Beyond the Incubator: The Experiences of Mothers of Infants with Neonatal Abstinence Syndrome

by

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Abstract

Neonatal Abstinence Syndrome (NAS) is a serious condition in newborns experiencing withdrawal from substance exposure in pregnancy. Symptoms affect an infant’s central nervous system and metabolic, vasomotor, respiratory and gastrointestinal systems, and this condition could lead to seizures or death if left untreated. The rate of newborns diagnosed with NAS is on the rise, with approximately one infant born every hour in the US demonstrating signs of withdrawal.

Research and practice in the field of NAS has focused on the vulnerable infant in a medical model that addressed symptomatology, toxicology screening, pharmacological treatment, and length of hospital stay. Little is known about the contextual factors in the lives of affected infants despite the fact that infants will be eventually discharged from the hospital to the family home or into the child welfare system. More importantly, the experiences of mothers of infants with NAS is absent in the literature. A more comprehensive understanding of mothers’ experiences is needed to expand the understanding and treatment of NAS in a larger social context.

Newborns are completely reliant on a caregiver to meet their basic needs. Therefore, to diagnose and treat an infant without an understanding of the maternal experience may serve to fragment the mother-infant relationship. The purpose of this research is to explore and describe the lived experiences of mothers of newborns with NAS. This understanding may influence the development of a more comprehensive treatment of NAS that extends beyond the incubator.

To accomplish this inquiry, I used descriptive phenomenology and conducted face-to-face interviews with eight mothers of infants with NAS. Data was collected in Thunder Bay, Ontario between August 2011 and December 2011. Following the interviews, I used Colaizzi’s model of
thematic analysis that aims to describe the experiences that were common across participants. Analysis revealed nine themes: 1) trauma, abandonment and loss; 2) the cyclical nature of depression; 3) the trajectory of drug use; 4) becoming a mother: pregnancy; 5) self-sacrifice: the paradox of methadone maintenance; 6) being a mother: experiences with the newborn; 7) ambiguous motherhood; 8) against the odds: resilience and overcoming obstacles; and 9) the meaning of motherhood. Each of the themes contributed to uncovering the transformative nature of motherhood. This transformation is the essence of participant’s experiences with NAS. Prior to this dissertation, there was a lack of scholarship exploring the experiences of mothers of infants with NAS. These findings influence a more holistic appreciation of NAS that extends beyond the newborn and is inclusive of the mother. Understanding the experiences of mothers may reduce stigma, encourage early and comprehensive intervention for mother and newborn, and lead to a greater understanding of the challenges and unique needs of mothers.
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CHAPTER 1: INTRODUCTION

The birth of a baby is often a highly anticipated life event that is welcomed by expectant parents. However, for pregnant women who use substances, the anticipation of birth is often filled with anxiety and concern resulting from their drug use and its potential impact on the newborn. A substantial body of research has concluded that drug use by pregnant women has implications not only for maternal health, but also for the health of the newborn (American Academy of Pediatrics Committee on Drugs, 1998; Finnegan, Kron, Connaughton, & Emich, 1975; Jansson & Velez, 1999). These studies conclude that one potential effect of prenatal substance use is the development of a withdrawal condition in infants known as Neonatal Abstinence Syndrome (NAS) (Finnegan et al., 1975; Lifshitz, Gavrilov, Galil, & Landau, 2001). NAS is characterized by a range of symptoms in newborns that affect the central nervous system and that also include gastrointestinal, metabolic, vasomotor and respiratory disturbances (Finnegan et al., 1975; Kuschel, 2007; Marcellus, 2007). This condition can lead to seizures or death if left untreated (Finnegan et al., 1975). Research on NAS is replete with medically focused assessments and interventions (D’Apolito & Hepworth, 2001; Finnegan et al., 1975; Johnson, Greenough, & Gerada, 2003; Sundquist Beauman, 2005). However, due to the psychosocial complexities of the syndrome, NAS is an important clinical and research area for social workers.

Researching the prevalence of NAS can be difficult, particularly as a result of missed diagnosis, early discharges from hospitals, and the failure of pregnant women to report their substance use (Bolnick & Rayburn, 2003). In addition, the incidence of neonatal drug exposure and subsequent withdrawal conditions is believed to be underestimated in hospital discharge databases (Hudak & Tan, 2012). In a retrospective cross-sectional analysis of a nationally
representative sample of newborns with NAS in the United States, the rate of newborns diagnosed with NAS upon hospital discharge increased from 1.20 (95% CI, 1.04-1.37) to 3.39 (95% CI, 3.12-3.67) per 1000 hospital births per year. The Kids’ Inpatient Database was used to sample 80% of pediatric hospital discharges and 10% of uncomplicated births (N= 7.4 million). This database revealed 13539 newborns with NAS in the US (noted by the diagnostic code of 779.5, which denotes drug withdrawal syndrome in a newborn), which is approximately one infant born per hour with signs of withdrawal (Patrick et al., 2012). The health care costs associated with the care of infants with NAS are significant and have increased dramatically in the past decade. Although an evaluation of the costs in caring for an infant with NAS in Canada is unknown, an evaluation of the hospital charges for NAS in the US is available. Between 2000 and 2009, the total hospital charges for NAS in the US are estimated to have increased from $190 million to $720 million, or a current mean hospital charge of $53,400 per patient (95% CI, 49,000-57,700) (Patrick et al., 2012). These costs reflect the period of hospitalization, and the long-term costs associated with NAS across the lifespan have not been established.

In addition to the costs of health care, NAS is a problematic issue for the social service system and family unity. Involvement in the child welfare system is common among infants with NAS, as maternal substance use is considered a risk factor in the lives of children (Sundquist Beauman, 2005; Vucinovic et al., 2008). While the care of infants diagnosed with NAS is of critical importance, intervening by removing the child from maternal care serves to sever the mother-child relationship. Research has shown that a positive maternal-fetal connection may contribute to motivation on the part of mothers to seek treatment for substance use (Pajulo et al., 2012). As such, understanding the experiences of mothers is important to assist in the
development of early intervention programs for both mother and infant in an effort to improve maternal, fetal and neonatal outcomes.

Given the considerable medical needs of diagnosed infants, NAS research and practice issues have centred on symptomatology (D'Apolito & Hepworth, 2001; Finnegan et al., 1975; Lifshitz et al., 2001), toxicology screening (Bar-Oz, Klein, Karaskov, & Koren, 2003; Eyler, Behnke, Wobie, Garvan, & Tebbett, 2005; Ostrea et al., 2001), pharmacologic treatment (Johnson, Gerada, & Greenough, 2003; Sundquist Beauman, 2005), and length of hospital stay (Johnson, Greenough, & Gerada, 2003). The research to date has successfully answered questions about methods of detection of substance exposure (Eyler et al., 2005) and most appropriate treatment (Finnegan et al., 1975; Sundquist Beauman, 2005). These positivistic experimental methods have led to the literature defining NAS solely as a disease state requiring treatment, and the knowledge gained to date in this regard is considerable. However, while screening, symptomatology and treatment are important areas for research, they are only concerned with the physical health of the infant, and advancements in this area have led the medical community to be highly responsive to the infant’s needs, which are most often treated in a Neonatal Intensive Care Unit (NICU) environment. Due to the complexity of the health needs of infants with NAS, infants are separated from their mothers, placed in incubators and primarily cared for by nurses. Consequently, many mothers become powerless observers, and are often only able to assist nurses in a secondary role.

Although NAS is a medical condition in newborns affected by in utero substance exposure, the absence of the mother in understanding and treating NAS has implications for understanding the contextual issues associated with the syndrome. While nurses and physicians are able to meet the needs for symptom management and nutrition, the psychological needs of
the infant, including the initial bond, are predominately filled by a parental figure, often the mother of the newborn.

Given that the mother is central in an infant’s life, attentiveness to maternal well-being is important. An infant is fully reliant on caregivers to meet their basic needs, including the need for love and affection (Bowlby, 1982). As such, understanding mothers’ experiences may impact the ability to help mothers meet the needs of their infants while simultaneously improving their own wellness. However, in the immediate postpartum period, many mothers of infants with NAS are not fully capable of meeting their newborn’s needs due to their peripheral role in the NICU environment. Furthermore, stigma from health care providers associated with mothers’ use of substances (Fraser, Barnes, Biggs, & Kain, 2007) may prevent them from engaging with professionals (Powis, Gossop, Bury, Payne, & Griffiths, 2000). A new approach to understanding and treating the complex condition of NAS that is more encompassing of the mother’s experience and her role in her infant’s life is needed in order to attend to the full scope of newborns’ psychosocial and medical conditions.

To date, the experiences of mothers of infants with NAS are absent in the literature, thus perpetuating the current practice that is almost exclusively focused on the medical needs of the newborn. This focus disregards the social context of the newborn and the multifaceted needs of the mother. Subsequently, medical professionals essentially “fix” the infant’s condition by managing symptoms and then discharge the infant to a mother, who typically has had inconsistent involvement and has often formed little attachment to her infant, or to child welfare services due to an assessment of parental incapacities. Regardless of the discharge plan, the social context of the infant remains consistent—there is often a strained initial attachment and a
complex social environment consisting of addiction issues and other problematic contextual variables such as poverty, homelessness and lack of social support (Powis et al., 2000)

My experience working in the field of medicine as a perinatal social worker has raised many unanswered questions regarding NAS. The medical community has developed its response to NAS from a medical perspective. It is clear that this perspective has led to effective care for infants but has rendered mothers silent. Substance using mothers are often highly criticized for their inability to protect their child (Boyd, 1999; Boyd, 2004), which is largely perceived as the primary function of the mother. Mothers of affected infants face multiple levels of stigma, leading them to remain silent and casting them in a peripheral role in the care of their newborn. These mothers often refrain from seeking prenatal care or support from professionals due to their fears of judgement and child welfare agencies (Powis, 2000). An exhaustive literature search completed in 2012 for a 10 year period using PubMed, EBSCO and Google Scholar revealed an absence of literature describing mothers’ perspectives on having an infant with NAS. Because these women often remain silent and have not been the subject of investigation, this research affords the opportunity to hear directly from mothers about their perspective on their lives, the context in which they live, the role of addiction, and their experience of mothering an infant with NAS. In an effort to expand the knowledge associated with the psychosocial aspects of NAS that is inclusive of the maternal experience, this research will explore the question, “What are the lived experiences of mothers of infants with NAS?”

Given that research on NAS is predominately focused on the medical needs of the newborn, psychosocial research that seeks to explore the perspectives of mothers requires a research methodology that would uncover the experiences of mothers directly from their vantage point. As such, a descriptive phenomenological approach to the research was utilized to garner a
rich, thick description (Moustakas, 1994) of the essence of the experiences of mothers whose infants are diagnosed with NAS. Through face-to-face semi-structured interviews, mothers who have had an infant diagnosed with NAS were asked about their experiences during pregnancy, at the time of their infant’s birth, and in the immediate postpartum period. Furthermore, based on the belief that there are shared features to any lived experience that are common to all persons who have had the experience (Lopez & Willis, 2004), the findings reveal some of these common features among research participants. Descriptive phenomenology offered an opportunity for a greater understanding of the experiences of mothers, which invariably contributes to a more holistic understanding of the experiences of affected newborns, as newborns are dependent upon their mothers.

How I Came to the Research Question

This research is a result of my experience for more than a decade as a clinical social worker in the NICU of a regional hospital in Ontario. Throughout my tenure as a perinatal social worker, I had the opportunity to work with many families of infants with NAS. I observed NAS as a growing problem in my community with many newborns exhibiting symptoms of withdrawal. My work with infants with NAS has posed several challenges for me due to the complex needs of these infants, combined with the need to ensure their safety upon discharge from the hospital. Furthermore, the social work role in the NICU in which I was employed was largely reactive and there was limited opportunity for therapeutic work with mothers. This caused considerable ethical tensions, as hospital social workers have the potential to bring about positive change in family functioning and mother-infant relationships. This tension was exacerbated by the fact that health care professionals such as physicians and nurses appeared to
misunderstand the realities of women who use substances (Murphy-Oikonen, Brownlee, Montelpare, & Gerlach, 2010) and their role in their infants’ lives.

My perinatal social work career began when I was a new university graduate. I had little life experience in perinatal work; I did not have my own children and my clinical experience was limited to placements with the elderly population. In the initial years of my career, I saw very few cases of substance-exposed newborns. When one was presented, despite my training, I couldn’t help but have negative feelings, as I thought, “what has the mother done to her child.” These cases often involved child welfare, and upon reflection, I now know that I was identifying with the vulnerable infant, not the mother, who I believed had “caused” this to happen. After all, I questioned why couldn’t she just stop using substances?

After a couple of years of working in the NICU, there were increasing numbers of referrals of infants who experienced withdrawal, and I involved child welfare in each case, as I thought these women required assistance because of their substance use. We did not have methadone maintenance programs in our community at the time, and the issue was somewhat foreign to me and the other members of the health care team. I have many regrets about this early part of my career stemming from my naivety and ignorance to the power of addiction and the injustices that mothers who use substances face on a daily basis. I witnessed and participated in many newborn apprehensions in hospital labour rooms when it was deemed that the mother was unsafe to parent due to her history of substance use. Observing these apprehensions became increasingly difficult once I had children of my own. I wondered about the immense difficulty that women must face when a professional has determined them to be unfit as a mother.

