental presence in the NICU (Wigert, Berg, & Hellström, 2010). Chrystal’s explanations concerning not being able to provide basic, non-medical care for Andrea and her sporadic appearances in the NICU frequently left the NICU nurses questioning if Chrystal really cared for and wanted her baby.

There were many disparaging remarks made in relation to Chrystal and the other ‘methadone mothers’ (a label used when referring to mothers with known substance misuse issues) who had infants admitted to the NICU. This situation led me to feel frustrated and embarrassed by my colleagues and my profession. I knew that these experienced nurses were also frustrated as they saw many of the same mothers time and time again, but the comments the nurses made and the way they acted was unprofessional, unsupportive, and incongruent with caring for the family. I wondered about how the nurses’ perceptions and behaviours may have affected the mothers’ perceptions and behaviours during the time their babies were in the NICU.

The preceding is a true story of my experience working in the NICU. I found the situation described here, which I encountered multiple times and the attitudes of everyone involved very upsetting. Trying to constantly locate the mothers with substance misuse issues was very discouraging. The NICU was an ‘open unit’ for parents to come and go
as they needed; the only time parents were asked to leave was at shift change because all nurses listened to a taped report together at the desk. Any parent in close proximity to the desk would be able to hear what was said about each infant, which was not conducive to patient privacy and confidentiality. I could not understand why the mothers with substance misuse issues were not more attentive of their infants: for example, we usually had to suggest to the mothers who did not have substance misuse issues that it was okay to leave for a little while and take a break.

The NAS infants did not require a great deal of medical care apart from NAS scoring and morphine administration. What they needed was someone to hold and comfort them, which was not something the NICU nurses always had or made time to accomplish depending on the number and acuity of other infants. Also very frustrating were the attitudes of the ‘methadone mothers’; they appeared happy to let the nurses care for their children, coming in and out of the unit when it was perceived to suit their purposes.

As time progressed and I think back to this situation, it is more likely the women were reacting to the treatment they received from the nurses in the NICU; if we were judgmental and not approachable, why would the mothers with substance misuse issues put themselves in an uncomfortable situation (Mitchell & Bunkers, 2003)? It was perhaps easier for them to stay away and not encounter the stigmatizing attitudes of the NICU nurses. I also found the comments made by the senior nurses in the unit very disparaging, disrespectful, and unsupportive of the mothers with substance misuse issues. I would often find myself apologizing for their comments and attitudes when mothers
with substance misuse issues would tell me what they had overheard from not only the staff, but also other parents in the unit who knew we had infants undergoing withdrawal.

Hence, the topic of this research, to uncover the meaning of nurses’ experiences caring for families where mothers and infants are addicted to substances came into being. By completing this work, I intended to not only learn how nurses felt about working with mothers and their infants who have substance misuse issues, but also to provide nurses with this information, with the hopes of perhaps enhancing their understanding. With this knowledge, nurses could choose other strategies which would help to create the best environment possible to facilitate helping relationships with these families.

I accomplished this research using Giorgi’s (2009) descriptive method, a phenomenological research method that aims to uncover the meaning of lived experiences through descriptions of the phenomenon from those who live it and to understand the essential structure of the experience. Nurses who examine a phenomenon from a phenomenological perspective are trying to understand the human experience (Beck, 1994; Gordon, 2009; Speziale & Carpenter, 2007). This understanding was accomplished by seeking out participants (nurses who have cared for families where mothers and infants are addicted to substances) who had experienced this phenomenon, and were willing to share their experiences (Speziale & Carpenter, 2007). Giorgi’s (2009) descriptive method was ideally suited to describe this experience (Aquino-Russell, 2003; Gordon, 2009; Santopinto, 1989).

The use of Giorgi’s (2009) descriptive method was suited to nursing research because it required the researcher to use a theoretical lens from the researcher’s discipline through which to view the findings. I chose to view the results through the theoretical
lens of Doane and Varcoe’s (2005) family nursing as relational inquiry because this lens stressed the importance of family and context in nursing, specifically allowing the family to guide nursing interactions according to their needs. Using this lens also allowed the meaning of the descriptions to be understood phenomenologically, critically, and spiritually (Doane & Varcoe, 2005).

Learning the meaning of nurses’ experiences working with families where mothers and infants are addicted to substances was important for I believe that nurses enter the profession because they care. Currently, I do not believe that nurses who portrayed stigmatizing attitudes towards the women who misused substances were aware of what they were doing, nor were they aware of how those actions alienated and belittled families who arguably needed the most support. My goal was to provide an opportunity for nurses to share and reflect on these stories so that future interactions with families struggling with substance misuse issues would be more caring and helpful. I also hoped that this research would enrich nursing science by illuminating how nurses could care for the mother-infant dyad contextually, allowing family members to lead the nurse-family interaction (Doane & Varcoe, 2005). The NICU environment has been described as being an uncomfortable one; the following section will explore the NICU environment.

The NICU Environment

There were many articles depicting the NICU environment, namely: how intimidating and foreign it was to most people (De Rouck & Leys, 2009; Franklin, 2006; Hall, Kronborg, Aagaard, & Ammentorp, 2010; Latour, Hazelzet, Duivenvoorden, & van Goudoever, 2010; Mundy, 2010; Reis, Rempel, Scott, Brady-Fryer, Van Aerde, 2010; Wiebe & Young, 2011; Wigert, Berg, & Hellström, 2010; Wigert, Johansson, Berg, &
Nurses working in the NICU were often seen as abrupt and strict due to the rules they believed they must enforce within NICUs, but according to Hall, Kronborg, Aagaard, and Ammentorp (2010) NICU nurses saw themselves as meeting a variety of professional challenges but lacking confidence in family care, which was also revealed by this study. Nurses often felt left out of the ‘big picture’ of family care (Fraser, Barnes, Biggs, & Kain, 2007). They were tasked with caring for the baby rather than the family and not included with other healthcare providers when planning for discharge as were physicians, social workers, physiotherapists, and occupational therapists. It has been suggested that within the NICU, it was not what the nurses knew it was what they did that had the biggest impact on parental comfort (Reis et al., 2010; Wiebe & Young, 2011; Zimmerman & Bauersachs, 2012). Wiebe and Young (2011) found that the strongest theme that emerged from their qualitative research with minority parents who had infants in the NICU was the importance of feeling that their babies were sincerely cared for by the NICU nurses and physicians. One strategy to reduce the level of intimidation, that was validated by both families and nursing staff alike was the importance of effective communication. Parents found it particularly helpful when the NICU staff would speak with them in normal language explaining what was currently happening and not getting caught up in medical jargon and possible future issues (Latour et al., 2010; Mundy, 2010; Reis et al., 2010; Wiebe & Young, 2011).

I, too, found this particularly helpful and comforting to parents as they wanted to concentrate on the present and understand what was currently occurring. Speaking to families also validated that they were important members of the team caring for the
infant, not outsiders looking in through the window of an incubator. In one encouraging Italian study, researchers described educating all staff on effective counseling methods and had a counselor in the NICU or on call at all times (Coscia et al., 2010). Further suggestions to improve the NICU environment for parents included having caring and trusting provider-client relationships, culturally responsive care, accessible social and spiritual support, and a welcoming and flexible organizational environment (Wiebe & Young, 2011). All of these suggestions seem very basic, but in reality these strategies rarely occur (Wiebe & Young, 2011; Wigert et al. 2010), subsequently removing the family from the nursing care. Next, the challenges of being a mother who misuses substances will be explored.

**Mothers who Misuse Substances**

Becoming a new mother is challenging at the best of times, however, when an individual has an issue with substance misuse mothering is even more difficult. Unfortunately, many people including nurses and other healthcare professionals treat people who misuse substances very poorly as they believe substance misuse is a choice and that if mothers who misuse substances really wanted to stop using drugs, they would exercise their willpower (Hepburn, 2004; Jambert-Grey et al., 2009). Contrary to this belief, substance misuse problems are not a personal choice. Use of substances has been described as a coping mechanism often resulting from childhood abuse, neglect, and mental illness amongst people who were unable to meet the social determinants of health (Abdel-Latif et al., 2007; Adams, 2008; Armstrong, 2005; Arnold & Boggs, 2011; Bandstra et al., 2010; Burns et al., 2006; Carter, 2002; Cavanaugh & Latimer, 2010; Fraser et al., 2007; Hepburn, 2004; Jambert-Gray et al., 2009; Klee, 1998; Weaver, 2009;
Young & Martin, 2012). Unfortunately, many health care professionals do not understand substance misuse as a coping mechanism and do not acknowledge the contextual component of addiction amongst mothers with substance misuse issues.

Patrick et al. (2012) reported that the rate of maternal opiate use has increased nearly three-fold in the years between 2000 and 2009. According to research predominantly from Australia, the United Kingdom, and the United States (US), between 3.3 and 7.4 % of pregnant women used illicit drugs during pregnancy (Abdel-Latif et al., 2007; Carter, 2002; Miles et al., 2010; Substance Abuse and Mental Health Administration, 2011), with that number jumping upwards to 16.2 % amongst pregnant teens (Substance Abuse and Mental Health Administration, 2011). The estimates of opioid misuse fluctuate for many women do not admit they misuse substances because they are afraid of the stigma associated with being a pregnant substance misuser (Young and Martin, 2012) or they are afraid of having their infant and any other children removed from their care (Dowdell et al., 2009; Hepburn, 2004; Jambert-Gray et al., 2009; Klee, 1998; Miles et al., 2010; O’Donnell et al., 2009; Wright & Walker, 2007; Young & Martin, 2012).

The media has also villainized parents who misuse substances, reinforcing negative stereotypes held by the public. Some US states have tried to impose punitive actions such as involuntary detoxification and jail of pregnant women in efforts to protect their unborn fetuses (Armstrong, 2005). These efforts have been shown to be completely ineffective as well as being abrogation of human rights. Instead, the use of harm reduction models (referring to public health policies which aim to reduce the harmful consequences of human behaviour; for example a needle exchange or a methadone
program) have shown better results (Allman et al., 2007; Burrows, 2005; Hepburn, 2004; Jambert-Gray et al., 2009; Miles et al., 2010; Morton & Konrad, 2009; Norman, 2001; Wright & Walker, 2007).

Carter (2002) found that among American women, 18% reported using alcohol and 20.4% reported smoking during pregnancy. These statistics were alarming as it has been shown that any alcohol and/or tobacco use during pregnancy could be more detrimental to long term outcomes for children (i.e. facial disfigurement, lower birth weight, and premature labor) than illicit substances (Burns et al., 2006; Chisolm et al., 2011; DeVille & Kopelman, 1998). Unfortunately, because the use of alcohol and tobacco are usually ‘white wealthy’ licit drugs, many minority women were unjustly targeted and judged as mothers who misuse substances. Women who came from a minority culture were more apt to live in poor socioeconomic circumstances and use free healthcare (in the United States), which frequently included drug screening in prenatal care leading to the ‘substance abuser’ label after drug screens came back positive for illicit substances (Burns et al., 2006; Carter, 2002; Fraser et al., 2007; Miles et al., 2010; Norman, 2001). This leads to the question: what can be done to support women with substance misuse issues?

**Support Methods**

As was mentioned above, harm reduction has consistently shown positive results. Dowdell et al. (2009) in Australia used midwifery notes to gauge the attitudes and practices of mothers who misused substances up until six months postpartum. Although very low drug use during this time was found, drug use by some mothers which gradually increased as time progressed depending on the support received by these women. This
study also found that mothers who misused substances repeatedly mentioned consistent care by the same midwives over this period as a positive coping mechanism and deterrent to begin misusing again (Dowdell et al., 2009).

The same sentiment was echoed by Hepburn (2004) and Wright and Walker (2007) who discovered that single visit service based on a harm reduction model for mothers taking methadone during pregnancy benefits mothers. Another suggestion that was pervasive in the literature was the encouragement of breastfeeding (Bartu, Sharp, Ludlow, & Doherty, 2006; Hepburn, 2004; Jambert-Gray et al., 2009; Miles et al., 2010; Unger, Metz, & Fischer, 2012). Breastfeeding not only allowed the infant to receive small doses of methadone via breast milk (Jambert-Gray et al., 2009), but it also kept the mother and infant together, provided positive psychological experiences to mothers with depression, decreased stress response, and of course, promoted infant-mother bonding (Jambert-Gray et al., 2009). Another suggestion was instead of trying to reduce methadone dose during pregnancy, women should maintain their dose and even raise it during the third trimester to account for the increased fluid balance in the body (Hepburn, 2004; Jambert-Gray et al., 2009; Unger et al., 2012, Wright & Walker, 2007; Young & Martin, 2012). This maintenance or increase of methadone would decrease drug cravings and perhaps preclude women turning to illicit and legal substances that could cause harm to the developing fetus (Jambert-Grey et al., 2009).

Another factor that could help support mothers with substance misuse issues was the encouragement of mother-infant bonding. It has been widely acknowledged how vital the first few hours and days are for forging the mother-infant bond. Separating infants from their mothers during this time for admission to the NICU where further
alienation of mothers by nurses portraying judgmental and stigmatizing attitudes adversely influenced bonding. The following section provides a closer inspection of methods to encourage mother-infant bonding.

**Mother-Infant Bonding**

Bonding is believed to occur just after the infant is born, but experts argue it can occur up until the infant is much older (Bienfait et al., 2011; Figureiredo, Costa, Pacheco, & Pais, 2007) with the time needed to establish mother-infant bonding varying greatly between individuals (Bienfait et al., 2011; Figureiredo et al., 2007; Kennell & McGrath, 2005). Factors that encouraged mother-infant bonding included skin-to-skin contact (STS) immediately following birth (Hawkins, 2010; Hunt, 2008; Kearvell & Grant, 2010; Kennell & McGrath, 2005), encouraging parental care of the infant (Figureiredo et al., 2007; Franklin, 2006; Fraser et al., 2007; Hunt, 2008; Kearvell & Grant, 2010; Martinez, Fonseca, & Scochi, 2007), rooming-in during hospitalization after infant birth (Hunt, 2008), Kangaroo Care in the NICU (Franklin, 2006; Hunt, 2008; Kearvell & Grant, 2010; Wigert et al., 2006), and Residential Parentcraft Units (Matthey & Speyer, 2008).

From the biomedical perspective, placing the infant on the mother’s abdomen immediately following birth is performed so that the infant is not hyperperfused with blood before the umbilical cord can be clamped and cut. This practice also carries with it a more holistic care method as the stimulation from STS contact encourages bonding and increases infant oxygen saturation (Hunt, 2008). In the last 20 years this method was rediscovered in the form of Kangaroo care (Franklin, 2006; Hunt, 2008; Kearvell & Grant, 2010; Wigert et al., 2006) in which premature infants were removed from their incubators and given STS contact with either of their parents to encourage not only tactile
stimulation, but to decrease the number of oxygen desaturations of the infant and provide an opportunity for mother-infant bonding (Hunt, 2008).

