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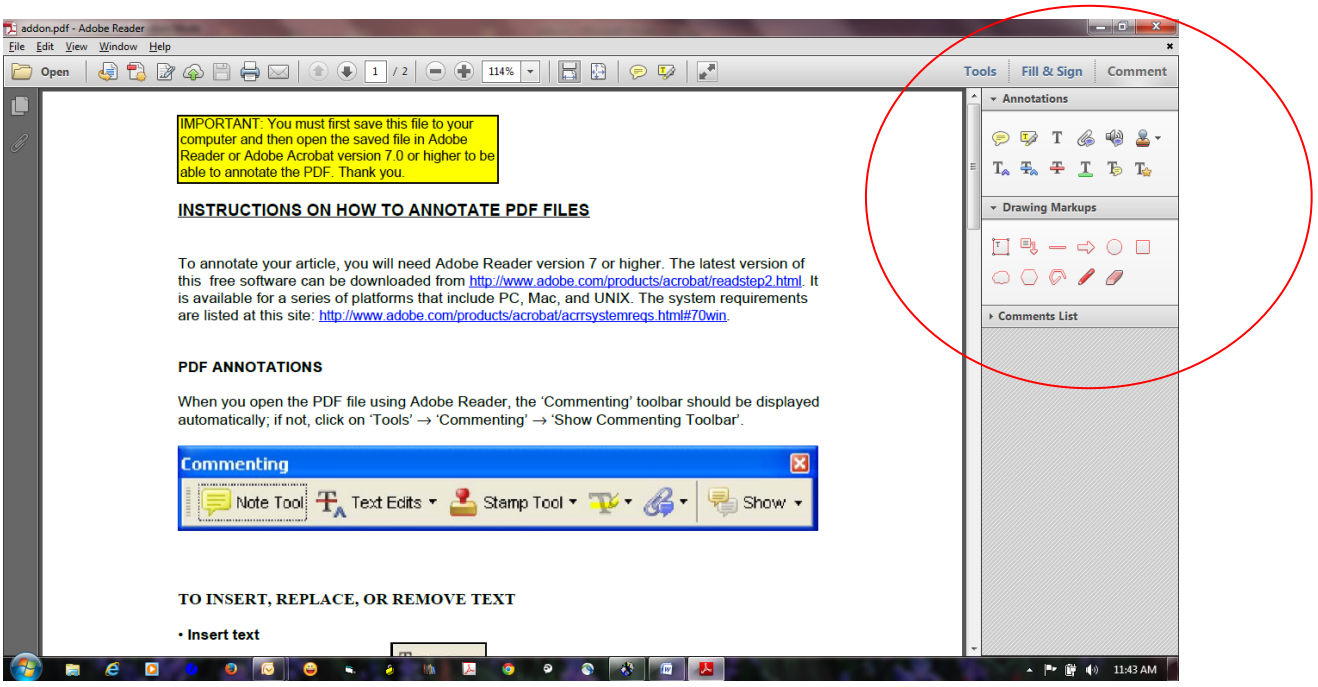

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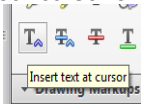
Place your cursor on the space where you want to insert new text. Click the button "Insert text at cursor" 

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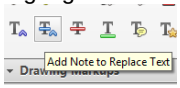
Highlight the text you want to replace then click on the button "Add Note to Replace Text" button 

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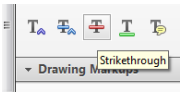
Highlight the text you want to delete and click on the Strikethrough button 

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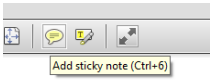
Click on the “Add sticky note (Ctrl+6)" button 

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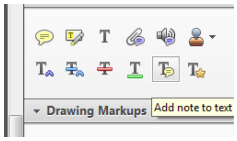
Click on the “Add note to text” button 

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Perspective

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A Call for Compassionate Care

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Karen Alexander, MSN, RN

Abstract

The Substance Abuse and Mental Health Services Administration (2014) reported that 1.1% of pregnant women used nonprescription opiates (either heroin or prescription pills) in the last 30 days. Methadone and buprenorphine are the most common treatments for opiate addiction in pregnant women. Reasons for seeking opiate maintenance treatment (OMT) include keeping custody of one's children and the hope of developing a healthy parenting relationship. Yet, healthcare organizations and professionals have mixed opinions regarding health promotion within the maternal OMT population.Proper education regarding the growing and complex opiate epidemic continues to remain a void for many healthcare professionals. It is imperative that nurses who regularly interact with women in OMT show compassion and competence. It is important to highlight the universality of the challenges and needs of caring for the OMT population. This Perspectives column will explore and describe the context of maternal nonprescription opiate use and the care mothers in OMT should receive based on established nursing ethical standards.