Infants with NAS were difficult for all members of the health care team to care for. There was a lack of understanding of their needs, a lack of knowledge regarding how to best treat them,
and a growing concern for the absence of mothers in their lives. It was common for mothers to leave the hospital after delivery while their infants remained in the NICU for long periods of time. The increasing number of cases and the escalating absence of mothers was difficult to understand. Consequently, I sought out learning opportunities in this area. I discovered more about addiction, and I attended a workshop in which a speaker discussed empowering women to self-refer to child welfare when risks have been identified. My initial impression was that the speaker was wrong, but nonetheless I initiated this approach in my practice and began not just asking women questions as part of a psychosocial assessment, but I also started truly listening to their stories, and even when risks presented, I partnered with women to engage the appropriate supports. This changed my views on addiction in pregnancy, and I began to see the condition in newborns as too narrowly defined. I recognized that mothers face multiple hardships and have many strengths that must also be considered in the context of the newborn.

With a goal of improving care for newborns, I worked with a research team to develop and evaluate clinical practice guidelines for better management of infants with NAS. It became apparent that although gains were being made in the treatment of infants with the syndrome, there continued to be a division between mother and newborn, and the health care team failed to engage new mothers. I was compelled to create a research study that would allow mothers to share their stories about having a baby with NAS. My hope is that this research may potentially influence a more holistic understanding of the infant and family as well as increase the knowledge of health care providers and the general public.

As I grew professionally, I had the privilege of being changed by the women I worked with. I now believe that each of the mothers I have worked with in my career loved her children. This may represent a bias, but after careful reflection and learning directly from women, I have
noticed that the stories I have heard over the years focused on women being stuck and making difficult choices, some of which were not always in their newborn’s best interest, and despite some women not being in a position to parent due to their substance issues, they never intended to hurt their baby. I found a balance in my career in both ensuring the safety of newborns that required support and identifying with mothers, their stories and their needs. I developed an appreciation that one does not have to identify exclusively with the infant or the mother. This enhanced my belief in the work and contributed to a better appreciation for the plight of the entire family. However, the role of social work in health care is often reactive, given the lack of prior work with the family and the short length of hospitalization, which necessitates a need for quick decisions that are centred on the safety of the child. This often prohibits in-depth work with mothers and fails to consider the mothers’ experiences and needs. Thus, gaps continue to exist, and this research was driven by the belief that women’s stories need to be represented and understood in the context of NAS to expand our view of the issue from seeing it as a medically driven problem to understanding that it extends well beyond the confines of medicine.

**Purpose**

A driving factor for this study is a belief that mothers and newborns are interdependent and that their identities are forged together in a relational context. Therefore, to simply diagnose and treat an affected newborn without also understanding the newborn’s mother may serve to fragment the mother-infant relationship. This fragmentation is particularly problematic because infants are entirely dependent on their primary caregiver to meet their basic needs. To fully understand and influence the treatment of NAS beyond the incubator, the lived experiences of the mothers of affected newborns requires exploration.
When I initially proposed this research, I was interested in understanding the contextual factors in the life of the newborn. One important contextual factor was the experience of the mother. Although the findings successfully contribute to the newborn’s context, the early life experiences and the trajectory of drug use leading to becoming a mother of an infant with NAS was of equal importance to the participants. The broad scope of the shared experiences of participants strengthened the findings of this research.

However, although the well-being of mothers who use substances is a worthy research topic in and of itself, the present study explored the experiences of mothers in the context of newborns with NAS. Through this lens, it was anticipated that insights into maternal experiences would broaden the field of NAS while also uncovering important issues for mothers.

The purpose of this phenomenological study was to describe the lived experiences of mothers of newborns with NAS. The study endeavoured to answer, “What are the lived experiences of mothers of infants with NAS?” According to Creswell (2007), in an attempt to gain understanding of those who have had an experience, phenomenological inquiry seeks meaning through a small number of sub-questions directed at uncovering descriptions of the experience. In the following dissertation, mothers were asked to share their experiences in pregnancy and immediately following the birth of their newborn, through diagnosis of NAS and until the cessation of symptoms in their newborn. This exploration of maternal experiences across multiple participants uncovered the shared essence of the events under study.

**The Medical Model – Current Theoretical Framework of NAS**

Traditionally, the provision of health care in Canada is based on the medical model of identifying ailments and employing evidence-based treatments to resolve them (Barbour, 1995). Medical schools across the globe have traditionally trained up-and-coming physicians in the
natural sciences and medical education is rooted in disease, diagnosis and treatment, as their primary focus of addressing illness in individuals (Barbour, 1995). The medical model ascribes to a reductionist approach to patient care, whereby physicians identify parts that are malfunctioning rather than conducting an evaluation of the whole person whose needs extend beyond the identified ailment and into the social and cultural environment (Engel, 1977).

NAS has been predominately explored from the standpoint of the medical model and was further supported by the development of the NAS scoring system (Finnegan, 1975). This scoring system evaluates the symptoms of withdrawal in newborns and quantifies symptoms to assess the severity of the infant’s withdrawal. This method of identifying and measuring symptoms of distress in newborns experiencing signs of withdrawal remains the prevailing measure of NAS to date (Hudak & Tan, 2012). The tool addresses the observable ailment in the infant (the symptoms of withdrawal) but neglects to identify the social environment (Finnegan, 1975).

Given this focus on the symptoms, the tool may provide an oversimplified depiction of the syndrome. The tool is consistent with the philosophical beliefs inherent in the medical model, which has organized symptoms and applied science to fix the observable problem (Barbour, 1995). Doing so however, neglects a closer examination of possible underlying issues, including the infants’ social context. As the following dissertation argues, the medical approach of treating symptomatology in infants fails to recognize two things: the important role that mothers have in the lives of infants, and that a mother’s experiences of having a newborn with NAS shapes and is shaped by the infant’s immediate condition.

The tendency for health care professionals to utilize a medical model framework of reductionism may lead them to overlook the human situation in favour of diagnosis and treatment. However, problems or symptoms reside in people, and knowing the person helps
humanize illness while identifying possible deeply rooted causes and explanations situated outside of a narrowly defined diagnosis (Barbour, 1995). While the biological components of NAS are important, the psychological, social and cultural variables that affect the health and well-being of the infant are equally worthy of exploration (Kaslow et al., 2007).

To understand the well-being of a child, Axford (2009) outlines five measures currently used in the field. The first measure concerns the issue of “violated rights” which defines the well-being in children as related to the violation of any of his or her rights to provision, protection or participation. Well-being is also defined as “needs” when the health or development of a child is impaired or likely to become impaired without intervention. A third measure is when poverty is used to determine children’s well-being in relation to poor living standards and the impact on the child. Poor Quality of Life (QOL) is also applied as a measure of well-being in relation to poor circumstances such as lack of housing, lack of basic items, lack of care and affection and fun and friendship. And lastly, social exclusion is a final measure of well-being.

While each of these definitions has merit, they are individually inadequate to define the full scope of a child’s experience. Axford (2009) states that each of these perspectives must be taken into consideration in order to develop a clearer perspective of the well-being of children. The Axford model is important to the present dissertation as it exemplifies the connection between a mother’s and infant’s well-being. It is important to note that each definition mentioned above shares an integral component, namely, the existence of another individual (presumably a mother). If a child lives in poverty, it usually means the caregiver does not make an adequate family income. Similarly, a mother plays a critical role in ensuring a child’s rights are protected. Therefore, while understanding the well-being of a child is essential, one must also include
mothers in the discourse, and a complete understanding is only possible if mothers are included in this examination.

The focus of the present dissertation is the experiences of mothers. In an effort to explore the context of the infant, maternal experiences were explored as one element of that experience. Examining mothers does not preclude the existence of other types of caregivers in the lives of affected infants. The experiences of fathers, grandparents or foster parents may also be an important area of inquiry, though they have not been included in the scope of the present dissertation.

In summary, well-being is considered a holistic concept and encompasses all aspects of a child’s life. A theoretical model that may be used to understand the needs and concerns of children is the biopsychosocial model, as this model emphasizes a more holistic framework to the understanding of a particular phenomenon (Engel, 1977).

Towards a New Theoretical Framework: The Biopsychosocial Model

The medical model’s ability to guide physicians to reduce suffering in infants from symptoms of NAS is notable and its offers considerable benefits. The philosophical shortcomings of the medical model, though, have distorted the spectrum of the human experience in understanding NAS by eliminating mothers from the discourse. The biopsychosocial model offers an alternative philosophical framework for understanding NAS beyond the limitations of the medical model by applying a more holistic framework to the study of this syndrome.

In 1977, George Engel offered the biopsychosocial model as an alternative to the medical model to account for its missing dimension: the human experience. The model has as its premise
the belief that nothing exists in isolation (Engel, 1980), and that psychological and social contexts impact a patient’s experience of illness and as such are equally important to the biological factors that receive widespread attention from the medical community (Biderman, Yeheskel, & Herman, 2005; Engel, 1977; Moniz, 2007; Vetere, 2007). This model espouses a belief in the subjective experiences of human beings and provides a framework for understanding NAS in the larger context of infants whose multilevel needs include living in a family systems environment.

The World Health Organization (WHO) supports Engel’s biopsychosocial framework in its definition of health. “Health is not only the absence of infirmity and disease but also a state of physical, mental, and social well-being” (WHO Europe, 2012). The WHO further defines the social determinants of health as economics, stress, early life, social exclusion, work, unemployment, social support, addiction, food and transport. Its position is that individuals’ lifestyles and the conditions in which they live strongly influence their health and well-being (WHO Europe, 2012). Each of these social determinants of health signifies an important component of an infant’s experience. The biopsychosocial framework lends support for focus on the holistic components of NAS beyond the symptoms experienced by the infant. Although a number of determinants each has an important place in the experience of the infant, this research focused on one: the experiences of mothers. Given that infants are reliant on a caregiver (which is predominantly the mother) to meet their basic needs, an increased understanding of mothers’ conditions is needed. This raises the issue of whether solely treating the infant’s symptoms is sufficient to restore good health.

In understanding health from a holistic perspective, a collaborative process between patient and physician enables an increased understanding of the patient’s needs (Zimmerman &
Dabelko, 2007) and a shared responsibility for the outcome (Barbour, 1995). In the case of an infant, collaboration begins with the family, particularly the mother, where the context of the infant’s life is brought to the forefront. Mothers of infants affected with NAS offer a unique opportunity for health care providers to engage at a transitional time in the family’s life. Infants inevitably bring change to a family and requires new parents to focus on needs beyond their own. Collaboration empowers parental decision making and involvement with the newborn. Kaslow et al. (2007) report that positive health outcomes are associated with strong family and social support systems. Vetere (2007) reports that individuals operate in families and larger kinship groups, and that the quality of kin relationships has a strong impact on “how life turns out.” The biospsychosocial model promotes a family systems perspective (Engel, 1980; Vetere, 2007) and draws health care providers’ attention past the objectivity of problem orientations.

The systems perspective is at the core of the biospsychosocial model and is endorsed by Engel (1980) as a means of addressing the complexities of the human experience. A systems approach encourages understanding the dynamic interplay of various levels of a person’s experience from the individual to the family, the community and the larger social context. In the field of NAS, a biopsychosocial framework may influence our understanding of infants and result in seeing them as contextually and relationally bound human beings rather than as a collection of symptoms. Exploring the experiences of mothers subsequently influence our contextual understanding of affected newborns. Engel’s model may promote physicians to address the biology (the symptoms and treatment), the psychology (the emotional needs for touch, soothing and cuddling), and the social (the environment of addiction, parental capacity, poverty and family context) factors that impact on the life of the newborn with NAS.
Critics of this approach in medicine argue that complex conditions often require linear approximations (Epstein & Borrell-Carro, 2005). Given the need to make quick decisions in order to relieve symptoms causing distress in newborns, it is likely that some pediatricians ascribe to this belief when treating the complex condition of NAS. While the biopsychosocial model is endorsed by Engel (1977; 1980) as a philosophical belief system that guides treatment and thus should not require additional time to put into practice, there is no doubt that exploring aspects of NAS beyond the present biological issues would inevitably place constraints on physician resources. Furthermore, in the current fee for service health care environment, and given demands on physicians to discharge patients from much-needed hospital beds, the biopsychosocial model can potentially lead to overwhelming physicians with issues beyond the immediate needs of the newborn. One could also argue that physicians are trained in highly technical medical procedures, and that allied health professionals such as social work and psychology are more equipped to engage in dialogue with patients and address the psychosocial aspects of the condition (McIntosh, Lyon, Carlson, Everette, & Loera, 2008). Though this may be true, while collaborative care models are positive for patient care, they do not necessitate a division of roles but rather insist on mutual responsibility in caring for various aspects of a condition. Despite the limitations of the biopsychosocial model, there are multiple benefits in viewing patients from a holistic framework.