Another method that had been found to help promote mother-infant bonding was the encouragement of parental care of the infant (Figureiredo et al., 2007; Franklin, 2006; Fraser et al., 2007; Hunt, 2008; Kearvell & Grant, 2010; Martinez, Fonseca, & Scochi, 2007). The encouragement of parental care helped the mother to explore her new infant and also to become attuned to the infant’s pattern of communication (Figureiredo et al., 2007). Mothers frequently mistook crying as a judgment of themselves and the feelings about the mother by the infant rather than what it actually was; infants trying to communicate needs to their mothers. For NAS infants this understanding was particularly important as NAS infants tended to cry a great deal. In situations where mothers were already feeling judged this could have been very harmful to the formation of the mother-infant bond. Encouragement of parental care was particularly important in the NICU setting where policies might not allow for STS contact and rooming-in, which dramatically reduced the opportunity for mother-infant bonding (Kearvell & Grant, 2010).

Rooming-in of the infant with his/her mother was an important way to help forge mother-infant bonding. By having the infant cohabiting with the mother throughout the mother’s hospitalization after birth, the mother learned the sounds her baby made and began to interpret what they meant. Rooming-in also encouraged parental care of the infant and frequent STS contact. Of course, this was not possible if the infant was very ill and admitted to the NICU. According to Miles, Sugumar, Macrory, Sims, and D’Souza (2007) a new practice for an infant undergoing chemical withdrawal was not to
admit them to NICU; rather, allowing the infant to room-in with the mother on the post-partum unit. It has been shown that this practice led to decreased use of chemical withdrawal aids, increased STS contact, increased breastfeeding, and an overall decrease in withdrawal symptoms leading to earlier hospital discharge than was previously observed.

Another factor that supports mother-infant bonding has been found exclusively in Australia. Residential Parentcraft Units function to help mothers resolve severe infant care difficulties (usually pertaining to lack of sleep). Families were admitted as a whole to these units where they were given professional help to resolve individual issues that were not treatable in the community setting (Matthey & Speyer, 2008). Upon discharge, upwards of 80% of mothers reported decreased fatigue and better mood, which created improved feelings towards the infant as well as encouraged mother-infant bonding in a population that may have been struggling (Matthey & Speyer, 2008).

A quote from Fraser et al. (2007) summarized another suggestion about the way health care providers should treat women with substance misuse issues: “we need to be non-judgmental. If we can accept the parent and where they are... [we] can get an honest, open communication going” (p. 1369). This same belief formed the basis of family nursing as relational inquiry (Doane & Varcoe, 2005). At the most basic level, non-judgmental care is what mothers with substance misuse issues needed. These mothers knew their drug misuse was not conducive to the development of their children. Therefore, vital to success was a safe place where mothers could let nurses know what they required to care for their children without fear of reprisal.
Since I stopped working in the NICU, the nursing care of NAS infants in the NICU where I work has changed. Now if infants require morphine for withdrawal they are still admitted to the NICU but if they do not require morphine, they are admitted directly to the post-partum unit for mother-infant nursing care, a practice supported by research (Miles et al., 2007). Although the post-partum environment is slightly less intimidating and more encouraging of the mother-infant dyad, mothers who misuse substances may still face judgment and stereotyping from the nurses assigned to care for them and their infants. Other institutions have continued to automatically send NAS infants to the NICU; however, no matter where the infant is sent for nursing care, I believe that the attitudes and actions of the nurses will impact the mother and infant bond.

**Summary**

In this chapter I described an experience that led me to undertake this research-the meaning of nurses’ experiences caring for families where mothers and infants are addicted to substances. The personal experience described in the first part of this chapter was purposely written with a judgmental tone to allow the reader to experience nurses’ perceptions and stigmatizing attitudes that families with mothers who misuse substances face after the birth of their children. The chapter continued with a description of the NICU environment and how intimidating it can be to outsiders; a glimpse into the lives of women who misuse substances along with some of the factors that may have shaped their lives; and I ended with a short introduction to factors that encourage mother-infant bonding. The next chapter will contextualize the research within the literature.
Chapter II: Contextualizing the Research

Nurses, similar to the general population, hold beliefs and perceptions about people who misuse substances (Bjorkman, Angelman, & Jonsson, 2008; Ronzani, Higgins-Biddle, & Furtado, 2009; Ross & Goldner 2009). By recognizing and reflecting upon these behaviours, as well as receiving education and support within work environments, nurses can gain insight into the challenges women who misuse substances face while providing sensitive and appropriate care in accordance with Doane and Varcoe’s (2005) theory, family nursing as relational inquiry. Unknowingly these beliefs may harm clients, who may be treated according to the nurses’ stigmatizing personal beliefs in an unsupportive or judgmental manner (Ross & Goldner, 2009). The following section will explore these concepts starting with a review of the literature regarding nurses’ perceptions of people who misuse substances.

Nurses’ Perceptions of People Who Misuse Substances

In the general population there is an overall disapproval of illicit drugs and the persons misusing them (Ford, Bammer, & Becker, 2008). There is no reason to assume that nurses are any different. While everyone is entitled to his or her own opinions, problems do arise when nurses bring these beliefs into the workplace and these beliefs either consciously or unconsciously influence their behaviours, and their treatment and interactions with clients and coworkers.

The reason I highlighted the above point concerning the importance of coworker relationships from the literature was because I believe that any working nurse would report the tone of the patient care unit, which may be positive or negative, is set by the strongest personalities working in that unit (Glembocki & Dunn, 2010; Persky, Nelson,
Watson, & Bent, 2008). Rytterström, Cedersund, and Arman (2009) have studied this reality and found that caring behaviours were influenced by the strongest personalities on nursing units. I believe that this has resounding repercussions, especially for families with substance misuse issues. For example, if the nurse ‘leaders’ of a unit held strong beliefs that were not congruent with the way persons, who misused substances were choosing and living their reality and the nurses acted on those beliefs by behaving in unsupportive and judgmental ways, those stigmatizing actions would influence other nurses with weaker personalities. It would result in the family who experiences the resulting stigma.

**Stigma**

The concept of stigma was first expounded by Goffman (1963). This seminal work described stigma simply as “a mark of discredit that sets a person apart from others” (Gouthro, 2009, p. 669). Much of the work describing stigma related to individuals who suffer from mental illness and what they encounter on a day-to-day basis. Very little information was found directly related to nurses’ perceptions of people who misuse substances, and no literature was uncovered to date, relating to nurses’ perceptions of mothers who misuse substances. Substance misuse is considered a mental illness. The following sections will explore the topic of stigma from the perspectives of nurses, the public, and self-stigma.

**Nurses’ Perspectives of Stigma**

It is established in the literature that nurses’ perceptions of substance misuse and stigmatization did not differ from the general population (Bjorkman et al., 2008; Ronzani
et al., 2009; Ross & Goldner 2009). What was different was that nurses must work with and care for people with substance misuse issues on a daily basis and if nurses were not careful their attitudes could affect their working relationships with patients (Nelson, 2013; Ross & Goldner, 2009). For example, if a nurse was to approach a patient displaying nonverbal behaviours such as closed body language or posture, the patient might be wary of establishing a trusting relationship with the nurse because the patient sensed a judgmental attitude.

Bjorkman, Angelman, and Jonsson (2008) compared attitudes towards mental illness of nurses working in somatic illness units to those working on psychiatric units. They found that although the nurses who worked in somatic care had greater negative attitudes towards people with mental illness, those who worked in psychiatric care also displayed the same negative attitudes, only to a lesser degree. This finding was quite surprising given one would expect nurses who have chosen to work in the psychiatric field not to demonstrate the same negative attitudes as the general population toward mental illness. Ronzani, Higgins-Biddle, and Furtado (2009) described similar findings in their work with health professionals in Brazil. There, health professionals were found to stigmatize substance misusers at a rate equal to the general population, with nursing assistants and community health workers displaying the greatest negative attitudes when compared to physicians.

Why do nurses stigmatize? Ross and Goldner (2009) proposed that it was because nurses believed patients with mental illness were less deserving of care due to the incorrect conviction that mental illness (especially substance misuse) was self-induced. Ross and Goldner (2009) explained the nurses’ perceptions using Schulze’s
Model which outlined three positions healthcare providers have chosen to assume in relation to stigma: stigmatizer, stigmatized, and de-stigmatizer (Schulze, 2007). Within their study that looked at the stigmatizer and stigmatized role, Ross and Goldner (2009) found that nurses who stigmatized came from general medical settings and were afraid or unsure of how to care for patients with mental illness. They also found that nurses from psychiatric settings displayed negative attitudes and prognoses towards treatment and recovery of mental health patients. This study also examined the stigmatized role and found that nurses stigmatized nurses who suffered from mental illness as well as the psychiatric specialty in general.

Gouthro (2009) examined the stigma faced by mental health nurses at the hands of patients, the general population, other nurses, and other healthcare professionals and found that stigmatization of mental health nurses occurred because of their choice to work with stigmatized populations. She deemed the best way to remedy these negative perceptions was through using positive modeling in education and the media.

However, all is not completely negative when surveying the construct of stigma and how it was addressed in healthcare. Kelleher and Cotter (2009) undertook a study in Australia to determine emergency department physicians’ and nurses’ knowledge and attitudes around problematic substance misuse. They found that those who completed their assessment tool exhibited “near optimal attitudes for constructive working with substance using patients” (p. 3). However, this same study also found that the level of knowledge about substance misuse in general was only satisfactory with much room for improvement.
This leads to an examination of what nurses and other healthcare professions must do in order to overcome the stigma they exhibit in order to ensure therapeutic helping relationships were created with their patients. Ferrell (2010) described how librarians dealt with problematic client behaviours, namely identifying the clients’ behaviour as the problem. She then referred to nursing literature and found interactionist theories useful in contextualizing the problem in relation to how nurses view ‘problem clients’. Ferrell (2009) portrayed that the situations were strikingly similar in that both nurses and librarians were quick to label or attach stigma to the behaviours they deemed problematic, rather than striving to understand the needs of the client or how they were not meeting the client’s needs and causing the client to act in an undesirable fashion. She suggested this situation could be remedied through the development of interpersonal skills such as listening, non-verbal cue recognition, empathy, and role reversal. These ideas were echoed by McCreaddie et al. (2010) who examined how Scottish drug misusers were treated for pain management in acute care settings. They found the most effective way to ensure the needs of both parties were met was through effective engagement. When nurses used effective engagement, similar to the interpersonal skills described above, patients who also had substance misuse issues felt cared for, their needs were met and they did not feel ignored or devalued (McCreaddie et al., 2010).

Pauly, Goldstone, McCall, Gold, and Payne (2007) probed the issue of eliminating nurses’ stigma of substance misuse from a larger perspective. They found that the current focus in law enforcement on drug policy was ineffective. Rather, the emphasis should be concentrated on improving the lives of socially and economically marginalized persons within society by eliminating homelessness, poverty, racism, and
violence. Pauly et al. (2007) also contended that nurses worked in ethical milieus in which negative attitudes and judgment prevailed such that healthcare delivery was adversely affected by the demonstration of retributive treatment of individuals. Further, Pauly et al. (2007) suggested that harm reduction models to treat substance misuse should be embraced because they helped shift negative judgment from stigmatizing to improving access and helping relationships. Next, I will present a glimpse into the public perspective of stigma.

**Public Perspective of Stigma**

When Adlaf, Hamilton, Wu, and Noh (2009) examined stigmatizing attitudes of Ontario students in grades seven to twelve towards drug addiction, they found that stigma decreased as the age increased and amongst students who did not have friends who used drugs when compared students who had friends that did use drugs. Their argument was that stigmatizing attitudes toward individuals who misused substances were formed early in life, and although stigmatizing attitude decreased, it was not eliminated as the individual aged (Adlaf, Hamilton, Wu, & Noh, 2009). These results were supported by a study by Reavley and Jorm (2011) who surveyed young Australians between the ages of 15 and 25 on their attitudes towards people with mental health disorders. Reavley and Jorm (2011) found that young people held stigmatizing attitudes towards mental illness and negative attitudes were greater towards illnesses that were perceived to be character flaws (i.e., social phobia and substance abuse). Using this reasoning the authors hypothesized that stigmatizing attitudes were learned early and carried forward into adulthood.
Stigmatizing attitudes were not only held by the non-substance misusing public but also individuals with substance misuse issues. Radcliffe and Stevens (2008) interviewed 53 problematic drug users in England and found that among this group, efforts were made not to be associated with ‘junkies’ who were considered “dirty and smelly” (p. 1068). The ‘junkies’ were characterized by the media as anyone with a substance misuse issue who was involved with criminal activity and those interviewed did their best to justify why they were not to be coupled with the ‘junkie’ label. This group also found the substance treatment process very stigmatizing, especially the established routine of receiving methadone. Current methadone treatment practice had the individuals receiving methadone treatment entering the dispensing pharmacy from a different entrance than the public, only at certain times of the day and being made to sit and wait in a corner. This ritual made individuals feel singled out, shamed, and vilified (Radcliffe & Stevens, 2008). One participant described it being much easier to go to London three times a week to buy heroin than going to the pharmacy as it worked better with his work schedule (Radcliffe & Stevens, 2008).

Bayer (2008) presented a slightly different perspective of public stigma. He contended that nurses should not seek to eliminate the stigma that exists in the general public. The mobilization of stigma, he argued, could reduce the prevalence of behaviours that could lead to illness or death. One example the author described was that of tuberculosis (TB). Historically, members of the public were wary of breathing the same air as a person with TB, lest they contract the disease as those with a TB infection were said to render the air impure (Bayer, 2008). Prior to the known existence of bacteria and germ theory, this advice would have been thoughtful. A modern example Bayer (2008)
described was that of smoking and public health. As cigarettes were known to be
carcinogenic, the fact that many people continued to smoke knowing these risks effects
the stigma of blame upon smokers when they become ill. Bayer (2008) acknowledged
that there were considerable ethical considerations when taking such a stance and that in
North American society, not aiming to reduce or eliminate stigma had numerous moral
and legal ramifications.

Self-stigma exists when those affected expect inequality and also doubt their
capabilities and social status (Schneider, Beeley, & Repper, 2011), which is where the
presentation of the literature will now proceed.

**Self-Stigma**

The theory of self-stigma was conceptualized by Corrigan and Watson (2002) to
name stigmatizing behaviours, decreased self-esteem, self-efficacy, and distancing,
amongst people with mental illness. Verhaeghe and Bracke (2011) wrote that self-stigma
developed from public stigma, in that public stigma created negative stereotypes that in
turn built negative attitudes which led to distancing or negative behaviours that were
characteristic of self-stigma. Verhaeghe and Bracke (2011) argued that self-stigma
created feelings of shame and inferiority that discouraged people with mental illness from
partaking in everyday activities as well as seeking treatment for their illness.