Keywords: compassionate care, neonatal abstinence syndrome, opiate maintenance treatment

BACKGROUND

In the United States, individuals with opiate use disorders have the second highest rate of admission to rehabilitation treatment, second to alcohol use disorders (McHugh, Wigderson, & Greenfield, 2014). Currently, opiate overdose is the leading cause of death for individuals aged 25–45 years in the United States (Saia et al., 2016). The Substance Abuse and Mental Health Services Administration (2014) reported that 1.1% of pregnant women used nonprescription opiates (either heroin or prescription pills) in the last 30 days. Between 2000 and 2009, a fivefold increase in maternal opiate use was reported and gained attention nationally (Patrick et al., 2012). The subsequent threefold increase in infants diagnosed with neonatal abstinence syndrome (NAS) during the same decade is not surprising and extended the concern from mothers to their children (Tolia et al., 2015).

Opiate detoxification is not advised during pregnancy because of the risks to the fetus (Kocherlakota, 2014). Methadone and buprenorphine are the most common treatments for pregnant women experiencing opiate addiction. Opiate addiction recovery programs provide parenting classes, social support, and psychotherapy, in addition to medication management. Reasons for seeking opiate maintenance treatment (OMT) include keeping custody of one's children and the hope of developing a healthy parenting relationship (Secco, Letourneau, Campbell, Craig, & Colpitts, 2014). In many states, OMT is the only option for pregnant women using nonprescription opiates to maintain custody of their children. With proper resources and support, positive adaptation to the role of parenting can occur within the context of OMT.

It is imperative that nurses who regularly interact with women in OMT understand the family's context and then also show compassionate care. This Perspectives column will explore and describe the context of maternal nonprescription opiate use and the care mothers in OMT should receive based on established nursing ethical standards.

CONTEXT AND SOCIAL DETERMINANTS OF HEALTH

Nursing leaders and scholars heard the call to action to focus on social determinants of health and their effects on long- and short-term health outcomes from the Institute of Medicine (Mahony & Jones, 2013). Subsequently, nursing curricula are changing to reflect competencies regarding prevention, health disparities, social justice, and upstream policies, which influence health. The important change to address social determinants of health needs to extend to all populations, including mothers who are substance using or recovering.

Mothers are the most important factor in the survival and flourishing of infants exposed to opiates prenatally (Jones et al., 2016). However, significant obstacles and barriers stand in the way as mothers seek to develop a parenting relationship with their infants. Contextual factors that increase the risk for poor parental adaptation of mothers in OMT include mental health comorbidities, history of trauma, inadequate social capital, and poverty (Alexander, 2013; Griffiths et al., 2009; Suchman, McMahon, Slade, & Luthar,

Karen Alexander, MSN, RN, Thomas Jefferson University, Philadelphia, Pennsylvania.

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Correspondence related to content to: Karen Alexander, MSN, RN, Thomas Jefferson University, 130 S. 9th St., Philadelphia, PA 19125.

E-mail: Karen.Alexander@jefferson.edu

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2005). In addition to other mental health comorbidities, high rates of postpartum depression, close to 50%, were reported in multiple studies of mothers in OMT (Holbrook & Kaltenbach, 2012; Secco et al., 2014). Some mothers in OMT also experience the added stress of watching their infants' withdrawal from their treatment drug in the neonatal intensive care unit (NICU).

Health occurs within a person, in a place, and at a particular point in time. For families, health is created, destroyed, maintained, and restored through a lifetime of interactions with one's behavior, genetics, and social and physical environment (Moreira, Gouveia, Carona, Silva, & Canavarro, 2015; Schytt & Waldenström, 2007). Drug use and addiction are not an exception to this reality. Drug use is initiated and sustained for factors that are not always in the control of the individual. The aspects that influence drug use include availability, peer pressure, neighborhood, and family stability (Binswanger et al., 2012; Earnshaw, Smith, & Copenhaver, 2013). These social determinants all contribute to the health of an individual and must be part of the awareness of nurses caring for populations with histories of drug use. It is foundational while working with mothers in OMT to show respect and partnership through seeing the mothers in the context of their social determinants of health. Addressing each of these factors will promote health in individuals and populations and is a call of each nurse.

A CALL FOR COMPASSIONATE CARE

Research finds that healthcare professional's attitudes toward addiction affect recovery success and health outcomes (Earnshaw et al., 2013; Van Boekel, Brouwers, Van Weeghel, & Garretsen, 2013). Healthcare professionals are reported in the literature as exhibiting a negative attitude and a lack of desire to work with individuals reporting substance use (Van Boekel et al., 2013). Stereotypes and biases surrounding people with illicit substance use history include ideas of inherent weakness, uncleanness, noncompliance, and criminality (Earnshaw et al., 2013). Enrolling in a drug treatment program does not often detract from bias but may increase it.

Nurses without specialization in addiction recovery and treatment interact with mothers in OMT through various avenues and specialties. Nurses in the NICU are especially involved in caring for these families for long durations as a result of infant withdrawal. Patrick et al. (2012) reported that one baby is being born diagnosed with NAS (evidenced by withdrawal symptoms) every hour in the United States. Distressing indicators such as poor feeding, tremors, high-pitched cry, and fever can occur in the first 3–7 days after birth. Nationally, 4% of NICU beds are occupied by babies diagnosed with NAS (Tolia et al., 2015). This fact alone necessitates non-addiction-specialized nurses to be in close relationship with mothers in OMT while caring for their infants.