**Significance of the Study**

The exploration of maternal experiences with NAS does not meet all of the requirements for holistically understanding NAS. However, understanding the perspectives of mothers will invariably shed light on the context for both the mother and newborn. It is anticipated that
exploring mothers’ stories will serve to decrease the marginalization of this vulnerable population through increased knowledge. Furthermore, an alternate discourse inclusive of mothers’ realities will be explored in relation to the affected newborn. Understanding maternal experiences has the potential to influence the development of partnerships with health care professionals that could empower mothers to be active participants in the care of their newborn. Additionally, developing an appreciation of the complex issues faced by mothers of affected infants has important implications for social workers, as they work with families while also ensuring the safety and security of substance-exposed newborns.

Although the impact of mothers’ experiences in relation to infants is an important area for research, understanding an infant with NAS’s reciprocal impact on the mother is of equal importance. Our view of NAS needs to move beyond a technical/medical definition if holistic interventions and approaches are to be established. Given the embodied connection of a mother and fetus, mothers are in a unique position to provide firsthand accounts of the experience of impending motherhood. These experiences have the potential to inform health care providers regarding the realities of substance use in pregnancy, increase awareness, reduce stigma associated with substance use, expand the dominant discourse by adding perspective to the dialogue of substance use and NAS, and empower other women to share their stories and advocate for the salient role they play in the lives of their infants.

Summary

This chapter explored the background informing the present study, as well as the choices made in the design and rationale for the present inquiry. The issue of context for newborns with NAS was an important consideration in the design of this research. One limitation of the inquiry is that the
parameters employed to research the experience of mothers limit this study to examining one aspect of the newborn’s contextual environment. Despite this limitation, this research into mothers’ experiences is conducted in the spirit of the biopsychosocial model. This model urges an understanding of patients beyond medicine and biology. Given the pivotal role a mother plays in the life of an infant, maternal experience is an important area of research for NAS.

The overall structure of the research takes the form of six chapters. Chapter two provides the background literature that is used to inform the inquiry. The third chapter outlines the chosen research methodology of descriptive phenomenology and the description of the resulting sample of participants that engaged in the research process. The fourth chapter thematically presents key findings in the research to better examine the essential essence of the experiences as reported by participants while the fifth chapter discusses the findings in relation to previous literature. The final chapter presents implications for research, policy and practice, and summarizes the essential findings of the research.

The next chapter will present a foundational review of the literature on NAS, including substance use in pregnancy and opiate replacement therapy, in an effort to formulate background knowledge relevant to the inquiry.
CHAPTER 2: REVIEW OF THE LITERATURE

The following review of the literature provides a background of information in the field of NAS and substance use in pregnancy. While both NAS and substance use in pregnancy have a wealth of research reflective of their topic domain, there has been an absence of literature connecting the two areas from the perspective of the mother. Furthermore, there is an absence of literature on the experience of becoming a mother to an infant that has been born ill as a direct result of maternal substance use.

The review of the literature focuses on four distinct areas. First, the issues present for women using substances in pregnancy are explored from the vantage point of contextual factors in women’s lives, stigma and discrimination, and maternal, fetal and neonatal adverse outcomes. The second section of the literature review explores the issue of NAS. Much is known about the syndrome in terms of screening, pharmacologic treatment and length of hospital stay for newborns. However, NAS has been explored primarily from a medical framework concentrating on the care of the newborn and contextual issues for newborns inclusive of the mothers who are their care providers are absent from the literature. The final section of the literature review explores the issue of opiate replacement therapy for substance abuse in pregnancy. As methadone treatment is the gold standard treatment for substance use in pregnancy, and it is well established that methadone has a negative impact on the development of NAS in newborns. Methadone Maintenance Treatment is a prime example of how the issues of substance use in pregnancy converge with the issue of withdrawal in newborns. And finally, the last section of the literature review focusses on motherhood and the challenges present for mothers who use substances.
The following literature review provides a comprehensive understanding of NAS and explores multiple aspects of substance use in pregnancy, including opiate replacement therapy. These areas of focus will provide the backdrop for understanding mothers’ experiences of NAS.

**Substance Use in Pregnancy**

It is difficult to ascertain the prevalence of illicit substance use given that rates are deeply embedded within the trends of different communities. The underreporting of substance use among women, and among pregnant women specifically (Bolnick & Rayburn, 2003), creates an obstacle to uncovering the size of the problem (Greenfield & Grella, 2009). Compounding the uncertainty is the fact that many women are polysubstance users, which inhibits the accuracy of data related to the frequency of use of particular substances. Nevertheless, in 2002–2003, one in four women in the US reported substance use during pregnancy (Havens, Simmons, Shannon, & Hansen, 2009), highlighting the scope of the issue.

However, there is also evidence to suggest a trend of decreasing substance use within this special population (Best, Segal, & Day, 2009; Bolnick & Rayburn, 2003) when compared to women who are not pregnant. In a comparison of a national sample of pregnant (N= 1800) and non-pregnant women (N= 37,527) in the US, pregnant women were significantly less likely to report the use of any substances (Havens et al., 2009). Furthermore, Best et al. (2009) reported a reduction in the frequency of heroin use over the course of pregnancy with the most significant decrease of use occurring between the second and third trimester and from the third trimester to the first three months postpartum. It is important to establish the prevalence of substance use among pregnant women given that the rates of substance use among men are more likely to
appear in the literature, and the needs of men and women who use substances differ considerably.

A gender-based analysis (Tuchman, 2010) reveals that the literature on substance use has largely focused on issues relevant to men. However, there are differences in the biological, psychological, and social factors associated with substance use that call for a more comprehensive evaluation of substance use among women (Tuchman, 2010). Biologically, women have been found to progress more quickly to addiction than men (Finnegan, 2010; Tuchman, 2010) and more rapidly develop health-related problems resulting from their use of substances (Finnegan, 2010). Women also experience gender-specific health-related consequences of substance use related to infertility, vaginal infections, miscarriages and premature delivery (Tuchman, 2010). Psychologically, women who use substances are more likely than men to suffer from co-occurring psychiatric disorders such as depression and anxiety, and are also more likely to have experienced trauma or victimization (Finnegan, 2000; Finnegan, 2010; Jansson & Velez, 1999; Tuchman, 2010). From a social perspective, compared to men, women who use substances are more likely to be unemployed and unmarried (Havens et al., 2009), are more likely to be the primary caregivers to children (Finnegan, 2010; Tuchman, 2010), are more likely to be in unstable relationships, and are often with a partner who uses substances (Bailey, Hill, Hawkins, Catalano, & Abbott, 2008; Tuchman, 2010; Tuten & Jones, 2003). They are also more likely to drop out of substance-use treatment as a result of their responsibilities at home and the lack of fit with traditional male-dominated treatment models (Jansson & Velez, 1999; Tuchman, 2010).

Pregnant women who use substance have multiple needs stemming from the contextual factors in their lives. Due to social, legal and moral discourses of addictions in pregnancy, these
contextual factors are often overlooked or misunderstood (Boyd, 1999). Although drug use in pregnancy crosses social, economic and geographical borders (Vucinovic et al., 2008), some commonalities exist. On the whole, pregnant women who use substances often have complex social situations, including a large proportion of individuals living in poverty (Powis et al., 2000), inadequate or complete lack of housing (Leggate, 2008), unsupportive or abusive relationships (Powis et al., 2000), a lack of social or professional support (Moy, Bayliss, Firth, Leggate, & Wood, 2007), a lack of education (Jansson & Velez, 1999), and involvement in prostitution and criminal activity to support their drug use (Leggate, 2008). In addition, there are a number of health concerns such as HIV, hepatitis and STIs (Jansson & Velez, 1999; Vucinovic et al., 2008), poor nutrition (Moy et al., 2007; Vucinovic et al., 2008), mental health disorders (Jansson & Velez, 1999; Powis et al., 2000), and psychological concerns such as guilt, denial and shame (Ehrmin, 2001; Jansson & Velez, 1999; Wiechelt, 2007). The result of such social and health concerns is often a reluctance to seek medical and/or prenatal care (Jansson & Velez, 1999), and a fear of seeking professional support (Mayet, Groshkova, Morgan, Maccormack, & Strang, 2008).

While these psychosocial and health-related risk factors are present in the lives of many women who use substances, the First Nations population of Canada is disproportionally affected by these risks (Health Council of Canada, 2011; Smith, Edwards, Varcoe, Martens, & Davies, 2006). According to Hertzman (2002), one common risk category for First Nations women is a lack of emotional and practical support and the prevalence of relationship difficulties, including domestic violence. Furthermore, access to health care is even more strained as a result of the high incidence of poverty as well as the stigma and discrimination faced when seeking care (Health Council of Canada, 2011; Hertzman, 2002). Further exploration of the unique needs of
the First Nations population is warranted. However, despite their high-risk situation, Aboriginal culture is ahead of Western paradigms in their holistic perspective on health care. In a national report on improving Aboriginal maternal and child health, advisors stated, “many participants stressed that good quality healthcare for expectant mothers and young children is not just prenatal care, delivery, postnatal care and checkups; it involves looking at the woman’s life as a whole.” One participant said, “we don’t just talk about the fact that she’s having a baby, how’s she doing at home? How’s her mental health? What are her relationships like?” (Health Council of Canada, 2011, p. 5).

Similar to First Nations women who have identified relationship difficulties and domestic violence as risk factors in their lives, (Hertzman, 2002), in the US, pregnant women who use substances are less likely to receive positive support during their pregnancies to assist with such things as commitment to prenatal care, a healthy diet or treatment of substance use disorders (Tracy, 2010). Research indicates that many pregnant women who use substances are in relationships with men who also use substances and who inhibit their opportunity and commitment to treatment (Bailey et al., 2008; Tracy, Munson, Peterson, & Floersch, 2010; Tuten & Jones, 2003). In a longitudinal study of gender based substance use patterns in pregnancy and postpartum in the United States, expectant fathers were much more likely than pregnant women to use substances over the course of pregnancy, and men’s substance use was not affected by their partner’s pregnancy. Although many women decreased their use of substances during pregnancy, many women who discontinued substance use resumed it following birth (Bailey et al., 2008). The pattern of decreased substance use among women may be indicative of women’s growing awareness of how a fetus develops. Radcliffe (2009) interviewed 17 substance-using women who were pregnant or were up to 24 months postpartum. Through an analysis of their
accounts, it is evident that despite the often-chaotic nature of their lives, women are engaged in enhancing their child’s well-being and claiming a maternal role through methadone treatment and seeking social and professional support. Given the complexity of addictions and the associated psychosocial needs of pregnant women, further interventions aimed at pregnant women and their partners may be warranted.

Access to services are limited for pregnant women who use substances, partially as a result of negative societal views of those who use substances while pregnant (Boyd, 1999). Pregnant women who use substances are faced with a high degree of stigma from society given their dual status as a woman with substance use issues and an impending mother. Social discourse on the issue has largely described such women as “bad” or “monstrous” mothers (Gubrium, 2008; Meyers, 2004). Public perception of pregnant women who use substances tends to identify with the vulnerable infant, viewing the mother’s substance use as a conscious poor choice and her behavior as the cause of infant suffering (Harrison, 1991). Beyond the social discourse, women who abuse illicit substances create tensions within the legal literature, moral discourse and in health care settings.

Substance use by pregnant women also invokes negative and judgmental attitudes among health care providers (Fraser et al., 2007; Murphy-Oikonen et al., 2010). Many health care professionals continue to view addictions as a compilation of poor choices, and such providers identify with the newborn (Murphy-Oikonen et al., 2010). In addition, social work and psychology, which by virtue of their code of ethics and core beliefs endorse a non-judgmental attitude and client empowerment (Ontario College of Social Workers and Social Service Workers, 2008), are viewed as adjunct services in health care, and there are very few of these human resources available in the system. This means that while health care professionals spend
much of their energy and expertise helping to relieve newborns of their symptoms of withdrawal, pregnant women who use substances often lack similar professional support for problems associated with their addictions.

Media representations of pregnant women who use substances have also perpetuated stereotypical societal attitudes towards those with addictions. In a narrative analysis of a news report entitled “Growing up with Crack,” Meyers (2004) outlines how the media has depicted mothers who use substances as junkies, and the use of crack as an “epidemic” that represents a “poverty of values”. Given that the media can influence the dominant social discourse, which has implications for public perception and policy (Meyers, 2004), representations of pregnant women who use substances within various media venues causes concerns regarding their misrepresentation. Public perception of substance use in pregnancy impacts the ability for women who use substances to seek care for themselves and for their pregnancy (Jansson & Velez, 1999).