Withdrawing from general society then reinforced negative stereotypes held by the public
of those with mental illness and it became a vicious circle. To avoid labeling, individuals
with mental illness tried to circumvent negative reactions using secrecy and withdrawal
(Verhaeghe & Bracke, 2011). Interestingly, a paradox exists (Corrigan & Watson, 2002;
Goldberstein, Eisenberg, & Gollust, 2009; Sitvast, Abma, & Widdershoven, 2011) in that
not every individual with mental illness developed self-stigma. Rather, many individuals were oblivious to public stigma and in turn did not let it affect their health-seeking behaviours.

To combat the issue of self-stigma Schneider, Beeley, and Repper (2011) evaluated a campaign to dispel the stigma surrounding mental health issues by improving public attitudes, removing barriers to employment of those with mental illness, promoting recovery and social inclusion, and reducing the incidence of stigma experienced by those with mental illness. Their results were favorable, finding that people with mental health issues did feel less stigmatized, but the authors admitted there was still a long way to go (Schneider et al., 2011). A unique suggestion to combat stigma came from Lamb (2009) who proposed the nurturing of artistic talent and connecting mental health clients with venues where they could display their work. This, she argued, would reduce stigma by showcasing the work of someone with mental illness thus dispelling public perception while constructing “self-efficacy and empowerment” for the client (Lamb, 2009, p. 57).

I have considered stigma from the perspective of nurses, the public, and self. Now the tone will change to looking at the needs of those who are stigmatized from their perspective.

**Needs of People Who Misuse Substances from Their Perspective**

An issue raised in the literature was the lack of research into the needs of people who misused substances, from their perspective (Robinson, 2006; Somervell, Saylor, & Mao, 2005). Robinson (2006) reviewed existing literature and suggested that further research was needed on the impact of substance misuse on: women of childbearing age, gender-specific treatment needs, the relationship between intimate partner violence and
substance abuse, past victimizations, role fulfillment, and the internalization of stress and substance misuse.

Somervell, Saylor, and Mao (2005) explored the needs of females who misused substances and had had their children removed from their care in California. They reported that what these mothers wanted most was information. They wanted to know how their children were doing in care, that their children were being visited by public health officials, as well as what behaviours or delays may be observed in their children in relation to drug exposure. The mothers’ largest source of worry or stress was not their situation; rather it was their children and how the children were coping. I raise this point because although drug addiction was all encompassing for the mother who was misusing substances, I believe that this literature pointed to the fact that these particular women were still concerned mothers and still continued to care about the well-being of their children, even though they had substance misuse issues. The next section includes suggestions for what might be done to combat stigma.

**Resources to Combat Stigma among Nurses**

Suggestions to improve nurses’ perceptions of individuals who misuse substances and to combat stigma are offered. Ford, Bammer, and Becker (2008) believed that it was impractical to try and change nurses’ attitudes. Rather, they found that increased role support from managers combined with illicit substance education was the most effective method to increase nurses’ therapeutic attitudes. Education did not change beliefs, but provided nurses with a deeper understanding of their clients’ experiences from the context in which their clients exist. Glembocki and Dunn (2010) published similar work evaluating an educational intervention called *Reigniting the Spirit of Caring*. They found
this program, which included training sessions, the use of continuity of care models, and the establishment of clinically supervised areas was effective in increasing nurses’ perceptions of caring. There were times however, when nurses’ attitudes did not change.

The literature reviewed proposed that practitioners be aware of and reflect on the feelings practitioners themselves created also known as self-awareness (Owens, 2007; Perraud et al., 2006; Rayner, Allen, & Johnson, 2005; Scheick, 2011; Swatton, 2011) or reflexivity (Doane & Varcoe, 2005). Collectively they argued that if practitioners were unaware that they were displaying stigmatizing attitudes, negative feelings towards clients occurred that in turn developed into burnout amongst practitioners. The articles by Perraud et al. (2006) and Rayner et al. (2005) provided resource models to encourage self-awareness but the main concepts (e.g. awareness and reflection) remained common throughout the writing.

Scheick (2011) suggested the tool Element S, a self-concept assessment to increase self-awareness and increase the value of the nurse-client therapeutic relationship. She found that when used with nursing students the tool not only increased self-awareness within the students’ current clinical area (psychiatry) but that the awareness was transferred to other clinical areas and personal life situations resulting in nurses who were more aware of their actions and the impact they had on the nurse-client relationship. Swatton (2011) suggested that nurses in all areas should have regular access to debriefing and personal therapy to reflect on their practice the way other professions such as psychologists can and do. Self-awareness and context were very important when using Giorgi’s (2009) phenomenological method (that will be discussed in chapter three) and when considering the theoretical lens of family nursing as relational inquiry (Doane &
Varcoe, 2005) through which I viewed participants’ descriptions of the meaning of caring for families where mothers and infants are addicted to substances.

**Summary**

In this chapter I presented a review of nurses’ perceptions of individuals who misused substances and the stigma involved. Nurses are human; they bring their beliefs and perceptions to work with them. According to the literature, when nurses cared for their patients the nurses’ beliefs either consciously or unconsciously were integrated into the development of stigmatizing attitudes towards patients. However, the literature also presented ways to counter these unneeded and harmful responses. The first way was through self-reflection or reflexivity, a practice that is expected of all professional nurses. The second way was through education. Following the ideas of family nursing as relational inquiry (Doane & Varcoe, 2005), nurses cannot be expected to change their beliefs but they can be expected to seek to understand the choices their clients make as they journey through their own lived experiences.

It is proposed that by naming these issues and recognizing that there is need for change, this plethora of issues may begin to be resolved. Learning nurses’ meaning of caring for families where mothers and infants are addicted to substances is important and may result in alerting nurses to their own behaviours and the influence that their behaviours could have when working with this vulnerable population. For nurses, supporting ALL mothers is a first step in creating strong individuals, strong families, and strong communities. The next chapter will proceed to the research methodology for this thesis.
Chapter III: Methodology

I chose to use descriptive phenomenology (Giorgi, 2009), a qualitative research methodological approach to explore the meaning of nurses’ experiences caring for families where mothers and infants are addicted to substances. The research was guided by the theoretical underpinnings of Doane and Varcoe’s (2005) family nursing as relational inquiry. The following discussion will include theoretical underpinnings (Doane & Varcoe, 2005), an introduction to qualitative research and phenomenology, a discussion of the use of Giorgi’s (2009) descriptive phenomenological method in nursing research, and a description of analysis-synthesis processes for Giorgi’s method. In closing the chapter I will present the ethical principles guiding the research question from a qualitative perspective.

Family Nursing as Relational Inquiry

Family nursing as relational inquiry challenges the nurse to enter into relationships with families not as the expert but rather as the guide to what the family members tell the nurse their needs are at that time. Relational inquiry requires the nurse to be non-judgmental during her/his interaction with families by acknowledging and being conscious of one’s own power, knowledge, privilege, and biases (Doane & Varcoe, 2005). A nurse who was non-judgmental would use open body language, make eye contact when speaking with patients while not appearing rushed, and speak in a way that was not perceived as judgmental by using appropriate vocal tones. Consequently, it is the nurse’s responsibility to not only listen to the family but also to ask appropriate questions while taking into consideration the context as well as the family members’ nonverbal cues to validate that the nurse understands what she/he is being told. The family
members guide the nurse regarding their needs and the nurse responds to the identified needs. The family members know what they require; the nurse must listen and do what can be done in order to help the family achieve those needs by being open and receptive to what the family may be willing to share.

Family nursing as a relational inquiry way of being is imperative when caring for mothers with substance misuse issues. Many times the nurse will focus on the infant because the infant is viewed as having no choice in their situation. Following Doane and Varcoe’s (2005) theory, the mother and infant must be considered as a unit, for every decision impacts both members of the dyad. The term family does not necessarily conform the traditional Eurocentric context. Family is whomever the individual identifies as such and does not have to be a blood relation (Doane & Varcoe, 2005).

Doane and Varcoe (2005) have found three lenses particularly helpful when approaching families and family nursing: phenomenological, critical, and spiritual.

**Phenomenological Lens**

The aim of using a phenomenological lens is to take into account the social context of experience. Doane and Varcoe (2005) suggested the key ideas associated with the social context of experience included: “living experience; meaning; concern; and significance, situated and constituted” (p. 56). We cannot separate a person from his/her environment; the person is a product of his/her environment and will use personal experiences to form ideas and take action. A decision that might be judged as selfish to the nurse may be completely acceptable to that particular family member. Take for example Meaghan* (*pseudonym), a pregnant woman who has chosen to receive methadone treatment. A person who is not living the day to day battle with substance
misuse and drug cravings, and who does not have a history of physical/mental abuse at the hands of another may not understand why Meaghan has allowed herself to become pregnant while dependent on illicit substances. Yet for Meaghan, the pregnancy might represent a new beginning, someone to love and care for because she, herself, was not cared for, or perhaps a reason to abstain or stop substance misuse. To Meaghan, the choice to receive methadone treatment may not be exposing the unborn child to an opioid; it may be her choice not to expose her unborn child to the unregulated and the unknown content of street level drugs. One can see that context and meaning are everything when considering lived experiences and may completely change the way a situation is comprehended or viewed by another. Next, the critical lens will be explored.

**Critical Lens**

The critical lens, similar to the phenomenological lens, considers social context and perspectives that “challenge and disrupt the status-quo” (Doane & Varcoe, 2005, p. 61). Ideas associated with this lens included: “power, oppression, culture, economic conditions of life, social change, and emancipation” (p. 61). Referring to the example above, using a critical lens one might consider the societal values that allowed the ritualized abuse of young people at the hands of adults in trusted positions of power; the lack of education, or appointing of safe places and safe people to help in these situations; and the continued ignoring of social inequities that see the majority of resources bestowed on the minority of the population. Meaghan, the young woman described in the previous section, might be forced to live life on the street, as she has no permanent address or skills to access social security or employment insurance. Looking through a critical lens would lead an individual to question who has the power to make rules that
force others to rely on illegal means to earn income, rather than funding affordable housing and programs that would provide skills training to allow financial stability. The third lens in Doane and Varcoe’s (2005) work is the spiritual lens.

**Spiritual Lens**

Spirituality differs from religion in that spirituality is the primal search for meaning versus religion, which is based on formally recognized institutions, rituals, and beliefs (Doane & Varcoe, 2005). The spiritual lens can be associated with ideas such as “spirit, life force, ultimate concern, power, vision, and hope” (p. 77). This lens allows nurses to consider the concerns that are shaping people’s lives and what fundamentally matters to families at their deepest levels. Spirituality cannot be differentiated from other aspects of human existence. Instead it allows us to consider “what is taking place within, between, and beyond people” (Doane & Varcoe, 2005, p. 81). Again referring to Meaghan, looking through the spiritual lens would force one to consider; what drives this young woman? Is it her ultimate concern for her unborn child to ensure she grows up in a loving environment able to be cared for by a mother who is not constantly searching to ‘score’ or obtain illicit substances? Or, is it Meaghan’s desire to provide the love to her child that she did not receive herself? Next, will be a discussion of the methods used in this research.

**Qualitative Research**

Qualitative research follows a circular pattern in which the researcher is continuously examining and reflecting on collected data, making decisions about how to proceed based on what has already been discovered (Polit & Beck, 2010). Qualitative
research in the human sciences is used to discover the how and the why, rather than the
who, the what, and the where. One method common in qualitative research is
phenomenology.

**Phenomenology**

Phenomenology is both a philosophy and a research method that is rigorous, critical, systematic, and an investigative method to study human experiences (Cohen, 1987). Phenomenology as a philosophy originated in the early 20\textsuperscript{th} century (Cohen, 1987; Giorgi, 2002, 2009). Its founder, Edmond Husserl, was a philosopher and mathematician who believed that anything could be understood under the consciousness of what one was given or, descriptive phenomenology (Giorgi, 2009).

Phenomenology as a method is an approach to researching peoples’ life experiences, *phenomena*, and the essence of what these phenomena mean to them. Phenomenology is commonly broken down into two schools of thought: Husserl’s descriptive phenomenology that is tasked with describing the meaning of the human experience and forms the basis of Giorgi’s descriptive method, and hermeneutics (Heidegger’s branch) which stresses the importance of interpreting and understanding, not just describing phenomena (Polit & Beck, 2010). Phenomenology, the method, has continued to evolve from the above mentioned schools of thought to the point that as a whole it is hard to define because of the plethora of definitions that exist (Giorgi, 2009). Overall, it can be said that the human science perspective guides the method of phenomenology; humanness is respected throughout the research and therefore it cannot be dismantled into parts; or be guided by an empirical philosophy. Phenomenology is
more comprehensive and allows for irreal (phenomena that cannot be quantified) as well as empirical phenomena to be studied (Speziale & Carpenter, 2007).

The Appropriateness of Giorgi’s Descriptive Method: Phenomenology and Nursing

Nursing is generally regarded to be a holistic practice wherein nurses consider the entire person and do not break the individual into pieces to be viewed separately. Science and empiricism, it can be argued, dismantle the person into parts in order to understand how the whole operates (Parse, 1998). Science also deals with what can be seen and measured and is not considered valid unless it can be reproduced by another. As argued by Beck (1994), Giorgi (2008, 2009), and Speziale and Carpenter (2007), not reducing the individual into parts is what suits phenomenology as the research method of choice for nursing. Phenomenology is therefore congruent with the epistemology of nursing to come to know the lived experience that creates the person rather than a positivist philosophy that reduces a person into non-interacting parts (Beck, 1994; Cohen, 1987; Doane & Varcoe, 2005; Holtslander, 2008; Parse, 2001). Phenomenology has been used successfully by nursing researchers to develop descriptions of experiences (e.g. Aquino-Russell, 2003; Gordon, 2009; Murdoch & Franck, 2012).

The purpose of Giorgi’s (1992, 1994, 2002, 2004, 2006, 2008, 2009) descriptive method is to uncover meaning that has significance to the discipline. As such, Giorgi’s descriptive method requires researchers to use a disciplinary focus, or lens, for viewing their phenomenon of interest. This allows any discipline to use Giorgi’s descriptive method as a research method because the use of a discipline-related lens makes the resulting analysis relevant to the researchers’ profession. I chose to use family nursing as
relational inquiry (Doane & Varcoe, 2005) as this lens allowed me to view participants’
descriptions from within the context of family nursing.

Giorgi’s descriptive phenomenological method includes three steps (a) assuming
the phenomenological attitude, (b) searching for the essence of the phenomenon, and (c)
describing the essence (Giorgi, 2009). To assume the phenomenological attitude, the
researcher must break from his/her natural attitude of everyday life in order to view “all
objects from the perspective of how they are experienced regardless of whether or not
they are actually the way they are being experienced” (Giorgi, 2009, p. 87-88).
Described in another way, the researcher must view what is being presented exactly as it
is being presented without any preconceptions or bias. In the second step, the search for
the essence of the phenomenon, the researcher continues within the phenomenological
attitude and searches to articulate what makes the phenomenon the specific example or
instance it is. To do this free imaginative variation is applied. By letting one’s mind be
free when reading and re-reading a description, eidetic or vibrant visual images will
reveal themselves to the researcher that are the essence of the phenomenon. It must be
noted that this process is not a linear one; rather it is circular with the researcher
continually going back to the original description to elucidate the full meaning of the
participants’ words. The final stage, describing the essence, is simply to describe the
essence as accurately as possible by neither adding nor subtracting from what is present;
this means there is no interpretation (Giorgi, 2009).