The sustained periods NICU nurses care for infants diagnosed with NAS and their families have prompted studies investigating nursing care. From the nurses' perspective, studies have specifically described the moral dilemmas experienced by nurses who care for infants with NAS (Fraser, Barnes, Biggs, & Kain, 2007; Maguire, Webb, Passmore, & Cline, 2012; Silva, Pires, Guerreiro, & Cardoso, 2013). Often, nurses view mothers in OMT through a negative light because of the clear pain caused by NAS in their infants (French, 2013; Maguire, 2013). NICU nurses have also voiced a lack of training to help mothers engage and participate in their infants' care as well as a feeling of inadequacy as they attempt to calm the infants in withdrawal (Maguire et al., 2012). Nurses can perceive the infant's pain as caused by the mother and not include her in care as readily as other parents. Nurses caring for families in OMT have also expressed alarm over the verbal abuse received from mothers, inconsistent visitation by mothers, and certain mothers' ambivalence toward caring for the infant (Maguire et al., 2012). The stigma of OMT can then perpetuated and results in a devaluation of the mother's humanity.

Yet, in reality, the mothers are maintaining recovery through a medically supervised program to stay connected to their child and do what they have been told is best for their child (Suchman et al., 2005). In fact, separation from their children is seen in the literature as resulting in depression, poor addiction recovery outcomes, and a diminished sense of identity (Secco et al., 2014). Instead, a caring behavior such as offering a mother privacy to hold her infant in a welcoming environment can eventually contribute to the well-being of the infant through encouraging the mother's bond (Cleveland & Gill, 2013). With women in OMT already bearing significant burdens, the added stress of parenting in the NICU can be nearly impossible to manage alone. Nurses' support (or absence of support) as healing partners alongside mothers as they care for their newborn children should not be underestimated.

An intersection of the stigma of drug addiction and a nurse's duty to perform caring behaviors occurs when working with mothers in OMT. From the mother's perspective, women have expressed an awareness that the nurses do not show comprehension of addiction and recovery (Cleveland & Bonugli, 2014). Mothers in OMT feel guilty for the withdrawal symptoms the infants are experiencing. The mothers have often already been rejected, traumatized, and punished by family, society, and criminal justice systems (Earnshaw et al., 2013). Subsequently, a therapeutic relationship must be built. The juxtaposition of drug use history and maternal identity must be resolved through addressing our call to compassionate care for the entire family, despite their past or current context.

Recognizing the human dignity of mothers in OMT creates an opportunity for nurses learning to care for these families as a whole. The *ANA Code of Ethics* (American Nurses Association, 2015) Provisions 1.1 and 1.3 require nurses to honor human dignity and recognize the nature of an individual's health context. This can be realized through listening to mothers' stories, reflection, journaling, and discussion with addiction specialists. Training for nurses that allows for this type of interaction exists in several states through collaborative efforts, such as the Vermont Oxford Network (Patrick et al., 2016).

Reflection and interaction with the mothers' stories can help resolve bias. Presence is also essential to allow these

women to recognize that nurses want to have a relationship with them. Furthermore, sharing and openness with the mothers create a positive environment for a relationship to grow (Cleveland & Gill, 2013). Providing an affirming presence begins to form trust and brings hope to the long journey for women in OMT. Beyond reflection, presence, and openness, methods need to be shared that empower nurses to provide intervention and referral to further treatment when necessary (Puskar et al., 2013). Finally, experts agree that more exposure and experience with colleagues who practice compassionate care toward populations with substance use history increase the healthcare environment's compassion in general toward this population (Van Boekel et al., 2013).

CONCLUSION

According to the *ANA Code of Ethics* (American Nurses Association, 2015), nurses must "establish relationships of trust and provide nursing services according to need, setting aside any bias or prejudice" (p. 1). A caring relationship is central to the work of a nurse, despite the context within which a patient has lived his or her life. Researchers and scholars have called for formalized education for nurses regarding substance use and its maternal context (Fraser et al., 2007; Maguire et al., 2012; Puskar et al., 2013). Judgment from nurses regarding drug use is a frequent finding of qualitative research studies conducted with opiate-maintained mothers (Cleveland & Gill, 2013; Earnshaw et al., 2013; Van Boekel et al., 2013). Therefore, it is important for all nurses to recognize the fear, guilt, and shame present within the mothers' worldview (French, 2013). Mothers are often functioning without a firm maternal identity, and nurses can stand alongside these women as they learn their role.

Recognizing the mothers' context of health, addressing personal biases, and creating a relationship are important steps in providing nonjudgmental, compassionate care for mothers in OMT. In addition, placing the whole family's health at the center of care is essential for nursing practice. This focus cannot be ignored when caring for infants and mothers exposed to opiates. Our call as nurses and our standards of practice demand it.

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