The legal discourse of substance use in pregnancy again focuses on the needs of the vulnerable infant in isolation from the mother. According to Zivi (2000), prosecutors in the United States have charged many pregnant women with drug offenses, justifying the charges by proposing that making prenatal drug exposure a crime would protect the health and well-being of infants. Several studies have noted issues such as child protection after birth (Chavkin, 1990), the illegal activity surrounding substance abuse (Harrison, 1991; Zivi, 2000), and the punitive measures taken to protect infants from illegal drug-supporting behavior such as prostitution or theft (Marcellus, 2004). The debates regarding these legal issues seem to suggest that the pregnant woman is a willful participant in the harm of her child, perpetuating social stereotypes that pregnant women who use substances are a threat to their infant.
Contrary to these predominantly negative views, the reality is that most pregnant women who use substances do not simply choose to use drugs and harm their infant in the way that is typically depicted by these stereotypes. Substance use during pregnancy is problematic for women as their health is affected in addition to putting the fetus at risk. Sexually transmitted infections and HIV, as well as hepatitis and cellulitis, are common among this population of women (Finnegan, 2000). Obstetrical complications are also problematic and include miscarriages, premature rupture of membranes, septicemia, placental disorders, fetal growth restriction, preterm birth and intrauterine growth restriction (Bolnick & Rayburn, 2003; Finnegan, 2000; Vucinovic et al., 2008). Despite these adverse maternal and obstetrical outcomes, many non-treatment-seeking pregnant women with substance use issues are unaware of the negative consequences of their use and the potential harm to their unborn child (Perry, Jones, Tuten, & Svikis, 2003).

Greene and Goodman (2003) identify three types of risks to an infant that has been exposed to in utero substance abuse. These risks include the effects on fetal development, the short-term impact of acute withdrawal, and the long-term effects on neurodevelopment. Early identification of substance-exposed infants is critically important for early intervention and to avoid pregnancy-related complications (Bio, Siu, & Poon, 2011). For opiate-exposed infants, the majority of concerning outcomes occur at birth or in the initial postnatal period. Children born to women who use substances often have low birth weights, respiratory depression at delivery evidenced by a low Apgar score (which is a method of evaluating the health of a newborn immediately after birth), accelerated weight loss after delivery, increased risk of Sudden Infant Death Syndrome (SIDS) as well as infant mortality and increased risk of sepsis (Sundquist Beauman, 2005; Vucinovic et al., 2008). Therefore, identifying infants at risk through pregnant
women disclosing substance use may mitigate the harmful effects of opiates on the fetus while also aiding in the intervention of substance use treatment or harm reduction for mothers.

Substance use treatment may be beneficial in decreasing or ceasing the use of substances, which will improve maternal and neonatal outcomes. However, there are multiple barriers to women seeking treatment (Tracy, 2010). Substance use in intimate partner relationships creates an obstacle for women who may fear the loss of the relationship upon initiating treatment or whose partners hinder their ability to access treatment (Tracy et al., 2010; Tuten & Jones, 2003). Furthermore, the responsibilities of caring for dependent children prohibit many women from seeking inpatient treatment (Bolnick & Rayburn, 2003). This, combined with the fact that child protection services often base decisions to return children to mothers on the cumulative length of time a child is in foster care (Bolnick & Rayburn, 2003) may prohibit treatment for pregnant women who use substances. In addition, treatment models that are based on the needs of male substance users serve to reinforce women’s sense of guilt and shame, and may create an environment of discomfort for women (Jansson & Velez, 1999; Tuchman, 2010). Given the presence of these barriers, single-gendered treatment is needed for women (Greenfield & Grella, 2009).

Despite these obstacles, pregnancy has been termed a “window of opportunity” for drug treatment intervention, as it has been shown to improve participation in prenatal care and reduce the incidence of maternal and fetal co-morbidities associated with substance use (Terplan, Garrett, & Hartmann, 2009). The timing of treatment during pregnancy does not appear to greatly affect the rate of decreased use. Terplan et al. (2009) found that of the substance-using pregnant women who enrolled in treatment (N=847), substance use decreased overall from 100% to 40%. However, when evaluating the frequency of substance use by trimester, there were very
small differences in drug use following the first 3 months of treatment, with 41% of women reporting continued substance use at 3 months, 39% reporting use at six months, and 36% of women reporting continued substance use at 12 months.

Given the efficacy of substance use treatment in reducing the use of substances, the most appropriate treatment model for pregnant women requires careful consideration. The abrupt cessation of opiates may precipitate acute withdrawal in the fetus and cause obstetrical complications such as miscarriage, premature delivery or stillbirth (Jansson & Velez, 1999), and the recommended treatment for opiate addiction in pregnancy is methadone maintenance therapy (MMT), (Wong, Ordean, Kahan, 2011). However, one of the predominant adverse outcomes to both opiate use in pregnancy and MMT is the development of NAS.

**Neonatal Abstinence Syndrome**

NAS has been defined as a constellation of symptoms observed in infants experiencing withdrawal from drugs such as opiates and methadone (Johnson et al., 2003; Sundquist Beauman, 2005). As a clinical diagnosis, the definition of NAS was strengthened with the addition of an opiate withdrawal assessment tool created by Loretta Finnegan in 1975 that was intended to define the withdrawal symptoms in infants exposed to opiates in utero (Finnegan, 1975). Symptoms of NAS range from a high-pitched cry, sleep disturbances, poor feeding, loose stools and excessive suck to a hyperactive moro reflex, tremors, increased muscle tone and tachypnea (Finnegan et al., 1975; Lifshitz et al., 2001). If left untreated, NAS can lead to more serious health problems and death (Finnegan et al., 1975).

Many assumptions are made regarding the cause of substance use withdrawal in newborns, but three distinct routes of drug exposures leading to NAS have been identified
(Lucas & Knobel, 2012). The first occurs when pregnant women are addicted to illicit opiates. The second contributor is infant exposure to in utero prescription opiates taken by pregnant women for another disease state, and the third pathway to NAS includes infants born to women who receive opiate replacement treatment such as methadone or buprenorphine for their addiction to illicit or prescribed opiates. While illicit substance use in pregnancy is certainly implicated in the development of NAS in infants, prescribed opiates for pain control or addiction management also play a role in the development of the syndrome.

While opiate exposure is a factor leading to the diagnosis of NAS, the symptoms present in opiate-exposed newborns are the distinguishing characteristics of NAS (Bio et al., 2011). The presence of NAS depends on multiple factors related to the substance of exposure, the timing and degree of use, and the size of the dose (Wagner, Katikaneni, Cox, & Ryan, 1998). Furthermore, the onset of symptoms of withdrawal in infants is dependent on maternal metabolism, drug transfer across the placenta and the half-life of the drug (Hudak & Tan, 2012). Withdrawal from opiates such as heroin or oxycodone often begins within 24 hours of birth, while methadone withdrawal may not present until 24-72 hours after birth (Hudak & Tan, 2012). The timing of withdrawal is critically important to health care providers, as many exposed infants may be discharged from hospital prior to the onset of symptoms. Nevertheless, intrauterine exposure to opiates can lead to physical dependence in the infant, manifested by distressing symptoms after birth.

For an infant with NAS, the length of hospital stay is considerably longer than it is for a healthy newborn, separating mother and infant at a time when bonding and attachment are especially important. The length of stay is contingent on the agent causing withdrawal and the need for pharmacologic treatment. In a study by Johnson et al. (2003), the average duration of
hospitalization for a newborn exposed to methadone was found to be a total of 29 days, with 25.5 of those days required for pharmacologic treatment. For infants exposed to methadone as well as other illicit substances (N=17), the average total length of stay was 41 days, 37 of which were treatment days. Conversely, in the group of newborns exposed to substances that did not include methadone (N=10), the average total duration of hospitalization was 13 days, 8.5 days of which were as a result of treatment. In a study of the efficacy of a clinical practice guideline for NAS N=90, the mean length of hospitalization for infants with NAS was 8.6 days for the opiate-exposed group of newborns and 19.6 days for the newborns exposed to methadone (Murphy-Oikonon, Montelpare, Bertoldo, Southon, & Persichino, 2012). These lengthy periods in the NICU environment are not only costly to health care institutions, but they may also cause periods of stress within the mother-infant dyad.

The problem of opiate withdrawal in newborns is significant, with the incidence of infant drug exposure reported to be from 3% to 50%, depending on the patient population and societal trends (American Academy of Pediatrics Committee on Drugs, 1998). Furthermore, neonatal withdrawal occurs in 55% to 94% of infants born to women using opiates and heroin, and up to 85% of infants born to women on methadone (American Academy of Pediatrics Committee on Drugs, 1998). The use of illicit opiates is believed to be on the rise in the general population, and this trend includes pregnant women (Caverson, 2010; Hudak & Tan, 2012; O'Donnell et al., 2009). In a research study investigating the prevalence of withdrawal conditions in newborns over time, the authors report that their retrospective cohort study of linked health and child protection data (N=906) from 1980 to 2005 revealed an increased prevalence of neonatal withdrawal from 0.97 to 42.2 per 10,000 live births, plateauing after 2002 (O'Donnell et al., 2009). Similarly, Burns and Mattick (2007) found that the proportion of infants in New South
Wales, Australia diagnosed with NAS (N=796) rose from 20% of births in 1994 to 28% of births in 2002.

One of the difficulties in determining the prevalence of NAS is discrepancies in definitions of the syndrome. For example, a comprehensive search for literature on NAS reveals articles on alcohol withdrawal, withdrawal from Selective Serotonin Reuptake Inhibitors (SSRI), and from cocaine, all misappropriated as NAS. In a recent review of neonatal drug withdrawal conducted by Hudak and Tan (2012), withdrawal from cocaine, opiates and SSRIs were explored. The authors suggest that an abstinence syndrome from intrauterine exposure to cocaine and amphetamines has not been clearly defined and many research studies designed to assess withdrawal symptoms following cocaine exposure have used scoring systems that were intended for opioid withdrawal. In addition, the authors speculate that current research on the effects of SSRI exposure in utero may be indicative of newborn toxicity rather than NAS, and it may be more accurate to use the term “serotonin discontinuation syndrome.” Nevertheless, as symptoms of withdrawal among the various substances of exposure overlap, the term NAS may be overused in the literature to define withdrawal from a variety of substance exposures in utero. Because many North American hospitals use opiate scoring tools, such as the one developed by Finnegan (1975) as cited in Hudak & Tan, (2012), to capture any type of substance withdrawal, further research is required into the efficacy of the opiate withdrawal tools used to evaluate withdrawal from other substances.

Further complicating the known prevalence of NAS is the fact that research has demonstrated the propensity of women who use substances to use more than one substance simultaneously (Goel, Beasley, Rajkumar, & Banerjee, 2011; Hudak & Tan, 2012). Polysubstance exposure is common and the resulting withdrawal symptoms in exposed infants
are often included under the term NAS. However, Hudak and Tan (2012) suggest that while symptoms of neonatal withdrawal may present following exposure to a range of drug types, clinically important neonatal withdrawal is most commonly the result of opiate exposure, and as such, should refer to withdrawal from opiates. The specificity of the term NAS has been diluted since the seminal work of Finnegan (1975) more than three decades ago. Furthermore, Marcellus (2007) argues that while the term NAS is correct, the implication of long-term effects on a child beyond the initial withdrawal may result in an unnecessary label applied to a child over time.

One of the challenges in providing care to infants affected with this syndrome is the inability to accurately identify substance-exposed newborns. Chasnoff, Neuman, Thornton and Callaghan (2001) reported that substance use by pregnant women is one of the most frequently missed diagnoses in perinatal medicine. The inability to detect a mother’s substance use during the prenatal period can lead to delayed or missed treatment of symptoms in newborns and missed opportunities for substance use treatment and support for pregnant women.

In an attempt to decrease the immediate and long-term risks to infants, several approaches have been undertaken to screen for substance exposure in pregnancy and the immediate postpartum period. The most frequently utilized method of screening is maternal self-report (Eyler et al., 2005). This approach is flawed, however, because of the stigma associated with being identified as a pregnant woman who is a drug user. Fear of the child welfare system (Powis et al., 2000), guilt and shame associated with substance use (Eyler et al., 2005), and an innate fear of the legal system (Powis et al., 2000) limit the possibility to promote forthcoming substance use disclosures from mothers to health care providers. Verbal screening approaches by obstetrical care providers are also lacking due to expedited appointment times in a fee-for-service model as well as a lack of knowledge, availability and desire to use standardized
screening tools. Given the health needs of substance-exposed infants, establishing accurate and reliable identifiers of maternal antenatal substance exposure is critical.

However, in the absence of accurate disclosures of substance use over the course of pregnancy, detecting substance exposure is possible once the infant is born. While this does not mitigate the perinatal risk factors, identifying infants at risk of NAS immediately following birth may serve as a strategy for early intervention, non-pharmacologic management, and pharmacotherapy for affected newborns. Meconium (the first stool of the newborn) screening, urine and hair analysis in infants have been used as methods to detect in utero substance exposure (Bar-Oz et al., 2003; Ostrea et al., 2001). In addition, conducting a urine toxicology screening on the infant has the ability to detect substance exposure in utero within 24-72 hours prior to testing based primarily on the half-life of the drug (Moller, Karaskov, & Koren, 2010; Zenewicz & Kuhn, 1998). The meconium can be screened to offer a more longitudinal assessment of maternal substance use in pregnancy, and can detect substances used as far back as the beginning of the second trimester (Lester et al., 2001; Moller et al., 2010). Similarly, infant hair analysis can also be used to detect substance exposure in utero, with the ability to detect possible exposure from the third trimester (Moller et al., 2010). While each method has benefits and limitations, there is a lack of screening standardization to aid in diagnosing and treating newborns (Murphy-Oikonen et al., 2012). Infant toxicology screening also presents an ethical dilemma, as information regarding the newborn’s condition reveals personal health information about the mother’s substance use.