The validity of using phenomenology as a research method was an important
consideration for me, as I wanted this research to accurately reflect participant nurses’
meanings of caring for families (mothers and infants) who are addicted to substances.
According to Giorgi (2002) the validity of the phenomenological method is implicit, the researcher utilizes exactly what the participant has said or written in the analysis-synthesis. When participants describe the situation they have been asked to speak or write about; what they say is what they believe, it is a real life situation and not a measure of the situation. Participants describe their conscious beliefs of the phenomenon; one cannot tell another that their perception of an event is wrong. This perspective of going with persons in their choices and life experiences was congruent with the discipline of nursing (Beck, 1994, Speziale & Carpenter, 2007).

**Critiques of the Phenomenological Method**

The most frequently cited critique of phenomenology in the literature was that it lacked scientific, reproducible results (Morse, 2004; Rolfe, 2004; Sandelowski, 2004). Giorgi (1992, 1994, 2002, 2004, 2006, 2008, 2009) addressed this issue in many of his articles arguing that phenomenology can be a scientific method when his method is used correctly. He further elaborated that although analysis of the same descriptions by different researchers may result in differing meaning units, in the end the structure of the meaning experience is the same. Giorgi (2009) provided an example of this analysis difference in his latest book that outlined how another researcher and he came to form similar meaning structures from two descriptions that were analyzed independently.

The ability to generalize findings is a topic that is raised when dealing with qualitative research as a whole (Polit & Beck, 2010). When researchers undertake large double-blinded randomized controlled studies, the results are generalized to the population. On the other hand, qualitative researchers seek out small numbers of participants that meet very specific requirements. This lack of generalizability makes
some researchers in the empirical world question the value of qualitative work (Morse, 2004; Rolfe, 2004; Sandelowski, 2004). Although phenomenological findings cannot be generalized, this does not mean the findings are inferior. Rather researchers utilizing phenomenology encourage the undertaking of similar research amongst different groups of individuals to identify how these other groups find meaning from phenomena that they have experienced (Lovi & Barr, 2009). Next, the focus of this chapter will move to that of research processes.

**Research Processes**

Qualitative research designs have usually involved face-to-face participant interviews as the primary or sole method of data collection (Munhall, 2007). The face-to-face interview method allowed for direct observation of participants to note verbal and non-verbal cues. However, face-to-face interviews may be disadvantageous whilst dealing with topics of a sensitive nature (i.e. caring for families of mothers and infants with substance misuse issues) as possible participants could be less willing to share their experiences if they had to meet and talk with a researcher directly (East, Jackson, O’Brien, & Peters, 2008). As technology has advanced in the area of asynchronous computer mediated communication (CMC), or email, East, Jackson, O’Brien, and Peters (2008) contend that online communication has grown to be one of the most popular methods of communication throughout the world. In fact, CMC has become the method of choice for data/description collection by researchers (Curasi, 2001; East et al., 2008; Kralik, Price, Warren, & Koch, 2006; Norris, 1999).

The literature described benefits for both participants and researchers when using CMC. Benefits for participants included: greater flexibility concerning when to complete
an interview, not having to travel to meet with an interviewer for the interview, increased comfort for the participant as they could complete the interview in their home, and the participant could conduct the interview in stages when it was convenient for them rather than completing it all at once (Aquino-Russell, 2003; East et al., 2008). Curasi (2001) and East et al. (2008) also argued that CMC allowed for anonymity and in some cases for participants to be more open about their experiences as they did not have to face another person while detailing a description that could be particularly painful to the participant. There were also multiple benefits to the researcher. These included those listed above which decreased time and travel expenses but probably most importantly, CMC allowed the researcher to reach a wider pool of possible participants than they could have ever accessed before the advent of the Internet (Curasi, 2001; East et al., 2008; Kralik et al., 2006). Succinctly said, research using the internet was convenient, flexible, and easily accessible (Cotton, 2004).

The greatest disadvantage of using CMC could be that although use of CMC and the Internet has grown exponentially, this method of communication still may not be available in every community (Curasi, 2001; Davis, Bolding, Hart, Sheer, & Elford, 2004). Additionally, not everyone may be familiar with or comfortable using CMC (Davis et al., 2004). Another critique is that the use of CMC does not allow for the observation of participants during the interview to ascertain non-verbal behaviours, as would face-to-face interviewing. This could be overcome with the use of a web-cam if the researcher needed to observe the participant during the interview (Curasi, 2001; East et al., 2008). A final disadvantage leveled by East et al. (2008) was that the researcher must also be comfortable and effectively able to use the required software to assure
competence recruiting participants and/or obtaining the research descriptions. All of the aforementioned points were taken under consideration before deciding upon my description collection approach.

For my research study, I collected written email descriptions about the meaning of nurses’ experiences caring for families where mothers and infants are addicted to substances. In accordance with Giorgi’s (2009) descriptive method for analysis of phenomenological data, participants were asked to write a descriptive response to an interrogatory statement. *Please write a description of a situation or experience of what it was like for you to care for a family where the mother and baby were addicted to substances.* Asynchronous CMC (email) was used to collect descriptions of the research phenomenon.

By responding to an interrogatory statement via email, participants were able to decide the quantity and detail of information they wanted to include in their descriptions. This was congruent with Doane and Varcoe (2005), which required the nurse (or in this case the researcher) to listen and respond to the family’s (or interviewees) needs. This is contrary to an interview where the researcher leads the questioning meeting the needs of the researcher rather than the participant. Participants were requested to complete their description in a one-month period keeping with the nursing research data description collection strategies of Aquino-Russell (2003) and Gordon (2009) who found that this amount of time was sufficient when collecting CMC descriptions. Using email as a description collection method also increased the number of possible participants available to respond by increasing the recruitment area.
**Recruitment**

Participants were recruited via posters in areas visible to nurses working on family/newborn units within the Horizon Health Network, Twitter, and snowball sampling (see Appendix A- Recruitment Notice). I published a short description of my research project in poster format and encouraged nurses who wanted to participate to contact me via email-using a strategy that encouraged anonymity. Once contacted via email, I provided by email attachment a research information sheet (Appendix B- Letter of Invitation to Participants) outlining detailed information about the project and clarifying the purpose and methods of my research. I informed all interested potential participants about the research process: how I intended to obtain their descriptions from written email descriptions, what would be done with their descriptions, as well as their right to withdraw from the research at any time.

I used a new method of recruitment, Twitter, to attract participants by tweeting multiple short messages informing individuals about my work and how to contact me for further information on nursing specific twitter feeds including The Canadian Nurses Association, NurseGroups.com, Nurseland and informal groups consisting of my target demographic. There was no published literature on the use of Twitter to attract research participants in nursing research. In fact, a search of the published literature revealed only four scholarly articles about Twitter and two of those were in reference to employee recruitment (Baxter, Marcella, & Varfis, 2011; Davison, Maraint, & Bing, 2011). However, the existing literature concurred that recruitment of individuals through the use of Twitter was an efficient and productive method. I felt posters and Twitter were the most appropriate recruitment strategies to reach my desired participants.
The length of time since the participants cared for a mother and infant addicted to substances was not pertinent when collecting descriptions using Giorgi’s descriptive method (Giorgi, 2009). Giorgi (2009) argued “retentive and recollective phenomena contribute to our experiences more pervasively than we realize and so cannot be used as sole factors for objecting to the use of retrospective description” (p. 118). As a researcher, it was my responsibility to uncover the meaning of the experience according to the participant. I did not specify a time period since the participant had had the experience in my inclusion criteria.

**Inclusion Criteria**

The inclusion criteria for participants of this research included:

- Being a Registered Nurse
- Having worked with families where mothers and infants are addicted to substances either on a family/newborn unit or NICU
- Being willing to write about his/her experience and submit via email
- Being able to write in English and,
- Being able to access and use a computer with an internet connection.

**Sample Size**

Small sample sizes are utilized in phenomenological research, which does not take away from the findings (Giorgi, 2009; Kleiman, 2004). The norm when undertaking phenomenological research is to gain a rich understanding of the experience from persons who have lived the experience rather than having large numbers of participants and generalizing findings (Giorgi, 2009; Lovi & Barr, 2009; Polit & Beck, 2010).
There are differing perspectives related to the idea of sample size and saturation. Commonly, saturation is the term used to describe when no further details are gained from participants’ descriptions. According to Polit and Beck (2010) saturation is the guiding principle when conducting phenomenological research yet there were no firm criteria for determining qualitative sample size. As well, Patton (2001) noted that there were no rules to determine qualitative sample size.

After reviewing nursing studies that used Giorgi’s descriptive method, it was found that these studies have employed a variety of participant numbers, two participants (Koach, 1999; Santopinto, 1989), six participants (Lovin & Barr, 2009), seven participants (Aquino-Russell, 2003; Costello-Nickitas, 1994), and nine participants (Gordon, 2009; Murdoch & Franck, 2012). One author suggested that studies that strive to uncover the essence of an experience are recommended to include approximately six participants (Morse, 1994). Other authors have written that qualitative investigation of a clinical phenomenon is for the purpose of capturing themes and patterns within participants’ perceptions and to inform understanding, so saturation is not considered (Thorne, Kirkham, & O’Flynn-Magee, 2004). As well, Morse (1989) suggested that “saturation is a myth” and “new data may always be revealed” (p. 44). Aquino-Russell (2003) and Giorgi (2009) concurred, arguing that saturation in phenomenological research can never be achieved as every person will experience a phenomenon differently and therefore each description will render new details. This belief was also congruent with family nursing as relational inquiry. Doane and Varcoe (2005) stated “[B]ecause [we] are unique beings who each inhabit particular contextual and relational locations in life, those unique, personal, relational, and contextual aspects must be taken into consideration” (p. 7).
believe that each participant experienced the phenomenon from a unique perspective which added new meaning to the description and that there was always a possibility of new ideas emerging. So following this argument, I did not consider saturation.

Given the fact that qualitative research uses small sample sizes that yield rich descriptive data, snowball and purposeful sampling are typically employed methods of participant recruitment (Kleiman, 2004; Polit & Beck, 2010). As was stated earlier in this chapter, I purposely targeted a specific group of nurses (Post-partum and NICU nurses) through a variety of methods with the hope that they would inform their co-workers of the project (snowball sampling).

For the purposes of this research, description collection proceeded for three months after ethical approval was obtained with the aim of recruiting a minimum of two participants. I recruited three participants for which Giorgi’s (2009, p. 71) method allowed because the method focuses on using and analyzing the participants’ descriptions that were submitted rather than extrapolating results for wide generalization. I had hoped for and received detailed descriptions and believe that there was always the possibility of new information and ideas emerging from my participants. As well, participants sent in descriptions within the allowed time frame and the analysis met expectations and requirements for completing my master’s degree.

**Ethical Considerations**

Once the research proposal received approval from the examining committee, I then sought approval the University of New Brunswick Research Ethics Board and the Horizon Health Network Research Ethics Board. Participants were assured that the confidentiality of responses would be maintained to the best of the researcher’s ability
following the procedure outlined below, while also informing participants that no method of communication could be guaranteed to be completely anonymous. For this research, participants’ descriptions were collected via email. Collecting descriptions by email required the participant to actively decide to participate with no possible coercion on the part of myself. If a participant submitted her/his description then consent for participation could be assumed by the act of the submission (Canadian Institutes of Health Research (CIHR), 2010); for this research, description submission constituted implied consent, which was then documented in field notes.

As per the Tri-Council Policy Statement the term consent means “free, informed and ongoing consent” (CIHR, 2010, p. 27) and “that individuals who participate in research should do so voluntarily, understanding the purpose of the research, and its risks and potential benefits, as fully as reasonably possible” (CIHR, 2010, p. 27). I was able to comply with this requirement as descriptions were voluntarily submitted through email and all individuals expressing interest in participating in this research received an information sheet (see Letter of Invitation to Participants- Appendix B) outlining the purpose, risks, and benefits of my project. As well, participants were informed that they could email me and ask that their descriptions not be used in the research project should they change their mind and decide not to participate in this research. Also included in ethical considerations were rights to self-determination, confidentiality and anonymity, privacy, and protection from harm and discomfort (Burns & Grove, 2005).

**Self-Determination**

Interested participants were provided with information about the study in a recruitment notice (Appendix A) posted on family/newborn units of hospitals within the
Horizon Health Network and via Twitter. It was clearly stated that participation in this project was completely voluntary. Research participants were given the email address of the Assistant Dean of Graduate Studies in the Faculty of Nursing who was not involved in this research, my supervisor, and myself should they have had any questions or concerns relating to their participation in my project.

**Confidentiality and Anonymity**

Participants were not required to identify themselves by their name at any time if they did not wish to do so. Rather, when submitting their written description, participants were asked to include basic information consisting of sex, years of nursing experience, and to confirm they were registered nurses. The issues of confidentiality and anonymity, when collecting research by the use of CMC and the Internet, have been widely acknowledged to not be completely guaranteed (Cotton, 2004; East et al., 2008; Kralik et al., 2006). The largest threat to confidentiality and anonymity would have been having the submitted descriptions ‘hacked’ or accessed by someone other than the researcher (East et al., 2008; Kralik et al., 2006). Anonymity could be better preserved if the participant was not required to disclose their identity. Free email access was readily available through Yahoo, Hotmail, and Google (Gmail) so if the participant desired they could have created an email address for the sole purpose of submitting their description. The protection this method offered was two-fold. It allowed for the researcher to remain unaware of the identity of the participant and in the unlikely event that the email would have been unlawfully accessed; the false name would also have kept the participants’ identity secret from hackers. To decrease the chances of this occurring, when submissions were received they had all identifying information removed and were downloaded from a
password protected email account to an external, password protected flash drive (USB),
then printed in entirety (hard copy) and then deleted from my computer. When not in use
the USB drive, hard copies, and field notes were stored in a locked filing cabinet. All
research descriptions and field notes (personal notes or reflections on the research
process) will be kept for seven years and then destroyed. Pseudonyms were assigned to
each participant using the first three letters of the alphabet.

**Privacy**

Participants were asked to email their descriptions as a Word format email
attachment, with which all participants complied. The document was a description of
their experience written at a time and location of their choice. I encouraged all
participants to create an email account separate from their customarily used personal
email (using Hotmail, Yahoo, or Google). Providing added security and privacy for
participants so they did not mistakenly add my email address to another email they might
send, or send their description to another person who was unaware of their participation
in this research. All three participants chose not to do this. Also, included with the
information for participants I asked participants to identify their interest in being
provided with the results of this research; all participants requested a summary of the
results.