Various screening tools to identify symptoms of NAS are available. The most frequently used screening tool was developed in 1975 by Loretta Finnegan and colleagues (as cited in Hudak & Tan, 2012; O’Grady, Hopewell, & White, 2009). A Finnegan score denotes the level of
distress experienced by the newborn, and the potential need for medication to alleviate the newborn’s discomfort. These scores are taken and monitored consistently by healthcare providers throughout the duration of time the infant exhibits symptoms. While Finnegan’s scoring method of identifying and measuring symptoms in newborns experiencing signs of withdrawal currently remains one of the most effective measures of NAS, it only identifies NAS once the withdrawal has begun rather than identifying substance exposure in pregnancy. Nevertheless, in the absence of detection of substance exposure in pregnancy, the Finnegan scoring tool is used by physicians and nurses to identify and rate the intensity of symptoms experienced by newborns withdrawing from substance exposure at birth. The tool groups infant symptoms into the following categories: central nervous system disturbances, metabolic, vasomotor and respiratory disturbances, and gastrointestinal disturbances (Kuschel, 2007). When an infant exhibits one of the symptoms within a category, they are given a numeric score to indicate the severity of the symptom. The total Finnegan score denotes the level of distress experienced by the newborn and the need for medication to alleviate the newborn’s discomfort. No consistent approach to medication administration has been established, but pharmacotherapy is generally administered when the mean of three consecutive scores of eight are attained (Murphy-Oikonen, Montelpare, Bertoldo, Southon, & Persichino, 2012). While Finnegan’s method of identifying and measuring symptoms in newborns experiencing signs of withdrawal currently remains one of the most effective measures of NAS, its effectiveness addresses the observable ailment (the symptoms of withdrawal) and fails to consider the contextual factors that are present, particularly those related to the infant’s family system.

Treating newborns with NAS requires the collaborative efforts of an interprofessional team. Social workers, nurses, pharmacists and physicians often work together to optimize
assessing and managing newborns affected with this syndrome (Murphy-Oikonen et al., 2012). When NAS has been diagnosed, initial treatment involves non-pharmacologic supportive care from the family and the health care team in an effort to reduce symptoms and minimize the need for pharmacologic management, which would inevitably result in longer hospital stays (American Academy of Pediatrics Committee on Drugs, 1998). Supportive care includes decreased sensory stimulation for newborns combined with cuddling, swaddling and a quiet environment, as well as nutritive therapy through small frequent feedings and temperature stability as a means of soothing infants as their symptoms present (American Academy of Pediatrics Committee on Drugs, 1998; Bio et al., 2011; Greene & Goodman, 2003; Kuschel, 2007). In an effort to decrease the symptoms of NAS, supportive care can be modelled by nursing staff to new mothers to empower them to care for their baby independently. This supportive therapy provides an opportunity for mothers to take on the caregiver role. However, many infants will require treatment beyond supportive care to manage their NAS symptoms, and infants are often transferred to the NICU or special care nursery for pharmacotherapy.

When supportive care is unable to ameliorate the clinical signs of NAS, pharmacologic treatment is warranted. According to Jannson (2008), pharmacotherapy is necessary to allow infants to sleep, gain weight and interact with a caregiver. The primary goal of pharmacotherapy is to stabilize symptoms and restore normal newborn functioning (Bio et al., 2011). Several approaches to pharmacologic treatment have been used to reduce NAS symptoms, including phenobarbital, diazepam, methadone, tincture of opium, paregoric, clonidine, chlorpromazine, and morphine sulphate, (Kuschel, 2007; Marcellus, 2002; Sundquist Beauman, 2005). However, there is a lack of consistency in physicians’ methods of managing NAS symptoms (Sarkar & Donn, 2006). Regardless of how pharmacotherapy is employed, the use of screening tools, such
as Finnegan’s scoring tool, assists physicians in more objectively assessing the need for pharmacologic management (American Academy of Pediatrics Committee on Drugs, 1998). It is generally accepted that treatment medication should match the agent causing the withdrawal, e.g., morphine therapy for opiate-affected newborns. At times, a combination of more than one medication may be warranted (Sundquist Beauman, 2005) as determined by the prescribing physician and the needs of the infant. In a 2004 double-blind randomized trial by Jackson, Ting, McKay, Galea and Skeoch morphine treatment for affected newborns (N=41) demonstrated a decrease in NAS symptoms and a decreased length of hospitalization relative to treatment with phenobarbital (N=34). While this research is promising, further research is needed to determine the most appropriate pharmacologic treatment regimen for newborns exhibiting symptoms of NAS.

Infants with NAS often require specialized care in an NICU environment where their symptoms can be monitored accurately and they can be treated pharmacologically (Johnson et al., 2003; Sundquist Beauman, 2005). Parents often experience the NICU environment as stressful and difficult to understand (Franck, Cox, Allen, & Winter, 2005; Heerman, Wilson, & Wilhelm, 2005; Wigert, Johansson, Berg, & Hellström, 2006). The physical environment includes noisy life support and monitoring equipment and bright lights. In addition, the sight of their infant connected to equipment causes stress in parents (Franck et al., 2005). A parent’s fears and concerns when their infant is in the NICU are often intensified if that parent is a mother who uses substances. A fear of exposure as a “bad” parent accompanied by a fear of losing their child to the child welfare system are common concerns among women who use substances (Powis et al., 2000). These fears may impact on mothers becoming more guarded in their interactions with the infant during hospitalization. Consequently, in addition to their role in the medical care and
management of substance-exposed infants, nurses, at times, assume the role of the unattended infant’s caregiver.

While the NICU can be an overwhelming environment for parents, it is also a place of opportunity where nurses can teach and model newborn care to mothers (Fraser et al., 2007). Research by Mok and Leung (2006) exploring nursing support for mothers of premature infants (substance exposure in pregnancy not a delimitation of the research) (N=37) found that mothers became more active partners in the care of their infant as a result of the information, communication and support provided by nurses. However, pregnant women who use substances do not receive the same nursing support afforded to mothers of premature infants (Fraser et al., 2007; Murphy-Oikonen et al., 2010). Findings suggest that the care of infants born to women who use substances occurs in parallel rather than in partnership, leaving mothers of infants who may develop NAS with little professional support. In general, nursing staff’s negative and judgemental attitudes towards mothers who use substances has been documented (Fraser et al., 2007; Murphy-Oikonen et al., 2010), and this negative tendency is a concern given that mothers of newborns in an NICU environment report feeling powerless, frustrated and anxious (Heerman et al., 2005; Mok & Leung, 2006; Wigert et al., 2006; Wigert et al., 2008), and feel like an “outsider” as nurses assume a caregiving role towards infants (Heerman et al., 2005). Wigert et al. (2006) outline the exclusion felt by new mothers when their infant is in the NICU, noting that “it is natural that the care in the NICU focuses on the child’s needs, but when the mother is not seen as part of the care, the mother’s feelings of exclusion are strengthened” (p. 39). For women who use substances, it seems that supportive nurses have the potential to foster the development of the mother-infant relationship.
Beyond the hospital experience, there are very few long-term studies identifying problems in children that are linked to in utero opiate exposure. Since opiates are not teratogenic, it is unlikely that long-term effects are a result of the chemical’s impact on the newborn (Greene & Goodman, 2003). Given the multiple confounding variables linked to the child’s environment, longitudinal studies to uncover the effects of substance exposure are difficult to establish (Hudak & Tan, 2012). Infants with NAS often live in complex social environments that are more likely than the opiate withdrawal to affect their development and well-being (Boyd, 2004; Powis et al., 2000). Pregnant women who use substances are also frequently polysubstance users (Koren et al., 2003), making it difficult to attribute presenting issues in development solely to the infant’s opiate withdrawal. Additional unknowns exist in the relationship of prenatal opiate exposure and issues such as learning and executive functioning of school-age children, given that longitudinal research is scarce. However, Jansson and Velez (1999) suggest that preschool- and school-aged children are at risk of developmental lags, language difficulties, and emotional or behavioural problems. NAS outcomes in child development are in stark contrast to outcomes for infants with Fetal Alcohol Spectrum Disorder (FASD), as the impact of alcohol exposure on the developing brain makes FASD an area of concern for long-lasting deleterious effects on the child (Koren et al., 2003). However, one cannot assume that opiate-exposed newborns are clear of long-term outcomes, and there is a need for an expanded research portfolio for infants affected by illicit substances in utero.

NAS has been explored from the perspective of infant needs but scant literature reflects NAS’s impact on mothers and families. Conversely, little is known about the impact of social risk factors in the lives of mothers on infants born with NAS. Literature on substance use in pregnancy demonstrates the issues faced by pregnant women, and literature on NAS reflects
issues present in newborns. However, to fully understand the needs and opportunities for intervention with affected newborns, women and infants cannot be treated as mutually exclusive individuals, and approaching NAS from a holistic perspective that is inclusive of the mother’s experience is warranted.

**Opiate Replacement Therapy**

MMT is considered the gold standard treatment for opiate addiction in pregnancy (Cleary et al., 2011). The Society of Obstetricians and Gynecologists of Canada (SOGC) recommends opiate substitution therapy as the standard of care for women addicted to opiates (Wong et al., 2011) such as heroin, Percocet (a pain killer that contains acetaminophen and oxycodone), morphine, and oxycodone. Although it is common for individuals with addictions to make multiple attempts to discontinue or decrease their substance use, abrupt cessation of opiates during the course of pregnancy can pose risks to both mother and the developing fetus, and may result in relapse (Ward, Hall, & Mattick, 1999; Wong et al., 2011). Methadone is a long-acting opioid that is taken orally once daily, and it replaces shorter-acting opiates such as heroin or oxycodone that are often misused as a result of their euphoric effect (Ward et al., 1999).

As a treatment for opiate addiction, methadone provides multiple benefits. It is dispensed at a pharmacy or physician’s office, and those who dispense methadone are federally regulated to ensure periodic random urine toxicology screening of patients (Schilling, Dornig, & Lungren, 2006), which monitors compliance and addresses risks associated with polysubstance use. MMT is effective in providing a substitution for short-acting opiates such as heroin and oxycodone for which tolerance and cravings necessitate taking increasing amounts over time. The long-acting properties of methadone block cravings for 24-36 hours, and as cravings are blocked and additional doses are provided every 24 hours, methadone is effective in preventing opiate
withdrawal (Goff & O’Connor, 2007; Ward et al., 1999) and decreasing the use of illicit substances (Schilling et al., 2006).

While the biological benefits of reduced cravings, euphoria and withdrawal cannot be disputed, the harm reduction capacity of MMT is of equal importance. The Diagnostic and Statistical Manual IV has specific clinical features that distinguish substance abuse and dependence. One such feature involves a great deal of time spent in drug-seeking behaviour (American Psychiatric Association, 2000). As methadone blocks the need for illicit opiates, additional treatment benefits emerge. These include a reduction or cessation in drug seeking, reduced criminal activity or risky behaviours that were used to support the drug habit, a decrease in needle sharing and thus a reduction in the possibility of acquiring infections such as HIV or hepatitis, and an increase in retention in treatment over time (Goff & O’Connor, 2007; Schilling et al., 2006; Ward et al., 1999). Furthermore, additional benefits exist for methadone-maintained pregnant women, as a standard daily dose of methadone serves as a protective factor for the fetus from in utero acute withdrawal from opiates (Ward et al., 1999). Prenatal benefits of MMT include a greater compliance with antenatal care, longer gestation, a higher birth weight, prevention of fetal distress, improved maternal and mental health, and increased likelihood of infant discharges to mothers rather than child welfare agencies (Cleary et al., 2010; Hudak & Tan, 2012; Lim, Prasad, Samuels, Gardner, & Cordero, 2009; Pizarro et al., 2011; Wong et al., 2011).

Despite the benefits of MMT, the main adverse effect of the treatment is the development of NAS (Hudak & Tan, 2012; Liu, Jones, Murray, Cook, & Nanan, 2010; Wong et al., 2011). Given that MMT is the recommended treatment for opiate addictions in pregnancy, many pregnant women enter methadone maintenance programs in an effort to improve neonatal
outcomes (McCarthy, Leamon, Stenson, & Biles, 2008). However, they may experience emotional difficulties if their infant develops NAS as a result of their engagement with treatment. While not all methadone-exposed infants experience withdrawal, a prevalence rate of 45% to 97% has been reported for medically treated NAS among methadone-exposed newborns that were scored on an objective scoring tool (this finding is reported in a meta analysis with a total of 45 neonates within two studies) (Cleary et al., 2010). Further, although methadone maintenance is a treatment for opiate addiction, NAS in methadone-exposed infants is often more severe and more prolonged than it is in infants exposed to opiates such as heroin (Hudak & Tan, 2012). The increased prevalence and severity of symptoms among infants born to women on a methadone treatment program may be difficult for those engaged in treatment to understand.

In an effort to reduce the incidence and severity of NAS, considerable efforts have been made to correlate maternal methadone dose with the onset and intensity of the syndrome, but there is a lack of clarity in the research regarding these correlations. Liu et al. (2010) conducted a five-year retrospective medical record review of methadone-maintained pregnant women (N=228, resulting in 232 live births). Through logistic regression analysis, methadone dose was found to be a predictive factor for the development of NAS requiring pharmacologic treatment. Similarly, Lim et al. (2009) conducted a retrospective cohort study of methadone-using pregnant women (N=68) and found that higher doses of methadone prior to pregnancy resulted in increased treatment for NAS and a longer treatment duration. These findings are often used to guide methadone prescribers in decreasing methadone doses in an effort to ease adverse effects to newborns. However, this research has several limitations, including a relatively small sample size and the inability to control for additional substances used by mothers, and therefore must be interpreted with caution.
Despite the findings of a positive correlation between maternal methadone dose and NAS, there is considerable literature to refute these findings. McCarthy, Leamon, Parr and Anania (2005) for example, conducted a retrospective review of mother-infant pairs (N=81). The cohort was divided into two groups: those who take a high dose of methadone (>100 mg) (N=45), and those who take a low dose of methadone (<100 mg) (N=36). Although 51% of the high-dose exposed neonates and 49% of the low-dose exposed neonates required treatment for NAS, higher doses of methadone were not correlated with the incidence and pharmacologic treatment of NAS. The findings also revealed that the higher-dose group had significantly less drug use than the lower-dose group, which suggests that methadone is a mitigating factor for continued substance use among pregnant women. Similarly, Pizarro et al. (2011) conducted a retrospective review of 174 methadone-maintained pregnant women, dividing the groups into those who take a low dose of methadone (<50 mg) (N=59), those who take a medium dose (51-100 mg) (N=63), and those who take a high dose (>100mg) N=52. The findings did not reveal a significant difference in the incidence or severity of NAS among the three cohorts. However, given the ethical challenges in conducting randomized trials in this population (Cleary et al., 2010) and multiple confounding variables such as polysubstance use and nicotine dependence challenges exist in the interpretation of the results.

Cleary et al. (2010) conducted a systematic review and meta-analysis of 67 studies with a total of 5139 neonates with NAS that were exposed to methadone in pregnancy. The findings of the systematic review do not demonstrate a statistically significant difference in the incidence of NAS among infants exposed to a low methadone dose compared to a high methadone dose. These findings are clinically relevant for physicians who make decisions regarding decreasing maternal methadone doses to mitigate NAS. The SOGC recommends that the maternal
methadone dose should be consistent with the requirements to suppress the opiate addiction rather than low-dosing to decrease the incidence of NAS. In this regard, methadone maintenance presents a conundrum as the issues faced by mothers and those faced by newborns converge, and decisions regarding methadone doses must weigh the benefits and risks of both the infant and the pregnant woman. Pregnant women are more likely to benefit from the multiple harm-reduction properties of methadone maintenance over the course of their pregnancies while the long-term benefits to infants in returning to more stable family units may outweigh the immediate risks of withdrawal.

Neonatal morbidity subsequent to methadone exposure has been well established in the literature. While the harm-reduction benefits of methadone, most notably the decrease in illicit substance use, are considerable, infants exposed to methadone in utero are at risk of slight prematurity, low birth weight, increased incidence of tobacco exposure prenatally, intrauterine growth retardation, risk of exposure to more than one illicit substance in utero, and increased risk of admission to an NICU or special care nursery (Burns, Mattick, Lim, & Wallace, 2007; McCarthy et al., 2008; Sharpe & Kuschel, 2004). In a six-year retrospective cohort study of 61,030 births resulting in a 1% (N=618) incidence of methadone-exposed pregnant women, maternal characteristics included high rates of unemployment, high rates of tobacco use, and an increased prevalence of unplanned pregnancies. Neonatal outcomes included withdrawal, preterm birth, small size for gestational age, admission to NICU, and a diagnosis of a major congenital anomaly (Cleary et al., 2011). In research that has compared pregnant women receiving MMT throughout their pregnancies with those on MMT who began MMT late in the second or third trimester, findings suggest that women continuously on methadone throughout the course of their pregnancies have improved maternal and neonatal outcomes (Burns et al.,
Burns et al. (2007) also found that pregnant women who accessed late MMT (N=306) were more likely to receive late prenatal care, lack preparation at delivery resulting from inconsistent prenatal care, be unmarried, be indigenous, use tobacco, and have infants born less than 37 weeks. Among this group there was also a subsequent increase in admissions to a special care nursery. Similarly, McCarthy et al. (2008) indicated that women who were maintained on methadone throughout their pregnancies (N=22) (with conception occurring while on methadone) were less likely to have positive toxicology screens for illicit substance use than those who received MMT late in pregnancy (N=35) (conceived-off of methadone). This research reported a 39% rate of preterm birth and a 35% rate of low birth weight in newborns with no differences between the groups. Maternal smoking was also found to be a risk factor for both groups, with a reported smoking rate of 81% for the conceived-off group and 78% for the conceived-on group. These findings support the findings noted above regarding significant morbidities among substance-exposed neonates, with poorer outcomes associated with late-onset MMT.

However, not all methadone use during pregnancy is intended as a treatment for opiate addiction. Many methadone-using pregnant women are prescribed methadone for pain control for comorbid conditions. Sharpe and Kuschel (2004) explored neonatal outcomes following in utero methadone exposure by comparing a group of women using methadone for pain control (pain group) (N= 19), and a group of women using methadone for opiate addiction (maintenance group) (N=24). Neonatal outcomes revealed a higher incidence of prematurity in the maintenance group, and conversely, better growth parameters in the pain group. However, less need for pharmacologic treatment of NAS was determined in the pain group (11%) compared to a high proportion of treated neonates in the maintenance group (58%). These findings may be
attributed to a lower methadone dose, shorter duration of methadone treatment, and later initiation of methadone treatment among the pain group. The small sample size and a large number of additional pharmacotherapies for pain control used within the pain group are limitations, but this research nonetheless uniquely identifies outcomes for infants within a group of women who were not addicted to illicit opiates.

Despite the effects of methadone on neonatal outcomes, in comparison with illicit opiate-exposed neonates, the benefits of MMT are extensive when it comes to reducing harm to women and establishing a more stable life that is free from drug seeking and continuous withdrawal. However, the rigidity of daily MMT at a pharmacy or clinic, combined with urine toxicology screening, poses challenges to those who seek this type of treatment. In addition, pregnant women seeking methadone treatment may be overwhelmed by the withdrawal symptoms in methadone-exposed infants. While NAS is a very serious medical condition in newborns, treatment to assist newborns with withdrawal is available and maternal engagement with MMT is beneficial in reducing the risks and improving the odds of mother and infant remaining together post-hospitalization.

Buprenorphine is an alternative opioid replacement therapy that was approved by the FDA the US in 2002 (Hudak & Tan, 2012). Although it has had limited use among opiate-addicted pregnant women, research is emerging regarding the benefits of buprenorphine relative to MMT and neonatal outcomes. There are two types of buprenorphine: a single agent (Subutex), or a combination that includes naloxone (Suboxone) (Hudak & Tan, 2012). The safety of both pharmacotherapies during pregnancy is unclear, and access to the medication is limited through Health Canada’s special access program (Wong et al., 2011). Buprenorphine is administered orally by prescription, which decreases barriers for methadone-using women in that
buprenorphine treatment can be administered in the comfort of one’s home environment. In addition, given that buprenorphine has a ceiling effect (Wong et al., 2011), there is a reduced risk of overdose in comparison with MMT. Buprenorphine’s ceiling effect reduces the need for the protection of clinic administration and enables individuals to take responsibility for their own treatment. With this in mind, the use of Subutex or Suboxone enables more normalcy and freedom as individuals can carry on their daily activities, including employment or travel, without needing to be close to a treatment clinic, as is the case with MMT.

In recent years, there has been an emerging body of research that explores the impact of buprenorphine compared to MMT on perinatal morbidity and NAS. Although there is evidence to suggest a decrease in the incidence and severity of NAS among buprenorphine-exposed neonates (N=38) relative to methadone-exposed neonates (N=32) (Binder & Vavrinkova, 2008), there continues to be a lack of clarity on the benefits to NAS and neonatal outcomes (Lacroix et al., 2011), and further research is needed. However, the involvement of pregnant women in research is a complex issue due to the ethical concerns of providing medications to pregnant women that may have an effect on a developing fetus, and because a fetus is unable to provide informed consent (Unger et al., 2011).

Binder and Vavrinkova (2008) conducted a five-year randomized prospective comparative study to evaluate the effect of different types of opiate substitution therapy on perinatal outcomes and NAS in a sample of pregnant women. A total of 117 pregnant women were included in the study and divided into three groups: the heroin-exposed group (N=47), the methadone-exposed group (N=32), and the buprenorphine-exposed group (N=38). Although the study demonstrated a statistically significant difference in birth weight, with the lowest birth weight occurring among the heroin-exposed group of neonates, there was no difference in the
duration of pregnancy across groups. Findings also revealed a statistically significant difference in the severity of NAS and the duration of pharmacologic treatment, with the most severe symptoms present in the methadone-exposed group of newborns; 100% of newborns in the methadone-exposed group were symptomatic of NAS, while 89% and 86% of newborns were symptomatic in the heroin-exposed group and the buprenorphine-exposed group, respectively. The buprenorphine-exposed group presented the least symptomatic of NAS. The average Finnegan scores across neonates was less than nine.

In a randomized control study, 131 pregnant women participated in a double-blind research study comparing methadone and buprenorphine on neonatal outcomes such as treatment for NAS, peak NAS score, quantity of morphine dispensed to treat NAS and length of hospital stay. Study participants were observed daily while they took seven tablets containing buprenorphine or placebo and liquid containing methadone or placebo. Both treatment groups were similar on baseline characteristics and exposure substances. There was no difference between the buprenorphine group and the methadone group with respect to incidence of treatment for NAS or peak score on the modified Finnegan’s scoring tool, though there were significant differences in the amount of morphine required to treat NAS and the length of hospital stay, with the buprenorphine group requiring 89% less morphine and 43% less time in the hospital than the methadone group (Jones et al., 2010). Additional case analysis of three women in the RCT who had two pregnancies during the course of the study revealed further findings. Each of the three women received methadone or buprenorphine during their first pregnancy and the opposite during the second (still blinded). Buprenorphine was associated with less incidence of treatment for NAS, with only two of the three infants requiring treatment compared to all of the methadone-exposed infants requiring treatment. Furthermore,
buprenorphine was associated with less medication for withdrawal (a mean of 1.2 mg) than the methadone group (a mean of 2.5 mg) and a decreased length of hospital stay, with a 4.7-day average length of stay for the buprenorphine-exposed group versus a 9.0-day average length of stay for those in the methadone-exposed cohort (Unger et al., 2011). Although the sample size was small, this unique case analysis provided insights into perceived confounding variables such as maternal metabolism and personal characteristics.

Research by Lacroix et al. (2011) also explored the impact of opiate-substitution therapy on neonatal outcomes and found that methadone-exposed newborns (N=45) were more likely to experience withdrawal (62.5%) than buprenorphine-exposed newborns (N=90) (41.2%). Pharmacological treatment of infants was indicative of a more severe withdrawal among the methadone-exposed group of newborns, with 80% requiring pharmacotherapy for NAS compared to 57% of newborns in the buprenorphine group requiring pharmacologic treatment. Women in the methadone group were more likely to use heroin in late pregnancy (35%) than those in the buprenorphine group (12.9%), and subsequent to adjustments for heroin exposure during the course of treatment, there were no significant differences in withdrawal. These findings contradict the notion that NAS is less severe among buprenorphine-exposed neonates as no differences between treatment groups could be determined.

Despite a lack of clarity in the efficacy of buprenorphine treatment in decreasing the incidence and severity of NAS, it is clear that buprenorphine is a viable alternative to methadone maintenance to treat opiate addiction in pregnancy. In addition to the effects of buprenorphine on the physiological effects of opiates, the subjective benefits of the therapy may provide additional independence for opiate-dependent women and less reliance on the system for compliance.
monitoring. However, further research is required to evaluate the impact of treatment type on neonatal outcomes and NAS.

Opiate replacement therapy offers insight into the convergence of substance abuse by a pregnant woman and NAS among substance-exposed infants. While opiate substitution therapy offers multiple benefits to the new mother, it has serious adverse effects on the immediate care of newly born infants. MMT or buprenorphine treatment forces health care providers to deal with the issue of substance use and NAS simultaneously. Decisions made for the immediate benefit of the mother may be endorsed by women’s advocates or those in the field of women’s health, while child advocates and those in children’s health may ethically struggle with endorsing a treatment that has been well-established as a contributing factor to the negative neonatal outcome of NAS. This conundrum provides merit to the exploration of mothers’ experiences with NAS in an attempt to garner insights from those who are most directly impacted by the syndrome.