**Protection from Harm and Discomfort**

Participants in this study experienced caring for families where mothers and
infants are addicted to substances. By requesting the participants write and then submit
their descriptions, participants were able to choose exactly what they wanted to disclose.
This is contrary to a face-to-face interview where participants might unintentionally divulge information that they might, on later deliberation have chosen not to divulge. Using written descriptions allowed participants to reread what they had written and also the opportunity to leave their description for a period of time and come back at a later point to possibly add or omit details before submission. This not only provided protection from harm and discomfort to the research participants, but it also had the potential of having a therapeutic effect as the participants were potentially offered an opportunity to reflect on the meaning of their lived experiences.

**Rigour of Qualitative Research**

Qualitative rigour was a topic that received much debate (Drummond, 2010; Freshwater, Cahill, Walsh, & Muncey, 2010; Guba & Lincoln, 1989, 1998; Meyrick, 2006; Oliver, 2011). Annells (1999) described four specific criteria for phenomenological research to evaluate trustworthiness and authenticity. The four requirements outlined by Annells guided how I ensured the rigour of my research. The first criterion was that the interpretation must be understandable to the reader. This was accomplished by writing the results in a clear, succinct, and interesting way so that nurses who read the findings would understand their meaning. Next, the researcher must make explicit and understandable the process of inquiry. I achieved this by making the analytical process transparent as well as through the use of field notes throughout the research process so that I could become self-aware; field notes have been shown to be an acceptable method of maintaining rigour (Bradbury-Jones, 2007; Koch, 2006; Tuckett & Stewart, 2004). The third criterion posits that the outcome of the research should be useful in informing nursing practice as well as benefit those receiving care. I believe this
was accomplished by providing nurses with findings written in such a way that they may choose to become aware of how their attitudes might affect the way they work with mothers and infants who are addicted to substances. Lastly, the researcher’s approach to inquiry (research method used) must be congruent with the research question, which was demonstrated earlier in this chapter.

Summary

In this chapter I have described the theoretical underpinnings of the research, Doane and Varcoe’s (2005) family nursing as relational inquiry, and qualitative research; specifically the phenomenological research method, its appropriateness to use in nursing research, and my research processes. Ethical considerations were described and addressed as well as issues of rigour that guided the reader in evaluating this qualitative research. Giorgi’s (2009) descriptive method proved to be a challenging but appropriate method to uncover meaning and the structure of the lived experience of nurses caring for families where mothers and infants are addicted to substances. The following chapter will describe in detail the analysis-synthesis process.
Chapter IV: Data Collection and Analysis

In this chapter I discuss how the submitted email descriptions were analyzed-synthesized to describe how nurses feel caring for families where mothers and infants are addicted to substances.

Giorgi’s Descriptive Phenomenological Method

Broadly, Giorgi’s descriptive phenomenological method involves three phases: assuming the phenomenological attitude, searching for the essence of the phenomenon, and describing the essence (Giorgi, 2009). More specifically, Giorgi’s descriptive method is a process that involved five very specific steps. The first step involved grasping a sense of the whole. To do this, I read and reread the descriptions assuming the phenomenological attitude by viewing what was submitted by the participant exactly as it was submitted. I allowed myself to be sensitive to what it meant for the nurses to care for families with substance misuse issues by not allowing my own preconceptions or biases to influence their descriptions. I was cautious not to try “to clarify or make more explicit the global sense of the description” (Giorgi, 2009, p. 128) as this would develop further into the analysis-synthesis process.

The second step required me to determine meaning units. Meaning units were formed when I determined there was a significant shift in meaning within the description (Giorgi, 2009). I denoted this change in meaning by placing a mark where I believed there had been a change in meaning. One could surmise that this would have occurred at the end of every sentence, but in reality that was not the case. As the first step had required me to read and reread the description, I had become so familiar with the
description that subtle changes in meaning were readily identified. At this point it is important to note that the determination of meaning units was somewhat arbitrary but Giorgi (2009) noted that as the meaning units carry no theoretical weight, the arbitrariness would have no effect on the final product.

Giorgi (2009) argued that the third step is the most laborious. Step three involved identifying the focal meanings, which was transforming the words of the participant into expressions or language that would be used by the researcher, or in this case, the epistemology of nursing. To do this I analyzed each meaning unit taking care to draw out and elaborate on the nursing implication of the description and put it into nursing language.

Step four comprised developing a situated structural description. To do this I reviewed and synthesized each participants’ focal meanings producing a situated structural description. The synthesis of the situated structural description allowed me to grasp the individual nurses meaning of the lived experience of caring for families where mothers and infants are addicted to substances, using the language of nursing.

The final and fifth step was the creation of a general structural description using common elements from the situated structural descriptions. Completing this step was both gratifying and troubling, as I doubted my ability to generalize three unique experiences. For example in my journal I wrote:

*October 15, 2012*

*How am I ever going to analyse-synthesize my data? Going from meaning units to focal meanings seems do-able. Transforming the focal meanings into situated structural descriptions and in turn into general structural descriptions scares me.*
What if I don’t get it right? I want to really understand what the participants are telling me. It would be a disservice for me to get it wrong.

Interestingly, I found solace in the following statement from Giorgi (2009):

It is granted beforehand that every single description is going to be different from every other, even if the same phenomenon is being researched. However, even if the facts differ, the psychological meaning can be identical. Psychological meanings achieve a level of invariance that can comprehend multiple facts. (p. 132)

As I became more fully engaged in the analysis-synthesis process my fears abated and I wrote:

October 19, 2012

I am very pleased with our meeting. We went through Anne’s description; Catherine leading. But, as Heather and I got the hang of things we spoke more and more, offering our ideas and suggestions. I think I’ll be able to do justice to the words I have been entrusted with.

Analysis-Synthesis

As I described earlier in this thesis I intend to ensure the rigour of my research using Annells’ (1999) criteria. To fulfill the second requirement (the researcher must make explicit and understandable the process of inquiry) and instill confidence in the interpretation, following the written italicized verbatim descriptions from my participants I have included steps one to three in tabular format (please see Tables 1, 2, and 3) so that the reader can see how I was thinking as I carried out the analysis-synthesis.
Participant A (Anne)

First, I am a female Registered Nurse and have been a nurse for nine years.

Description

As a nurse in the NICU, I often worked with babies who were on morphine, and their mothers who were on methadone. I always felt bad for the babies; like they hadn’t done anything to deserve the anguish they were going through when we were weaning them from the morphine. It was like they were suffering so much. But, I also knew that we were treating them with morphine and titrating it, and that their mother’s had made a good choice to take methadone not street drugs. That kind of helped me cope with having to listen to those poor babies scream and scream. I can remember the relentless crying, scoring for withdrawal, and how some of their bottoms got so red and raw that they had to go without a diaper and have oxygen blowing on their bottom to help it heal. It was quite traumatic when I couldn’t help a baby settle. I felt like a bad nurse; like I somehow didn’t have enough skill to take care of them. I remember seeing them be jittery, and it was hard to watch. I really advocated for the baby, trying to get them at a good dose, but didn’t know if it was good to keep giving it or if I should be trying to wean and putting up with the crying. There really wasn’t a lot of information about it. We (the staff) weren’t given training about it, and weren’t told how to help mothers cope. It was sad to see babies go to foster homes or not live with their mothers. I think I remember other nurses saying it was better because someone could steal the morphine from the baby (implying that it was the mother), but I always felt like it was horrible to take a child from her mother. At the same time, I wanted the baby to get it’s [sic] morphine and not feel the discomfort of withdrawal. I remember the poor little dears crying and crying and sucking
at the bottle like they had never been fed. I guess I just felt really bad for them; like I wished I could do something, but had no idea what I could do. We rarely saw the mothers. That is strange, thinking back on it. Mother’s [sic] are always in the NICU, but not these ones. I wonder if they felt judged. I would have. It was especially evident on the maternity ward. Those nurses seemed to hate the moms and never wanted to take care of the babies. Like they didn't want them; they didn't want to make the time for them.

Table 1

Illustration of Analysis-Synthesis Steps 1-3 for Anne

<table>
<thead>
<tr>
<th>Sense of the Whole</th>
<th>Meaning Units</th>
<th>Focal Meanings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anne was trying to tell me that she felt bad about her perceived inability to care for the infants. She felt like a bad nurse because she could not cure the withdrawal symptoms the babies exhibited and she also felt guilty because of the lack of education to aid this particular group of patients. She recounted that both the NICU and Post-partum floor nurses judged the mothers of the addicted infants.</td>
<td>1. As a nurse in the NICU, I often worked with babies who were on morphine, and their mothers who were on methadone. I always felt bad for the babies; like they hadn't done anything to deserve the anguish they were going through when we were weaning them from the morphine. It was like they were suffering so much. But, I also knew that we were treating them with morphine and titrating it.</td>
<td>1. Anne felt sympathy for infants whose mothers had been addicted to substances as she titrated narcotics to alleviate the infants’ agony.</td>
</tr>
<tr>
<td>2. and that their mother's had made a good choice to take methadone not street drugs. That kind of helped me cope with having to listen to those poor babies scream and scream. I can remember the relentless crying, scoring for withdrawal, and how some of their bottoms got so red and raw that they had to go without a diaper and have oxygen blowing on their bottom to help it heal. It was quite</td>
<td></td>
<td>2. Anne experienced distress and feelings of helplessness and uncertainty with attempts to alleviate the infants’ inexorable physical pain.</td>
</tr>
</tbody>
</table>
traumatic when I couldn’t help a baby settle. I felt like a bad nurse; like I somehow didn’t have enough skill to take care of them. I remember seeing them be jittery, and it was hard to watch. I really advocated for the baby, trying to get them at a good dose, but didn’t know if it was good to keep giving it or if I should be trying to wean and putting up with the crying.

3. There really wasn’t a lot of information about it. We (the staff) weren’t given training about it, and weren’t told how to help mothers cope.

4. It was sad to see babies go to foster homes or not live with their mothers. I think I remember other nurses saying it was better because someone could steal the morphine from the baby (implying that it was the mother), but I always felt like it was horrible to take a child from her mother. At the same time, I wanted the baby to get its morphine and not feel the discomfort of withdrawal. I remember the poor little dears crying and crying and sucking at the bottle like they had never been fed.

5. I guess I just felt really bad for them; like I wished I could do something, but had no idea what I could do.

6. We rarely saw the mothers. That is strange, thinking back on it. Mother’s are always in the NICU, but not these ones. I wonder if they felt judged. I would have. It was especially

3. Lack of knowledge from education within the Cartesian lens limited Anne’s abilities to assist mothers’ with the situation.

4. Anne experienced feelings of ambivalence towards the disintegration of the family unit while others surmised misuse of the helpless babies’ treatment strategies.

5. Anne wrote of feelings of helplessness and unknowing in alleviating the infants’ suffering.

6. Anne ponders if the lack of mothers’ presence in the NICU and maternity ward could possibly be due to negative labeling and perceived disregard, uncaring.
Those nurses seemed to hate the moms and never wanted to take care of the babies. Like they didn’t want them; they didn’t want to make the time for them.

and insensitivity of other nurses.

Focal Meanings for Anne

1. Anne felt sympathy for infants whose mothers had been addicted to substances as she titrated narcotics to alleviate the infants’ agony.

2. Anne experienced distress and feelings of helplessness and uncertainty with attempts to alleviate the infants’ inexorable physical pain.

3. Lack of knowledge from education within the Cartesian lens limited Anne’s abilities to assist mothers’ with the situation.

4. Anne experienced feeling ambivalence towards the disintegration of the family unit while others surmised misuse of the helpless babies’ treatment strategies.

5. Anne wrote of feelings of helplessness and unknowing in alleviating the infants’ suffering.

6. Anne ponders if the lack of mothers’ presence in the NICU and maternity ward could possibly be due to negative labeling and perceived disregard, uncaring, and insensitivity of other nurses.

Situated Structural Description

For Anne, the meaning of nursing families where mothers and infants are addicted to substances involved feelings of sympathy, helplessness, and uncertainty during attempts to alleviate the infants’ inexorable physical pain. Anne’s perceptions of her own
lack of educational preparation within the Cartesian lens limited her abilities to assist mothers with the situation. Anne experienced feelings of ambivalence towards the disintegration of the family unit, while others surmised mothers’ misuse of the helpless infants’ treatment strategies. Anne pondered rationale for the mothers’ lack of presence in the NICU and maternity ward as being due to negative labeling and mothers’ perceived disregard, uncaring attitudes, and insensitivity from other nurses.

Participant B (Beth)

I am a female RN with 36 years nursing experience, 33 in OBS.

Description

It’s only been the last 10-15 years that we have begun seeing these women & as I work post partum I only see them for 2-3 days post delivery. We have a CNS who works with them for weeks-months ac [before] delivery & continues her support during the pp [post partum] period, time spent in NICU & DISCHARGE [sic].

We treat them as if they were regular pts [patients] i.e. pp assessments, br fdg [breast feeding] support, social work needs and their daily dose @ 1000 of methadone. Nearly all have a support person with them (usually their partner, occasionally a friend).

With us they are very involved with their baby’s care. Most smoke and are off the floor during the day either out smoking (?) or in the NICU FDG OR ROCKING [sic] the baby. Most choose to Br [breast] feed or pump. The majority seem very keen & attentive to their babies & are easy to care for pts. This is because the CNS has spent a lot of time prenatally preparing them for the post natal period and even gone so far as helping some find apartments once they are ready to take baby home. If the mother is a known
prostitute and has no fixed address or any interest in finding a home [it happens] the baby is usually apprehended. Overall, for the short period of time I work with them most are caring and loving to their newborns & have a discharge plan.

Table 2

*Illustrations of Analysis-Synthesis Steps 1-3 for Beth*

<table>
<thead>
<tr>
<th>Sense of the Whole</th>
<th>Meaning Units</th>
<th>Focal Meanings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beth is trying to tell me that caring for mothers and infants with substance misuse issues is a relatively new issue that she has had to address in her practice. She finds caring for these patients no different then caring for non-substance misusing patients except they receive a daily dose of methadone. She is grateful for the clinical nurse specialist who works with these patients preparing them for their short time in hospital. Finally, she finds many of the mothers very interested in caring for their newborns.</td>
<td>1. <em>It has only been the last 10-15 years that we have begun seeing these women &amp; as I work post partum I only see them for 2-3 days post delivery. We have a CNS who works with them for weeks-months ac delivery &amp; continues her support during the post partum period, time spent in NICU &amp; discharge.</em></td>
<td>1. With shortened post partum hospital stays, the preadmission educational role of the clinical nurse specialist is essential for ensuring the needs of this patient population are met.</td>
</tr>
<tr>
<td></td>
<td>2. <em>We treat them as if they were regular patients i.e. post partum assessments, breast feeding support, social work needs, and their daily dose @ 1000 of methadone.</em></td>
<td>2. When faced with unknowing and uncertainty, Beth relied on habitual ways of knowing for providing care rather than addressing contextual necessities.</td>
</tr>
<tr>
<td></td>
<td>3. <em>Nearly all have a support person with them (usually their partner, occasionally a friend). With us they are very involved with their baby’s care. Most smoke and are off the floor during the day either out smoking (?) or in the NICU feeding or rocking the baby.</em></td>
<td>3. Beth observed the participation on the part of the mother and family ebbed and flowed during their short hospital stay.</td>
</tr>
<tr>
<td></td>
<td>4. <em>Most choose to breastfeed or pump. The majority seem very keen &amp; attentive to their babies &amp; are easy to care for pts. This is because the CNS has spent a lot of time prenatally preparing them for the post natal period and even</em></td>
<td>4. Beth attributed the mothers’ breastfeeding, eagerness, and simplicity of care to prenatal and post partum education from the clinical nurse specialist.</td>
</tr>
</tbody>
</table>


Focal Meanings for Beth:

1. With shortened post-partum hospital stays, the preadmission educational role of the clinical nurse specialist is essential for ensuring the needs of this patient population are met.

2. When faced with unknowing and uncertainty, Beth relied on habitual ways of knowing for providing care rather than addressing contextual necessities.

3. Beth observes the participation on the part of the mother and family ebbed and flowed during their short hospital stay.

4. Beth attributes the mothers’ breastfeeding, eagerness, and simplicity of care to prenatal and post-partum education from the clinical nurse specialist.

5. Beth has observed intervention by social services when mothers’ situational context was not deemed by members of the health care team as being appropriate for the infant.

6. From Beth’s perspective, many mothers she has worked with were committed to their infants’ physical and emotional needs.

---

<table>
<thead>
<tr>
<th>5. If the mother is a known prostitute and has no fixed address or any interest in finding a home {it happens} the baby is usually apprehended.</th>
<th>5. Beth has observed intervention by social services when mothers’ situational context was not deemed by members of the health care team as being appropriate for the infant.</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Overall, for the short period of time I work with them most are caring and loving to their newborns &amp; have a discharge plan.</td>
<td>6. From Beth’s perspective, most mothers she has worked with were committed to their infants’ physical and emotional needs.</td>
</tr>
</tbody>
</table>
Situated Structural Description

For Beth, the meaning of nursing families where mothers and infants are addicted to substances involves unknowing and uncertainty, when at times she relied on habitual ways of knowing for providing care rather than addressing clients’ contextual necessities. Beth observed the mothers’ and families’ participation ebbed and flowed during their short hospital stay, attributing mothers’ breastfeeding, eagerness, and simplicity of nursing care to prenatal and post-partum education from the clinical nurse specialist. Beth has observed intervention by social services when mothers’ situational context was not deemed by members of the health care team as being appropriate for the infant. From Beth’s perspective, most mothers she has worked with were committed to their infants’ physical and emotional needs.

Participant C (Chloe)

*I am a female RN with 36 years’ [sic] experience in OB and NICU*

Description

-Mom’s [sic] can be loving, concerned & trying very hard to stay on the Meth. [methadone] Program. There are various reasons’ [sic] they are on the M. [methadone] Program. *Often it is drug abuse (Re: street drugs of various sorts). But occasionally it is the fact these moms are being treated for chronic pain from a previous car accident for example.*

*These Momma’s [sic] often feel guilty and are trying their best; even though it may have been many, many years on the M. [methadone] Program.*

*Although often they don't appear to feel guilty at all.*
Or

I have seen Mom's [sic] so addicted that they do not show up to tend their baby consistently. Often these mom's [sic] appear stoned. I have seen a few of these mom's [sic] get caught in the hospital with drugs such as cocaine and have their baby apprehended.

-- Often either of these two examples are so addictive [sic] they never seem to be able to get off the Meth.[methadone] from pregnancy to pregnancy.

-the one thing I find odd is that they don't seem to understand why their baby's [sic] are "cranky ", totally not getting what effect this truly has on their child.

The babies are often quite severely addicted, and when weaning them from the Morphine they react with a bounce back of high Finnegan scores. They tend to go home cranky and startle with neuro. responses being highly sensitive to noise, touch and everyday care.

Gosh knows how long this takes because I no longer see them. We pray the parents get it together and have good supports... So the baby does not come back in with shaken baby syndrome or worse.

Table 3

Illustration of Analysis-Synthesis Steps 1-3 for Chloe

<table>
<thead>
<tr>
<th>Sense of the Whole</th>
<th>Meaning Units</th>
<th>Focal Meanings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chloe is trying to convey that, in her experience, there are multiple reasons why mothers take methadone. She also concedes that mothers have a range of feelings in regards to the effects of taking methadone on their baby.</td>
<td>1. Mom’s can be loving, concerned &amp; trying very hard to stay on the Meth. program. There are various reasons they are on the M. program. Often it is drug abuse (Re: street drugs of various sorts). But occasionally it is the fact these moms are being treated for chronic pain from a previous car accident for example.</td>
<td>1. Chloe justified maternal addiction by imparting there were a variety of contextual reasons why mothers may be utilizing a methadone program.</td>
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<tr>
<td>Infant although many of the mothers did not recognize or appreciate these effects. Finally, she hopes for the welfare of the infants that their mothers have an effective support system in place.</td>
<td>2. <em>These Mommas often feel guilty and are trying their best; even though it may have been many, many years on the M. program. Although often they don’t appear to feel guilty at all.</em></td>
<td>2. When reflecting upon the mothers’ emotions, Chloe perceived a paradox of feelings ranging from remorse to good conscience.</td>
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<td></td>
<td>3. <em>Or</em>&lt;br&gt;I have seen Mom's so addicted that they do not show up to tend their baby consistently. Often these moms appear stoned. I have seen a few of these moms get caught in the hospital with drugs such as cocaine and have their baby apprehended.</td>
<td>3. Chloe described mothers’ chemical dependence overriding the drive to care for their infant.</td>
</tr>
<tr>
<td></td>
<td>4. -- Often either of these two examples are so addictive they never seem to be able to get off the Meth. from pregnancy to pregnancy.</td>
<td>4. Chloe believed substance addiction was so powerful that the same mothers were repeatedly giving birth to addicted infants.</td>
</tr>
<tr>
<td></td>
<td>5. <em>The one thing I find odd is that they don’t seem to understand why their baby's are &quot;cranky&quot;, totally not getting what effect this truly has on their child.</em></td>
<td>5. Chloe pondered mothers’ unknowing of the effects of methadone on their infants behaviours/health.</td>
</tr>
<tr>
<td></td>
<td>6. The babies are often quite severely addicted, and when weaning them from the Morphine they react with a bounce back of high Finnegan scores. They tend to go home cranky and startle with neurological responses being highly sensitive to noise, touch and everyday care. Gosh knows how long this takes because I no longer see them. We pray the parents get it together and have good supports... So the baby does not come back in with shaken baby syndrome or worse.</td>
<td>6. Chloe expressed uncertainty about the length of time the infant displayed the physical symptoms of withdrawal while at the same time desiring safety of the infant with hopes parents found an adequate support system thus avoiding readmission for child physical abuse.</td>
</tr>
</tbody>
</table>
Focal Meanings for Chloe

1. Chloe justifies maternal addiction by imparting there were a variety contextual reasons why mothers may be utilizing a methadone program.

2. When reflecting upon the mothers’ emotions, Chloe perceives a paradox of feelings ranging from remorse to good conscience.

3. Chloe describes mothers’ chemical dependence overriding the drive to care for their infant.

4. Chloe believed substance addiction was so powerful that the same mothers were repeatedly giving birth to addicted infants.

5. Chloe pondered mothers’ unknowing of the effects of methadone on their infants behaviours/health.

6. Chloe expressed uncertainty about the length of time the infant displayed the physical symptoms of withdrawal while at the same time desiring safety of the infant with hopes parents found an adequate support system thus avoiding readmission for child physical abuse.

Situated Structural Description

For Chloe, the meaning of nursing families where mothers and infants are addicted to substances involved justifying maternal addiction by imparting a variety of contextual reasons for mothers utilizing the methadone program. When reflecting upon the mothers’ emotions, Chloe perceived a paradox of mothers’ feelings ranging from remorse to good conscience. She believed mothers’ chemical dependence overrode the drive to care for their infants and that substance addiction was so powerful that the same mothers were repeatedly giving birth to addicted infants. Chloe pondered mothers’
unknowing of the effects of methadone on their infants’ behaviours/health. Chloe was uncertain about the length of time the infant displayed the physical symptoms of withdrawal while at the same time she desired safety of the infant with hopes parents found adequate support systems thereby avoiding readmission for child physical abuse.

**General Structural Description**

Once all of the situated structural descriptions had been developed, the final step was the creation of the general structural description. When composing the general structural description, one must “try to determine the most invariant constituents of the experience. An important criterion in this process is whether the structure would collapse if a potential constituent were removed” (Giorgi, 2009, p. 199).

To do this I read and reread the situated structural descriptions until all the similarities had been uncovered, grasping the most general significance of the phenomenon, in effect capturing the lived experience of the phenomenon under study (Giorgi, 1975). In contrast to when determining the situated structural descriptions where I had to suspend labeling and preconception, I consciously reflected upon ideas from behind my theoretical lens; Doane and Varcoe’s (2005) family nursing as relational inquiry. I felt that five important essences emerged and were predominant from the three descriptions. These essences included: (a) nurses experienced a paradox of knowing-unknowing (Doane & Varcoe, 2005) related to a lack of educational preparation, (b) mothers are contextually unique (Doane & Varcoe, 2005), (c) family is viewed as a gendered experience (Doane & Varcoe, 2005) (d) nurses ‘habitual doing’ (Doane & Varcoe, 2005) may cause them to mourn perceived disintegration of the family unit, and (e) there are limitations of using an objective Cartesian lens (the assumption that the mind
and body are separate and facts regarding individuals are unchangeable from context to context) to view situational responses (Doane & Varcoe, 2005). Therefore, the general structural description is as follows: *For nurses, the meaning of caring for families where mothers and infants are addicted to substances involves living a paradox of knowing-unknowing related to educational preparation, with the recognition that mothers are contextually unique and family is viewed as a gendered experience while at the same time acknowledging that habitual doing and the Cartesian lens to view situational responses can influence mourning of family unit disintegration.*

**Summary**

Throughout the course of this chapter I have exposed the analysis-synthesis process of Giorgi’s (2009) descriptive method that revealed nurses’ meaning of caring for families where mothers and infants are addicted to substances. I used Doane and Varcoe’s (2005) family nursing as relational inquiry as the lens for viewing the experience in an effort to enhance understanding of nurses’ meaning of the experience. In Chapter Five, I discuss the significance of these research findings, and will conclude with the implications for nursing practice, education, and research.
Chapter V: Significance and Implications for Practice

Through the analysis-synthesis process, there were five predominant essences identified in the meaning for three nurses’ experiences caring for families where mothers and infants are addicted to substances which are congruent with the theoretical framework guiding this study. These essences included: (a) nurses experienced a paradox of knowing-unknowing (Doane & Varcoe, 2005) related to a lack of educational preparation, (b) mothers are contextually unique (Doane & Varcoe, 2005), (c) family is viewed as a gendered experience (Doane & Varcoe, 2005) (d) nurses ‘habitual doing’ (Doane & Varcoe, 2005) may cause them to mourn perceived disintegration of the family unit, and (e) there are limitations of using an objective Cartesian lens to view situational responses (Doane & Varcoe, 2005). The following chapter will explore the findings in greater depth; examining the significance of these findings as well as the implications for nursing practice, education, and research. First the concepts of knowing and unknowing will be examined.

Examination of the Findings

Knowing-Unknowing

As a person you bring different ‘knowledges’ together in your unique way-filtering them through your own personal framework of understanding, your past experiences, your values, your beliefs and so forth. Subsequently, all knowing is personal because it arises from your own particular perspective. (Doane and Varcoe, 2005, p. 91-92)
Doane and Varcoe (2005) described knowing about families and health as based on multiple factors that included aesthetic patterns, Carper’s typology, empirical knowing, habits, and sociopolitical knowing. The first essence revealed by the analysis-synthesis process describing nurses’ meaning of caring for families where mothers and infants are addicted to substances was that participants described living a paradox of knowing-unknowing which surfaced from a lack of educational preparation on the part of both nurses and mothers. Unknowing has been acknowledged as a fifth pattern of knowing for nursing (Bonis, 2009; Clements & Averill, 2006; Heath, 1998; Holtslander, 2008). This concept was introduced by Munhall (1993) as an addition to the four previous patterns of nurses’ knowing described by Carper (1978) that included empirical (factual knowing), aesthetic (understanding what is of significance to patients), personal knowing (knowledge of self in relation to others), and ethics (knowing what is good and right and making moral decisions). Munhall (1993) argued “Unknowing is not simple, but it is essential to the understanding of subjectivity and perspectivity” (p. 125). Unknowing, often described as a negative phenomenon was actually a positive phenomenon if it was recognized and if appropriate action was taken by the individual experiencing unknowing. All too often when nurses were in a situation that they were unfamiliar with, they built a wall around themselves and closed off emotionally to the situation resorting to what they knew (Doane & Varcoe 2005; Heath, 1998; Munhall, 1993). By engaging in this protective behaviour and not embracing unknowing, nurses were unable to connect with their patients and learn from the patients’ perspectives of what was happening in their particular context. Munhall (1993) and others believed that by not acknowledging unknowing, nurses were not getting the most out of the nurse-patient interaction and
therefore missed important pieces of information as well as were unable to build trusting relationships with patients.

The participants, who were nurses, described unknowing in terms of not knowing “how to care for the mothers” or “what to say” (Anne) to mothers who were addicted to substances. Resorting to the literature to seek information to help guide their actions would have been challenging for these nurses as scant literature was able to be found (Leggate, 2008; Nelson, 2013) describing strategies of caring for and communicating with mothers who have misused substances aside from reviews of maintenance treatment programs for opiate dependent women (Minozzi, Amato, Vecchi, & Davoli, 2008). It should not have been surprising then that Anne disclosed: “I felt like a bad nurse; like I somehow didn't have enough skill to take care of them” and “[t]here really wasn't a lot of information about it. We (the staff) weren't given training about it, and weren't told how to help mothers cope”. Beth admitted to letting the clinical nurse specialist assume responsibility for communicating with and teaching mothers who were addicted to substances writing: “[w]e have a CNS who works with them for weeks-months ac [before] delivery & continues her support during the pp [post-partum] period, time spent in NICU & DISCHARGE”. Chloe echoed this sentiment revealing “[t]hey [the babies] tend to go home cranky and startle with neuro. responses being highly sensitive to noise, touch and everyday care. Gosh knows how long this takes because I no longer see them”. Context is always an important consideration when working with families.