**Motherhood**

Dominant cultural concepts of motherhood have idealized the maternal role. This has imposed expectations on mothers to be the consonant nurturer; compassionate, instinctive, ever-responsive, child-centered, and self-sacrificing (Klee, Jackson, & Lewis, 2002; Reid, Greaves, & Poole, 2008). Furthermore, mothers are often portrayed in the role of the good wife, who is educated, middle class, white, and in a nuclear, heterosexual family (Allen, Flaherty & Ely, 2010; Boyd, 2004). These notions of motherhood impose harsh expectations on women and are difficult to live up to in the everyday world of caring for children. Women who use substances are not immune to knowledge of societal discourse on mothering. The pervasive stereotypical discourse (Klee et al., 2002) that substance using pregnant women fail to live up to the good mother ideal is ever-present in the world of women who use substances as they struggle to live
up to the ideal while also at the mercy of their addiction. Silva, Pires, Guerreiro & Cardoso (2012) interviewed 24 women in a methadone maintenance program and found that motherhood was characterized by a strong ambivalence between addiction and parenting. Mothers reported excessive feelings of guilt as they attempted to dedicate themselves to the needs of their children while also continuing to consume drugs. Thus, being a mother while using substances poses many challenges to women as they claim their dual identity as both a mother and a woman struggling with substance use.

Societal discourse on mothers who use substances is primarily negative with assumptions that drug users make “bad parents” being propagated in the media and social circles (Rhodes, Bernays, Houmoller, 2010). This discourse fails to recognize the hardships faced by women who use substances. A high proportion of substance using mothers live in poverty, experience abuse, have mental health issues, are single parents, are involved with the criminal justice system, participate in the sex industry, experience social exclusion, and are unemployed (Allen et al., 2010; Hogan, 2007; Klee et al., 2002; Rhodes et al., 2010). These life circumstances highlight the multiple marginalizations that women who use substances are faced with, including their gender, race, class, and victimization status (Allen et al., 2010). Despite these life circumstances and the belief that mothers who use substances are failing their children, substance-using mothers can and do mother. Hardesty & Black (1999) interviewed 20 Latino mothers addicted to heroin or crack and found that women were ever aware that their drug use was not congruent with the good mother ideal, and they were all trying their best to be “good enough”. Mothers in this research attempted to limit the damage they may cause to their children by separating their drug use from their family life by keeping their drug use hidden from their children.
Furthermore, mothers who use substances experience shame and guilt for their use of drugs, and despite their addiction, express love and pride in their children (Allen et al., 2010; Virokannas, 2011). Although the expression of love for children among women who use substances has been cited in the literature, there is debate as to whether these mothers are simply filling the functional role of meeting the needs of their children (Silva et al., 2012), or claiming the stereotypical maternal identity of the consonant nurturer.

Virokannas (2011) interviewed addicted mothers about their maternal identity and found that despite awareness of moral pressure and social stigma, mothers who use substances felt compelled to prove their love for their children even in the face of addiction. However, mothering while using substances often involves separation from children and sporadic ability to fulfill the parenting role. Many mothers who use substances are involved with the legal system and have periods of incarceration thereby separating mothers and their children (Allen et al., 2010; Klee et al., 2002). Furthermore, Hogan (2007) reported that drug using parents lacked confidence in their ability to nurture and attend to their children during times of use. This finding is consistent with Silva et al., (2012) who found that drug addicted mother expressed a strong sense of guilt that contributed to ambivalence between dedicating themselves fully to the needs of their children, while also continuing to use substances. These findings shed light on the experiences of being a mother while using substances, however, there continues to be a gap in understanding the real life experiences of mothers from their perspective (Boyd, 2004). The experiences of mothers struggling with addiction are an important area of exploration, particularly in light of the stereotypical discourse that is pervasive in the larger social context (Reid et. al., 2008). This research will explore what it is like to be a mother of a newborn.
affected by maternal substance use in pregnancy resulting in NAS. Garnering experiential knowledge from the standpoint of mothers who use substances will inevitably shed light on the realities for mothers with addiction.

**Summary**

This literature review provides an exploration of the issues affecting pregnant women and mothers who use substances. Social, legal, moral and health care discourses have stigmatized substance-using pregnant women by depicting them as “bad” mothers. However, the literature highlights that these women face multiple vulnerabilities that contribute to their use of substances. Given the effects of maternal substance use on the developing fetus, knowledge of the issues faced by this population are important to the understanding of NAS.

This literature review also presents the complexity of NAS and the knowledge gained to date from the medical community regarding issues such as symptoms, treatment and length of hospitalization. There are few qualitative studies that examine issues related to NAS, and this literature review identifies the gaps that currently exist in scholarship. Furthermore, the lack of literature regarding the convergence of the issues affecting pregnant women who use substances and who have a newborn with NAS inform the current inquiry that seeks to explore these experiences among a sample of mothers. The lack of representation of mothers’ voices is a noteworthy omission because infants are primarily cared for by their mothers. As the condition in newborns is a direct effect of maternal opiate consumption, the absence of literature exploring the plight of mother informs the need for inquiry.

Lastly, the literature also outlines opiate replacement (methadone or buprenorphine) therapy as the gold standard for treatment for opiate addiction among pregnant women who use substances. Knowledge of the treatments available to mothers is important to the understanding
of NAS, as the treatments benefit both mother and newborn while also contributing to NAS. MMT is often sought by mothers who are motivated to undergo treatment, but as this review identifies, there continues to be a cost to both mothers and newborns. Developing a baseline understanding of substance use in pregnancy, NAS and opiate replacement therapy offers insight into the predominant issues present among this population. Further in-depth exploration is needed to identify the salient issues that merge the bodies of research of mothers and affected newborns. The next chapter presents the methodology used to explore the experiences of mothers of newborns with NAS.
CHAPTER 3: METHOD

This chapter describes the chosen research methodology and approach used to complete this research study. This approach is based on its fit with the research question and the researcher’s philosophical beliefs and skill set. Choosing a research method was a task that took considerable time and deliberation. In contemplating the proposed research, I began by reviewing several qualitative approaches in an effort to explore the experiences of mothers in relation to the experience of having an infant with NAS. After assessing several qualitative approaches, a shortlist was developed that included descriptive phenomenology, hermeneutic phenomenology, grounded theory, and case study, as I believed that each of these methods could yield findings related to the experiences of mothers. I determined that the methodological choice must be based on its central tenets, purpose and intended outcome as it applies to the intended research question. Some similarities and incongruities among the approaches exist.

This chapter will examine the choice to use a qualitative research design, and descriptive phenomenology specifically. For the purpose of this research, descriptive phenomenology is used as both a philosophy and a method. Unlike Hermeneutic Phenomenology, the descriptive tradition is not context dependant, but rather it focuses directly on the description of the experience as it presents itself to the individual having the experience (Laverty, 2003). While many methods explore lived experiences, descriptive phenomenology resonated for me as it reveals essential structures through rich description, is largely reliant on in-depth interviews, and uses a rigorous process of analysis that is free of researcher bias. Any prior interpretation stemming from the researcher’s experience is identified and set aside in an effort to allow for the phenomenon to present itself in a pure form.

The process of bracketing, sampling and recruitment, description of the sample, data
collection, data analysis, and the research’s trustworthiness are explored.

**Qualitative Design**

The traditional approach to science and research emerged from the positivistic paradigm, which espoused singular truth through prediction, justification, controlled variables, and the relationship between cause and effect (Lincoln & Guba, 1985). As such, quantitative research studies are designed with predetermined response categories that serve to either confirm or deny the researcher’s hypothesis (Lincoln & Guba, 1985; Patton, 2002). While this approach has led to important findings, Lincoln and Guba (1985) critique its philosophical underpinnings, stating, “positivism has produced research with human respondents that ignores their humanness” (p. 27). This deductive approach to research is believed by many quantitative scholars to produces conclusive evidence of a singular truth.

Despite quantitative findings’ important contributions, this method does not lend itself to a rich and detailed understanding of experiences and the meanings attributed to those experiences. Colaizzi (1978) notes that human experience has been eliminated in research methodologies in an attempt to maintain objectivity, and he argues that “to deny my experience is to not be objective” as objectivity means that his statements faithfully express what stands before him (p. 52). Human beings are able to offer expert firsthand accounts of their lives. As such, predetermining the outcomes or measures to be tested limits the breadth and depth of a phenomenon that may not be well understood.

Qualitative research offers a more palatable option for research that is aimed at discovery and exploration regarding human subjects. From a qualitative lens, the direct experiences and accounts of individuals are uncovered through an interpretive process that validates the existence
of multiple realities (Denzin & Lincoln, 2005). Creswell (2007) states, “[w]e conduct qualitative research when we want to empower individuals to share their stories, hear their voices and minimize the power relationships that exist between a researcher and the participants in a study” (p. 40). As such, the relationship between the researcher and participants is intimate in that a rapport is established, personal stories and experiences are shared, and the researcher becomes the instrument of gathering and analyzing data.

The qualitative approach to research locates the researcher within the world of the participants. This method does not align with objective science, but rather with an inductive and naturalistic interaction between the researcher and participants. Denzin and Lincoln (2005) state, “[e]ach interpretive paradigm puts demands on the researcher, including the questions the researcher asks and the interpretations he or she brings to them” (p. 22). While qualitative research designs share the philosophical underpinnings of respect for multiple truths and the situated nature of the researcher, there continues to be variation in method execution.

Nevertheless, as Patton (2002) argues, “[s]ome questions lend themselves to numerical answers; some don’t” (p. 13). Simply, the choice of methodology is guided by the choice of research question. At its core, qualitative research seeks to explore the social world that is best described through direct observation and rich situated data and analysis (Denzin & Lincoln, 2005). In qualitative research, the process unfolds as the research progresses, allowing for the participants to describe the phenomenon in question as opposed to predetermining and predicting what those findings may or may not be (Lincoln & Guba, 1985).

Lofland (1971) eloquently sums up the purpose of qualitative research:

The commitment to get close, to be factual, descriptive and quotive, constitutes a significant commitment to represent the participants in their own terms…One faithfully
depicts what goes on in their lives and what life is like for them, in such a way that one’s audience is at least partially able to project themselves into the point of view of the people depicted (as cited in Patton, 2002, p. 28).

Choosing a research method among the many qualitative traditions was a task that took considerable time and deliberation. In contemplating my proposed research, I began by reviewing several qualitative approaches. Deciding on a method to use within a research study is a task than cannot be taken lightly, and as noted above, it must fit with the paradigm of inquiry. Evaluating each method in relation to the purpose of the study and the research question, as well as intended outcomes (e.g., description or theory), will strengthen the trustworthiness of the research results (Starks & Trinidad, 2007). According to DiCenso, Guyatt and Ciliska (2005), “because no two qualitative sources will generate exactly the same interpretation, much of the art of qualitative interpretation involves exploring why and how different information sources yield slightly different results” (p. 129). With that being said, evaluating other methods’ suitability was essential to establish a rigorous methodological process.

A choice in methodology must be grounded in philosophical beliefs and its ability to answer the research question. In an effort to explore mothers’ accounts of their experiences with NAS, my goal was to describe the essence of their experience as directly reported by the mothers while maintaining cautious awareness of my own bias. I am confident that descriptive phenomenology is the best fit for my intended research question and the purpose of the research. The search for the essence of experience across participants in a purely descriptive form is the predominant rationale for choosing descriptive phenomenology as a way to explore mothers’ experiences.
Why research NAS from a qualitative lens? Consistent with the scientific method, NAS has been situated in the quantitative paradigm and is driven from a positivistic lens. This is evident through substantial research related to treatments and measureable outcomes (D’Apolito & Hepworth, 2001; Johnson et al., 2003; Sundquist Beauman, 2005). The merits of the quantitative approach to NAS cannot be discredited, as this research has influenced guidelines for effective treatments and identification of symptoms. However, one of the predominant limitations of the currently available research on NAS is its lack of comprehensive and holistic representation of the syndrome inclusive of the maternal experience. A qualitative approach to exploring NAS offers the opportunity to fill a gap in the existing knowledge by adding direct experiential knowledge to the existing understanding.

According to Creswell (2009), “qualitative research is a means for exploring and understanding the meanings individuals or groups ascribe to a social or human problem” (p. 4). An exploration of the subjective experiences of mothers through an intimate relationship between the researcher and the participant has revealed the firsthand accounts of mothers’ lived experiences. Although qualitative research is not generalizable to larger groups (Denzin & Lincoln, 2005; Lincoln & Guba, 1985), Denzin and Lincoln (2005) state that one strength of qualitative research is the ability to capture rich descriptions of the social world. Similarly, van Mannen (1997) offers, “the preferred method for human science involves description, interpretation and self-reflective or critical analysis. “We explain nature, but human life we must understand” (p. 4). Given that mothers’ experiences with NAS have not been previously explored, qualitative research provides the opportunity for a representation of mothers’ experiences directly from their own perspective, offering a depth of understanding not otherwise attainable through a deductive approach.
**Phenomenology**

Individuals make inferences about phenomenon and human behaviours on a regular basis. These inferences or assumptions are bound by culture, experience and historical context (Patton, 2002). This is consistent within the dominant epistemological position of the medical model which guides the current understanding of NAS. In a study by Murphy-Oikonen et al. (2010) of nurses’ (N=12) experiences with NAS, the nurses reported several assumptions about mothers of affected newborns. One nurse stated, “I find the mothers care more about themselves and their dilemma, than they do for the pain their baby is in.” Assumptions such as these are influenced by and influence the dominant discourse, enabling others to assume they understand these mothers’ intentions. Judgments regarding dishonesty, bad mothering and a lack of parental capacity have dominated NAS discourse for decades (Boyd, 2004). In this regard, inferences or assumptions about a particular condition or human behaviour without having personally experienced it will inevitably lead to misinterpretations and misunderstandings.