**Mothers are Contextually Unique**

The second aspect of the general structural description (or meaning of the experience) revealed by the descriptions was that nurses and mothers were contextually

unique having different values and concerns which may or may not conform to societal ‘norms’, calling for the use of ‘sociopolitical knowing’ (Doane & Varcoe, 2005). White (1995) wrote that this specific component of knowing was missing from Carper’s typology and argued that sociopolitical knowledge was essential to draw attention to the broader context of practice so that nurses would “question the taken for granted assumptions about practice, the profession, and health policies” (p. 83-84). When I read the participants’ descriptions I was left feeling that the descriptions focused on situational contexts relating to individuals (patients and nurses) having different “values and concerns” (Doane & Varcoe, 2005, p. 59). These differing values and concerns, in turn, may have hindered the “contextual understanding of family health and healing” (Doane & Varcoe, 2005, p. 221) for these nurses. Examples taken from the participants’ descriptions included “It was especially evident on the maternity ward. Those nurses seemed to hate the moms and never wanted to take care of the babies” (Anne), “[m]ost smoke and are off the floor during the day either out smoking ??” (Beth), and “[o]ften either of these two examples [of patients] are so addictive [sic] they never seem to be able to get off the Meth. from pregnancy to pregnancy” (Chloe). Context was an essential component of Doane and Varcoe’s (2005) theory.

Using the phenomenological lens described by Doane and Varcoe (2005), one would see that each individual has different concerns and priorities depending on his/her situation or context as well as other experiences that have brought them to where they are today. It has been said “curiosity and judgment cannot occupy the same space at the same time” (Liz Crocker, personal communication, January 14, 2013). By judging, nurses not only formed opinions but also pushed away patients instead of providing care
(Mitchell & Bunkers, 2003). From the discussion of stigma in chapter two and the examples from the descriptions above, stigmatizing attitudes were formed early in life and carry forward for individuals, including nurses (Bjorkman et al., 2008; Ronzani et al., 2009; Ross & Goldner 2009). Nurses need to push beyond the judging and stigmatizing attitudes they reveal or see portrayed by others in an effort to understand the family contextually, to be more curious, and to demonstrate a desire to understand persons’ and families’ experiences in more depth. Family is who the patient says it is, which does not always conform to a traditional Eurocentric family of a mother, father, and two children (Doane & Varcoe, 2005). From a humanbecoming perspective “family is an indivisible, unpredictable, everchanging connectedness with close others. It refers to the close others that at any given time an individual names as family” (Parse, 2009). The Code of Ethics for nurses directs nurses to be ethically obligated to provide care (Canadian Nurses Association, 2008) and to avoid the use of labeling, stereotypes, and social judgment because these unprofessional behaviours affect the quality of patient or family care (Doane & Varcoe, 2005). Rather than focusing on the judgment and stigma of addiction, nurses may choose to listen to the mother as she describes her experiences, choices, and appreciate that the mother has resisted going back to misusing substances. Context can make an extraordinary difference to the meaning of a situation. Next, family is viewed as a gendered experience.

**Family as a Gendered Experience**

Nurses’ meaning revealed that family was viewed as a gendered experience in relation to societal expectations. More specifically Doane and Varcoe (2005) defined family as a gendered experience as not “merely ‘choices’ made by individuals, but rather
are enactments of wider social values, expectations, and ideologies” (p. 67). Society expects that mothers will assume responsibility for their infants’ care, no matter the circumstance. These expectations were demonstrated by Wuest (2001) who wrote that caregiving can have a tremendous physical and mental impact on women. Further, Stajduhar (2003) and Wuest (2001) found that health care workers reinforce the expectation of women to provide care, which according to Doane and Varcoe (2005) could create or intensify problems for the caregiver. The participants’ descriptions highlighted mothers’ participation, or lack thereof, in infant care. This spoke of participants’ expectations of the mothers’ role, or according to Doane and Varcoe (2005, p. 67) “family as a gendered experience”. Anne reflected “[w]e rarely saw the mothers. That is strange, thinking back on it. Mother's [sic] are always in the NICU, but not these ones”. Beth was more optimistic reporting “[t]he majority seem very keen & attentive to their babies & are easy to care for pts. This is because the CNS has spent a lot of time prenatally preparing them for the post natal period”. Doane and Varcoe’s (2005) critical lens is essential for viewing family as a gendered experience.

Using the critical lens (power, social inequality, and structural determinants of health) described by Doane and Varcoe (2005) one needs to explore why family was seen as a gendered experience. There was woefully little literature examining gender roles in families where mothers were addicted to substances (Robinson, 2006). An article by Somervell et al. (2005) did explore the issue from the perspective of females who misused substances and had had their children removed from their care. They found that women who misused substances, for the most part, felt like failures, believing they had let down their children and that mothers were not supposed to do that. A positive finding
that came from the same study found that these mothers felt hopeful as they were being worked with to understand their needs rather than being disregarded and labeled (Somervell et al., 2005).

Although the majority of the literature reviewed for chapter one focused on parental perceptions of the NICU, Anne, Beth, and Chloe described how they felt when working with mothers with substance misuse issues. Was this because nurses expected the mothers to assume responsibility for the infant and the situation? Nurses may choose to embrace their unknowing and work with families to learn the family members’ perceptions of their family and family roles. The discussion will continue to explore the effect of habits in nursing.

Habits

Another aspect of the general structural description that came to light was that nurses’ habitual doing may influence them to mourn the disintegration of the family unit. Habitual knowing and expectations of what traditionally shapes a ‘family’ may unconsciously influence nurses to grieve its loss (Doane & Varcoe, 2005); this sentiment was expressed by all of the participants. Anne said “[i]t was sad to see babies go to foster homes or not live with their mothers”. Beth recounted “[i]f the mother is a known prostitute and has no fixed address nor any interest in finding a home [it happens] the baby is usually apprehended”. Chloe hoped “the parents get it together and have good supports... So the baby does not come back in with shaken baby syndrome or worse”. Habits play a role in everyday life.

Habits can be helpful as they provide the lived experience and knowing that allow individuals to be efficient in their daily lives (Doane & Varcoe, 2005). Parse highlighted
the importance of habits as a cornerstone (in conjunction with lived beliefs and customs) of what shapes culture (2007) and in turn how culture influenced family (Parse, 2009). For nurses working in a busy hospital or clinic setting, sometimes resorting to habit was the only means of being able to finish the immense amount of work they were expected to complete in a shift. Habits, or taken for granted truths, form our knowing and understanding of families and shape our practice (Doane & Varcoe, 2005); however, Doane and Varcoe (2005) warn that habits can be problematic. From the excerpts taken from the participants’ descriptions above, nurses appeared to mourn the disintegration of the family unit (Anne only refers to mothers, Beth mentions a support person, and Chloe hopes the parents “get it together”). Mourning a loss was itself not problematic, but if nurses in turn negatively changed the way they interacted or changed their habits with families where mothers and infants are addicted to substances and allowed stigma and judgment to lead their interactions with these families, both parties could leave the interaction feeling hurt and unvalued.

Substance misuse is considered a mental health challenge and literature abounds that there is negative stigma associated with substance misuse (Bjorkman et al., 2008; Ronzani et al., 2009; Ross & Goldner, 2009). Families who misuse substances could potentially experience double the judgment and stigma leveled toward them especially if they did not meet nurses’ traditional image of a family and they were living with mental health challenges. Nurses are expected to care for patients no matter the patients’ current reality. Doane and Varcoe (2005) suggested that nurses view their own and family habits from a spiritual lens considering what is shaping a family’s life as well as pondering what matters to the family at their deepest level. Using the spiritual lens, rather than resorting
to the habit of judging families with substance misuse issues as problematic or uncaring, Doane and Varcoe (2005) suggested that nurses listen and learn what the families wanted as well as what mothers needed to provide the best care for their infants. Nurses by no means have to condone substance misuse. Rather, it is nurses’ professional obligation to work with the family however the family presents itself, to help the family obtain from their brief hospital interaction the tools and resources they have identified as needing. The tools could be as basic as learning how to bathe the infant safely, or as complex as putting the infant up for adoption if the family felt it was unable to care for an infant in their current circumstance. The final concept to be explored will be the limitations of Cartesian knowledge when interacting with families.

**Through a Cartesian Lens**

The final phenomenon revealed in the meaning of the experience was nurses’ beliefs that they could determine the ‘truth’ by looking at the ‘facts’. This was in reference to nurses surmising they could use objective Cartesian ‘facts’ to determine what the mothers should or would be feeling, the ‘truth’. Anne pondered “I wonder if they felt judged. I would have”. Beth wrote “[t]he majority seem very keen & attentive to their babies”. Chloe reflected “[t]hese Momma’s often feel guilty and are trying their best; even though it may have been many, many years on the M. Program. Although often they don't appear to feel guilty at all”. Recognizing the limitations of Cartesian knowledge played an important role in Doane and Varcoe’s (2005) relational theory.

Doane and Varcoe (2005) defined Cartesian knowledge as originating from the Western medical model that allowed for the separation of subjective and objective knowledge. They further illuminated this concept by writing:
it is assumed that people can determine ‘the truth’ by looking at the ‘facts’—what can be seen, heard, smelled, tasted, or verified in some concrete way—and those facts are the same regardless of who is doing the knowing (p. 5).

However, this was rarely the case. Thinking back to the example from chapter three of the pregnant woman receiving methadone treatment, using Cartesian knowledge, she must be a substance misuser (truth) because she misuses substances (facts). Conversely when switching to the lens of Doane and Varcoe (2005), our perceptions change as we consider all of the relational factors that had brought the young woman to this point in her life. Crocker and Johnson (2006) summarized this point very well when they emphasized “the importance of honoring the uniqueness of patients and families and acknowledging their concerns, worries, and values” (p. 6) in describing the take-home message from their book entitled, *Privileged Presence* (2006).

Doane and Varcoe (2005) highlighted another limitation of the Cartesian perspective in that facts were unchangeable from context to context, so in following that belief what is known about family would be transferrable to all families. This assumption is not correct using relational inquiry (Doane & Varcoe, 2005). The literature described how nurses continued use a service model of care that directed attention to decontextualized problems rather than engaged a socio-environmental perspective of being and learning what families needed rather than being an expert doing to the patient or family (Austin, 2011; Doane & Varcoe, 2005). The stance of expert leads to compounding feelings of unknowing, dissatisfaction, helplessness, and inadequacy that could possibly reinforce judgment and stigma: a situation that benefits no one (Doane &
Varcoe, 2005). The discussion will now explore rigour and why these findings are significant.

**Rigour and Significance**

The four requirements outlined by Annells (1999) guided how I ensured the rigour of my research. The first criterion was that the interpretation must be understandable to the reader. This was accomplished by writing the results in a clear, succinct, and interesting way so that nurses who read the findings would understand their meaning. Next, the researcher must make explicit and understandable the process of inquiry. I achieved this by making the analytical process transparent (in chapter four) and using of field notes throughout the research process in order to become self-aware. The fourth criterion was in reference to the researcher’s approach to inquiry or the chosen research methodology. It must be congruent with the research question, demonstrated earlier in chapter three in that my research question drove the research method selection.

According to Annells (1999) the third criterion posits that the outcome of the research should be useful in informing nursing practice and be of benefit to those receiving care. Throughout the process of researching and writing this thesis, I did not encounter a single piece of literature describing nurses meaning of caring for mothers and infants with substance misuse issues. This is quite extraordinary considering the volume of work that I have reviewed as well as the statistics from chapter one illustrating a three-fold increase in the prevalence of NAS between 2000 and 2009 (Patrick et al., 2012). Nurses knew they were seeing more and more families where mothers and infants have substance misuse issues and the published data supported this supposition. So, why was there a dearth of literature describing nurses’ meaning of working with this population?
Arguably, it was nurses who had the most contact with and provided the majority of care for this vulnerable population. In chapter two, I cited literature that described how nurses interacted with patients, consciously or unconsciously, directly affected how patients felt and in turn how they acted (Ferrell, 2010; Pauly et al., 2007). Therefore, I believe I have fulfilled the third requirement of Annells (1999) in that this work informs current nursing practice. Through having the results available for nurses to read, the hope is nurses will choose to become aware of the profound impact of their actions on patients and this may in turn lead them to choose to act differently when interacting with this population of patients. The limitations of the study will now be presented.

**Limitations of the Study**

Participation in this study was limited to people who spoke English and were able to access and use email, so the findings must be viewed keeping those limitations in mind. It is possible there were other individuals who wanted to participate but were unable to do so because of their in-access to email. Another limitation was the number of participants from which the general structural description was drawn. Traditionally, one would consider that having only having three participants would make the findings limited. However, according to Giorgi small sample sizes are utilized in phenomenological research and they do not take away from the findings (Giorgi, 2009; Kleiman, 2004). The findings or general structural description is the meaning of the experience for these three participants and the findings may or may not resonate with others who are living a similar experience. One should always remember there may be other perspectives which could be illuminated by other nurses working in the NICU and post-partum settings. Next, my personal reflections will be offered.
Reflections

The purpose of this research was to synthesize a general structural description of nurses’ experiences caring for families where mothers and infants are addicted to substances using Giorgi’s (2009) descriptive phenomenological method with results viewed through the lens of Doane and Varcoe’s (2005) family nursing as relational inquiry. Completing this work was a major undertaking and something that would have never come to fruition without the descriptions provided by my research participants Anne, Beth, and Chloe. I am grateful for their choice to share their experiences.

As was revealed from my field notes in chapter four, there was a time when I truly questioned my ability to extract the meaning of phenomenon from the participants’ descriptions. This was not because the descriptions lacked meaning; rather because I doubted my ability to assume a phenomenological attitude. By reading and rereading I became very familiar with Anne’s, Beth’s, and Chloe’s descriptions and I found this concern subsided.

What made the process sometimes frustrating was the lack of literature on the subject of how nurses felt caring for families where mothers and infants are addicted to substances. One could argue the lack of literature makes this work a valuable tool for others who may choose to explore this phenomenon. I am hopeful that my belief in the importance of this work will encourage others to explore the same issue to illuminate how nurses feel caring for families where mothers and infants are addicted to substances in hospital as well as out-patient clinic settings. I also hope that practicing nurses will choose to read this work perhaps to increase their own knowledge and learn how other nurses may or may not be feeling when working with this vulnerable population.
On reflection, one aspect of this project that I found to be disappointing was the response from using Twitter as a recruitment method. Recalling from chapter three, I described the novel use of Twitter as a means of connecting with a large and geographically diverse group of potential research participants. Although I tweeted on multiple occasions using a variety of messages, none of my three descriptions were obtained using this method. However, I now have 34 Twitter followers, most of whom are nursing organizations that allowed my tweets to be passed on to their followers. My feelings are summarized in this excerpt from my field notes:

August 1, 2012

I am starting to doubt my choice to recruit using Twitter - I have yet to receive any responses. Am I using it to its full ability? Or is it just because I’m recruiting over the summer?? Hopefully things will pick up in September. I have 14 followers- and not just single individual followers. Most are organizations with LOTS of followers.

Although I did find this lack of response to be disappointing, I would not hesitate to use Twitter again for the recruitment of participants for future projects. Every day the membership of Twitter increases and those using it become more comfortable with responding to received tweets. I have little doubt this method of recruitment will begin to have major use in future research projects.

After completing this work, I still believe collecting the descriptions via email was suitable, the use of Giorgi’s (2009) descriptive phenomenological method was the most appropriate analysis-synthesis method, and Doane and Varcoe (2005) family nursing as relational inquiry was the most fitting lens through which to view the results.
Receiving written descriptions prepared by the participants allowed me to focus my attention on the participant’s words, exactly as the participant’s wanted their words presented. Giorgi’s (2009) descriptive method was fairly straightforward to use and allowed what I believe to be the correct meaning of the phenomenon to emerge. Doane and Varcoe’s (2005) relational inquiry lens was also congruent with my research as it focused on family and how to best interact with families in situations where nurses’ knowing may not have provided the best possible outcomes. Next the discussion will proceed to recommendations for practice, education, and research.

Recommendations

Implications for Practice

Doane and Varcoe (2005) advocated for nurses to take a relational approach to family nursing and use phenomenological, critical, and spiritual lenses while working with patients. They believe it “greatly enhances our ability to know and respond to people/families, in particular, it allows us as nurses to connect across differences” (Doane & Varcoe, 2005, p. 9). Patients also recognized the value of the relational approach. In a collection of true short stories, one nurse who wrote of her experience as a family member of a patient revealed “I learned that the best professionals are those who are open to sharing what they know and what they don’t. I learned about asking patients what is important to them rather than telling them what was important to me” (Crocker & Johnson, 2006, p.145). Many nurses have limited personal experience of what it means to have substance misuse issues and be pregnant at the same time. Current estimates are between 6% and 10% (McHugh, Papastrat, & Ashton, 2011; Wright, McGuiness,
Moneyham, Schumacher, Zwerling, & Stullenbarger, 2012) with one reference estimating 20% of nurses having substance misuse issues (Monroe & Kenaga, 2011), whether they are also pregnant remains unfounded. Rather than building a figurative ‘wall’ blocking patients’ needs, nurses need to acknowledge their own unknowing whilst recognizing “each patient has a unique perspective of [his/her] situated context and a unique perspective of who [he/she] is as a person in the world” (Munhall, 1993, p. 126), while working with the patient and being open to them guiding us through the interaction and their specific needs. Doane and Varcoe (2005) suggested nurses could incorporate the teachings of Parse (2010) and the theory of humanbecoming to guide their family practice. Parse (2010) described reverence one of her four ethical tenets of human dignity as “solemn regard for human presence” and that “humans are mysteries living co-created pattern preferences in contextually construed situations” (p. 258). By approaching families with reverence, nurses need to be aware that differences, ambiguity, and unknowing are inherently human qualities not to be feared but rather to be embraced and acknowledged as such (Parse, 2010). Learning is a lifelong journey and as nurses we have the privilege of guiding-following others on their journeys towards awareness, appreciation, and trust (Rosemarie Rizzo Parse, personal communication, April, 2012)

Nurses are obligated by the requirements of their professional organization to reflect upon their experiences and nurses have been educated on the importance of this practice during their time as undergraduates. Doane and Varcoe (2005) echoed the same sentiment concerning the need for self-reflection. What is needed is conscious reflection on practice, by that I mean when reflecting on a situation that may have been troubling or rewarding, nurses needs to think what brought them to that situation and what could have
been done differently to prevent or encourage the end result. There are many tools available to help complete the reflective process but the first step is acknowledging the importance of being reflective. In instances of working with families where mothers and infants are addicted to substances, nurses should examine their feelings towards the situation. That way nurses could be conscious of how they interacted with the family perhaps being careful not to phrase conversations or exhibit nonverbal cues that could be construed as judgmental or stigmatizing, or follow other nurses whose perspectives may be unprofessional (Leggate, 2008; Nelson, 2013). Living and demonstrating professional presence makes families feel welcome and comfortable to ask questions about their infants (Catherine Aquino-Russell, personal communication, February 9, 2013).

Another method to decrease unknowing, this time on the part of families would be to encourage mother-infant bonding. From the information presented in chapter one, it was shown that there were a number of factors that affected how mothers bonded with their infants. Rather than focusing energy on judgments of mothers with substance misuse issues, nurses may choose to embrace the time they have with these mothers to learn what the mothers want to know and guide that learning through the encouragement of mother-infant bonding. Although there are many estimates of the length of time it takes for bonding to occur (Bienfait et al., 2011; Figureiredo et al., 2007), any time a mother feels unwelcome being with her child decreases the opportunity for bonding to transpire. Many times women with substance misuse issues may have come from challenging family situations and may therefore have numerous questions and need encouragement that what they are doing is of benefit for their infant. By encouraging family presence in clinical settings and accepting family members not as visitors but as
allies in health care (Crocker & Johnson, 2006) and by providing positive reinforcement of mothers’ actions, nurses will build the foundations for trusting relationships. Trusting, non-judgmental relationships form the essential basis for nurse-family relationships (Nelson, 2013). This leads to implications for education.

**Implications for Education**

The nurses who provided descriptions all voiced ‘unknowing’. Their unknowing was precipitated by a lack of education concerning how to connect with mothers who misused substances and in turn how to connect mothers with their infants. This unknowing provoked judgment by nurses, led to mourning of the disintegration of the family unit, and highlighted the limitations of objective Cartesian knowledge. I propose that all of the above issues could begin to be resolved through the introduction and use of relational inquiry (Doane & Varcoe, 2005) in family nursing, reflection on practice or self-awareness (Doane & Varcoe, 2005; Owens, 2007; Perraud et al., 2006; Rayner at al., 2005; Scheick, 2011; Swatton, 2011); the encouragement of mother-infant bonding (Figureiredo et al., 2007; Franklin, 2006; Fraser et al., 2007; Hunt, 2008; Kearvell & Grant, 2010; Martinez et al., 2007); as well as changing the focus from family as visitors to family as allies (Crocker & Johnson, 2006). This education could occur in undergraduate programs and graduate programs and is in fact happening in some programs (Catherine Aquino-Russell, personal communication, February 9, 2013). For nurses not undertaking additional university education, it could also occur as short in-service education for those who are working with this vulnerable population of women and infants. Education is a tool that if used correctly and in a nonjudgmental way can go
a long way to enhance understanding of families. Finally, the discussion will explore implications for further research.

**Implications for Further Research**

Research, regardless of the method of study, is important to increase knowledge of phenomena for which one lacks understanding. Suggestions for further research include:

- Exploration of effective patterns of communication with mothers of infants who are living with substance misuse issues. Anne disclosed that she felt ineffective when caring for mothers with substance misuse issues as she did not know what to say to help the mothers cope.

- Another topic worthy of further research would be the examination of gender roles in families where mothers and infants are addicted to substances. There is substantial literature describing the demographics of families who misuse substances but very little describing the roles taken on by each family member under these circumstances.

- There is a complete lack of descriptive literature exploring how families with substance misuse issues feel they are treated within NICUs and the post-partum hospital setting. Further study into this topic would complement the findings of this study and go a long way to decreasing unknowing on the part of nurses and mothers.

- A final recommendation for further research is to recruit a larger sample of nurses’ experiences of caring for families where mothers and infants are addicted to substances to gain a greater understanding of the phenomenon.

Additional research on any of the above mentioned topics would increase nursing knowledge of the meaning of nurses’ experiences caring for families addicted to
substances, which has already been demonstrated to be lacking. Anytime one seeks to uncover the views of individuals living an experience will serve to shed light on common experiences and meanings while also clarifying unique individual experiences (Aquino-Russell, 2003).

**Conclusion**

By bringing the general structural description back to the words of the participants it was shown that nurses expressed unknowing and sometimes discomfort when caring for families where mothers and infants are addicted to substances. Through the course of this work, I have uncovered and discussed the meaning of the lived experience for three nurses of what it was like caring for families where mothers and infants are addicted to substances. I have also shown how the rigour of this work was assured, the limitations of the research, my personal reflections on the research process, and identified recommendations for practice, education, and research. By reflecting on their own practice, these findings may resonate with nurses who may choose to enhance their knowledge and understanding of families’ experiences and alter the way they interact with families who have substance misuse issues through suspending judgmental attitudes and acknowledging contextual realities.

**Summary**

The prevalence of families where mothers and infants have substance misuse issues is increasing (Patrick et al., 2012). The increasing prevalence means that nurses who work with populations of post-partum women and families will at some point care for families where mothers and infants are addicted to substances. There is relatively little
information or guidance available to nurses to help them navigate this issue. Therefore, it is essential that nurses and other healthcare professionals who work with this population understand what it means to care for a family with substance misuse issues. By using Giorgi’s (2009) descriptive phenomenological method I have synthesized the meaning of three nurses’ experiences of caring for families where mothers and infants are addicted to substances; meaning units, focal meanings, and situated structural descriptions were extracted before finally synthesizing a general structural description of the phenomenon.

This research was guided using Doane and Varcoe’s (2005) family nursing as relational inquiry. This study indicated that this philosophical lens had the potential to guide nurses’ interactions with families with substance misuse issues. I hope by sharing this work, nurses, who work with this vulnerable population, may choose to embrace their unknowing and reflect on what they can do to encourage relational practice in their workplaces and amongst their peers because “the future depends on what we do in the present” (Gandhi, n.d.).
References


Substance Abuse and Mental Health Administration. (2011). Results from the 2010 national survey on drug use and health: Summary of national findings. *NSDUH Series H-41, HHS Publication No. 11-4658.* Rockville: MD.


I am a Masters of Nursing student. When working in the NICU, I cared for families with mothers and infants who were addicted to substances.

I am interested in finding out about other nurses’ experiences caring for this population of families.

Would you be interested in participating in a study about nurses’ experiences of caring for families where mothers and infants are addicted to substances? I would like you to contact me if:

- you have worked as a registered nurse with families where mothers and infants are addicted to substances,
- you read and write in English,
- you are willing to write about your experiences, and
- you are willing to submit a description using email.

Please contact me if you are interested in participating: claire.williams@unb.ca. If you have any other questions, you may contact my thesis supervisor, Dr. Catherine Aquino-Russell-caquinor@unb.ca, or Dr. Kathy Wilson, Assistant Dean of Graduate Studies UNB-kcwilson@unb.ca.

Thank you for considering participation in my research.

Claire Williams, Master of Nursing Student, University of New Brunswick
UNB REB# 2012061
Horizon Health Network REB# 2012-1750
Appendix B - Letter of Invitation

THE MEANING OF NURSES’ EXPERIENCES OF CARING FOR FAMILIES WHERE MOTHERS AND INFANTS ARE ADDICTED TO SUBSTANCES
Claire Williams, UNB Master of Nursing Student

Purpose
This study is about enhancing what is known about what it is like for nurses to work with families where mothers and infants are addicted to substances. You are invited to write to me about your experiences: if you are a registered nurse who provided care to families where mothers and infants are addicted to substances, if you read and write in English, if you are willing to write about your experiences, and if you are willing to submit a description using email.

Method
Participation will involve a written response in Word document format or in the body of an email. You may write as much or as little as you wish. You do not have to use your own name; you may choose a false name. A false name is the name that will be used in email correspondence. Please include your sex and years of experience as a registered nurse. All other identifying information will be altered or deleted. Any identifying information will be altered or deleted; this extends both to the identity of the participating RN and the family about which you are providing information.

You may wish to set up a specific separate email account from your regular email account for this project; for example, falsename@hotmail.com. If you do so, I will have no way of knowing who you are. You will only receive email from me, Claire Williams, at that specific email address. You can respond to my email using reply. After you have written your description to your satisfaction, you can attach your Word document or place your description in the body of the email and send it to me, the researcher at claire.williams@unb.ca, preferably within one month of receiving this information sheet please. Your email will be accessible only to me, the researcher. Your document will be saved on a USB drive and kept in a secure location when not in use. A hard copy will be kept in a locked cabinet. All information will be kept confidential and coded with a letter. Please note that I may contact you after you submit your description if I require clarification of your description.
Descriptions will be destroyed/deleted 7 years after completion of the study. If you would like a copy of the findings, please indicate this in your email. A copy will be sent to you at the email address you provided. No reference to your chosen name or identifying information will be used in any reports, presentations, or papers.

**Risks**

If you choose NOT to use a false name or create another email account for this study, your private information is subject to the risks of using email. An unsecured email carries risks including breach of confidentiality and loss of anonymity through chance receipt, tracking, or third-party interception. As well, email programs store copies of received and sent documents. Thus, it is suggested that copies are erased.

**Benefits**

Being involved in this research may have no benefits. You may like having the chance to share your thoughts. Participation may enhance others’ understanding of nurses’ experiences of caring for families where mothers and infants are addicted to substances.

**Withdrawal**

You may stop participation by not sending the document; or by notifying the researcher at any time that you do not want your document used in the analysis.

If you wish more information about the study before you decide to participate, please email Claire Williams at claire.williams@unb.ca.

If you have other questions you may contact Dr. Catherine Aquino-Russell, thesis supervisor for Claire Williams, at caquinor@unb.ca; or Dr. Kathy Wilson, Assistant Dean of Graduate Studies UNB, at kewilson@unb.ca.

Thank you,
Claire Williams, MN Student
UNB Faculty of Nursing
claire.williams@unb.ca

This project has been reviewed by the Research Ethics Board of the University of New Brunswick and is on file as REB 2012061
This project has been reviewed by the Research Ethics Board of the Horizon Health Network and is on file as 2012-1750
Curriculum Vitae

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Conference Presentations:
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The Moncton Hospital, Moncton, New Brunswick

7th International Nurse Practitioner/Advanced Practice Nursing Network Conference, August 20-22, 2012
Imperial College, London, England, UK
Voice, Value, and Successes of the Clinical Nurse Specialist in New Brunswick, Canada With Serena Jones B.Sc., BN, RN and Dianne McCormack RN, Ph.D.

17th Annual Nursing Research Day, April 27, 2012
University of New Brunswick, Fredericton, New Brunswick
The Meaning of Nurses’ experiences of Caring for Families Where Mothers and Infants are Addicted to Substances

17th Annual Nursing Research Day, April 27, 2012
University of New Brunswick, Fredericton, New Brunswick
Defining the Clinical Nurse Specialist (CNS) Role in New Brunswick With Serena Jones B.Sc., BN, RN and Dianne McCormack RN, Ph.D.

Atlantic Region- Canadian Association of Schools of Nursing (ARCASN) Annual Conference, June 17 2011
St. Francis Xavier University, Antigonish, Nova Scotia
Defining the Clinical Nurse Specialist (CNS) Role in New Brunswick With Serena Jones B.Sc., BN, RN and Dianne McCormack RN, Ph.D.