Phenomenological research methodology offers an opportunity to dispel common (mis)understandings of mothers who have an infant with NAS through a rich understanding directly from mothers themselves. Descriptive phenomenology is rooted in philosophy and is defined as a method of inquiry that seeks to describe lived experience in an attempt to reveal and gain a rich description of the essence or underlying structure of that experience (Creswell, 2007; Dukes, 1984; Finlay, 2000; Osborne, 1994; Patton, 2002). According to Dukes (1984), human experience makes sense to those who live it. The importance of revealing mothers’ experiences is supported by Creswell (2007) who states that in phenomenological research, reality can only be perceived within the meaning of an individual who has directly experienced the phenomenon.
of interest. Therefore, while theories have emerged regarding the experiences of mothers of infants with NAS based on individual preconceptions and interpretations, in order to truly “know” or understand the issue, that knowledge must come directly from mothers of affected newborns.

Husserl (1931) is considered the father of descriptive phenomenology (as cited in Moustakas, 1994), and his primary goal was the development of a rich, thick description of the essence of experience as described directly from those who have had it, free from researcher bias (Laverty, 2003; Moustakas, 1994). An important feature of the method is to reveal the shared essence of experience across multiple participants based on the belief that there are shared features to any lived experience that are common to all persons who have had the experience (Lopez & Willis, 2004).

Some scholars critique this notion of “shared essence,” believing instead that each individual has a unique subjective interpretation of the meaning of a particular phenomenon and that truth is a matter of perspective (Finlay, 2000; Harding, 1987). In this research, participants are defined as mothers who have had an infant with NAS. While unique features of the experience exist, it is anticipated that there is a shared essence among mothers when their infant is withdrawing from substance exposure. The shared experience is important to understanding NAS beyond the infant’s symptoms, and studying it will contribute to the promotion of maternal-infant attachment and a more comprehensive understanding of the maternal context of the infant.

Central to the understanding of Husserl’s (1931) phenomenology is the concept of intentionality of consciousness. This concept proposes that in order for a phenomenon to be experienced, there must be interaction between a subject and an object. In this regard, experience contains the descriptive appearance combined with the internal experience of consciousness
based on memory and meaning (Creswell, 2007). Consciousness contains description and a depth of understanding based upon factors such as perception, feelings, judgments and meaning (Patton, 2002) as understood by those with the direct experience. For mothers of substance-exposed newborns, the experience of having an infant withdrawing from substances denotes the subject-object connection. Therefore, the experiences of the mother can be factually described and explained through more comprehensive meanings based on consciousness. The identification of the essence of the experience as committed to consciousness is based upon a thematic exploration of their meaning (Osborne, 1994). Given that the phenomenological method is reflective, one could argue that a limitation of this approach are changes in memory from the time of the event to the time of participation in the research process. However, because this research is concerned with understanding experiences as mothers perceive them, slight variation in the recall of experiences continue to be an important component of each mother’s personal interpretation of her experience.

A first step in phenomenological inquiry is the practice of epoche. Epoche is a Greek word meaning to refrain from judgment (Patton, 2002) and suspend the commonly held ways in which individuals perceive things. As originally defined by Husserl (1931), epoche is synonymous with the notion of bracketing in phenomenological research, and it allows researchers to see things as they are (Finlay, 2009). This critical element in the phenomenological approach ensures that the objective of the research (understanding phenomenon) is achieved by allowing the data to speak for itself (Osborne, 1990).

Bracketing involves the suspension of the researcher’s presuppositions of the phenomenon through ideas and previous understandings, personal knowledge and assumptions (Finlay, 2009; Lopez & Willis, 2004; Osborne, 1994) in an attempt to uncover the experiences as
it makes sense to those who have experienced it (Dukes, 1984). Finlay (2009) cautions that “any research which does not have at its core the descriptions of the things in their appearing, focusing on experiences as lived, cannot be considered phenomenological” (p. 9).

Many scholars reject the notion of suspension of beliefs and assumptions in the research process and criticize the attempt at value-free, objective forms of research (Denzin & Lincoln, 2005). Qualitative inquiry generally espouses a contrary belief in the co-creation of knowledge that exists when researcher and participant engage in a collaborative form of inquiry (Patton, 2002). Despite feminist scholars’ critiques of phenomenological inquiry, feminist standpoint theorist Sandra Harding (1987) does not reject objectivity altogether but argues for a perspectival analysis through the notion of strong objectivity.

My personal feeling of establishing epoche in the research process is that complete suspension of assumptions, experiences and beliefs is not possible and that epoche resonates for me as synonymous with Harding’s (1987) notion of strong objectivity. Strong objectivity urges us to look closely at how our experiences and our positions, as well as the language that we use, are influenced by social norms and subsequently influence our interpretation of all aspects of the research process (Maynard, 1994). This in turn places the researcher on the same critical playing field as the participant (Harding, 1987). Although epoche is defined as a first step in the phenomenological process, the process of setting aside presuppositions must occur through continuous reflexivity throughout the research (Colaizzi, 1978; Finlay, 2009). Perhaps critics of Husserl’s notion of bracketing viewed the suspension of presuppositions as a type of one-time confessional, thereby excusing some of the preconceived ideas about the research. However, I believe that identifying positionality does not just occur at the outset of the research, but rather it includes a commitment to continuous questioning of how that position affects the research.
process at all stages in an ongoing reflexivity (Brooks & Hesse-Biber, 2007). With an interpretation of bracketing as strong objectivity in an ongoing process throughout the research, bracketing preconceived experiences and assumptions is consistent with the fundamental value in social work of approaching clients with a non-judgmental attitude. While I do not believe that complete impartiality is possible, nor do I believe this was Husserl’s (1931) intent, my interpretation of epoche is that it reflects the need for the researcher to engage in an ongoing process of reflexivity throughout the research in an attempt to continually question the impact of self on the approach to and subsequent findings of the research, and to ensure that these biases are set aside in order to see things as they are.

**Delimitations**

This study was delimited within the framework of achieving a purposive sample. Given that the goal of using a phenomenological method is to study lived experience and to uncover the essence of the experience (Dukes, 1984), the inclusion criteria for this research involved only women who were biological mothers of infants who have been diagnosed with NAS. According to Patton (2002), “a person cannot reflect on lived experience while living through the experience” (p. 104). In this regard, the participants were selected based on experience of mothering an infant with NAS. Inclusion criteria consisted of biological mothers of affected infants that have experienced withdrawal between the dates of September 2007 and June 2011. Although the intended end date for recruitment was December 2010, due to a delay in the ethics approval from the regional hospital, the recruitment date was extended until the end of June 2011. This sampling frame was chosen as a means of uncovering reflective experiences. It is noteworthy that mothers actively caring for an infant with NAS at the time of the interviews
were not included in the sample as their primary focus was on the immediate needs of their newborn. This sampling strategy optimized the reflective capacities of participants. The sampling frame was also chosen based on the potential for participants to come forward in the research process from a period of time when the researcher was providing frontline work to women who have given birth to affected newborns. Given that I was no longer engaged in direct clinical practice in July 2007, choosing September 2007 as the initiation of recruitment was a means of safeguarding the integrity of the research process and ensuring that participant stories had not been previously shared with the researcher.

Beyond the noted delimitations of the study, the research was also limited by time and place. All participants were recruited in Thunder Bay, Ontario and from a single regional hospital that services the entire community. This means the sample was homogeneous in terms of their experience in the hospital and with a specific health care team. All but one participant gave birth to their babies in Thunder Bay, lived in the community and received similar messaging regarding NAS. Choosing Thunder Bay as a recruitment site was convenient in that there is a high prevalence of NAS in the community and there is an assumption that recruitment would therefore not take as long as it would in a community where NAS is uncommon. In addition, Thunder Bay was a well-suited location for the researcher due to proximity and familiarity with community agency recruitment sites. Given that Thunder Bay is a relatively small, homogeneous city, choosing to limit the research to this location inhibited representation across multiple cultural groups.

Further delimitations can be found in the design of the study and the choice of research question. Choosing to research mothers’ experiences is of critical importance due to its lack of representation in the literature. However, although the voices of mothers are very important, the
current research also fails to adequately explore the paternal experience, which is of equal importance to the experiences of mothers. In an effort to hear directly from mothers, and to sufficiently narrow the scope of the current research, an exploration of fathers’ experiences was not included within this research framework.

Each of these delimitations was chosen in an effort to narrow the scope of the research to a manageable endeavour. Further, the delimitations protected the integrity of the process in ensuring that the stories heard by the researcher were new and uninfluenced by the prior knowledge of the researcher.

**Sampling and Recruitment**

Consistent with qualitative inquiry, nonprobability sampling was used to explore the prenatal and postnatal experiences of mothers who have had an infant with a diagnosis of NAS. Purposive sampling was chosen based on its central tenet of selecting individuals who have experienced the phenomenon of interest (Creswell, 2007). Subsequent to ethics approval from the University of Calgary and the Thunder Bay Regional Health Sciences Centre, mothers were recruited to the study from two separate community programs. The first recruitment site was Hope Place, which offers a social support program for pregnant and postpartum mothers who use substances. The second recruitment site was the Maternity Centre at Thunder Bay Regional Health Sciences Centre. The Maternity Centre is a hospital-based prenatal clinic offering a range of services from prenatal care to a variety of interprofessional supports to promote a healthy pregnancy.

As a first step in the recruitment process, I approached the director of Hope Place and the Director of Maternal Child Services at Thunder Bay Regional Health Sciences Centre to
introduce the study and provide them with written information. Written information and consent forms were also provided to potential participants. I asked the respective directors to disseminate the prospective research information to frontline staff in their program to determine their willingness to assist with recruitment. Once frontline staff members within the agencies identified their willingness to assist with recruitment, they were provided with written information regarding the research and the researcher’s contact phone number if they have further questions.

Agency recruiters provided potential participants who met the inclusion criteria with brief information regarding the research as well as the informed consent letter. Participants did not sign the consent, but rather reviewed the information and advised the recruiter if they wished to learn more about the study from the researcher. Anyone who wanted more information signed a consent form to release their name and phone number to the researcher. The recruiter provided the names and phone numbers of individuals who expressed interest to the researcher.

In addition to personal dialogue with the agencies for recruitment purposes, posters detailing the study were placed in the waiting rooms of the two agencies. Women who wished to participate were asked to contact the researcher directly to express interest, learn more about the research and set an initial interview time.

Participants

Participants who met the inclusion criteria and who expressed interest in the research either contacted the researcher directly or were contacted by telephone following receipt of consent. I found that most of the women requested that the researcher contact them directly as opposed to doing so themselves. During the initial telephone call, the purpose of the research, the voluntary
nature of participation and the anticipated time commitment of 1-3 interviews of approximately an hour each were explained to the participants. All participants who expressed interest in the research scheduled an initial interview time at a mutually agreed-upon private location. While many of the women expressed a desire to meet in their homes, I outlined the limitations under the ethics review regarding meeting in an individual’s residence. Participants did not express concern with having to meet outside of their homes and meetings were scheduled at either Hope Place or the Maternity Centre, with the exception of two individuals. One mother requested a meeting in her private hospital room. Sufficient privacy was established and two interviews were conducted within that space. The second mother requested an interview in a private meeting room in her apartment building.

The emergent research design and continuous data analysis, combined with the lack of new data provided guidance into the final sample size. Parallel with the approach identified by Osborne (1994), participant recruitment was discontinued when no new data emerged from participant interviews. As such, recruitment efforts resulted in a total of nine women volunteering to participate in the research, though only eight women were included in the sample. One woman was interviewed and it became evident that although she perceived that her baby had NAS, the baby actually experienced withdrawal from an antidepressant, which did not fit the definition of NAS. Given that the purpose of the research was to explore mothers’ experiences in the context of NAS, she was excluded from the final sample. All of the mothers in the study chose a pseudonym to represent them during the reporting of the findings.

The mothers ranged in age from 22-40 years old at the time of the study interview and were between the ages of 19 and 39 at the time of their infant’s birth. Five women were living in common-law relationships while three women reported being single. Elementary school was the
highest level of education for the majority of women (N=5) and three women had completed high school. All women who reported being in a common-law relationship completed high school.

All of the women who participated in the study lived in poverty, with the majority of women reporting an income of $0-19,999, (N=6), and two women with an income of $20,000-$39,999. Despite these low income levels, five women had more than four children to support within the modest income. Furthermore, all of the women were supporting a number of children with the highest number of reported children per family being eight and the lowest number of children per family was two. The majority of women experienced one or more pregnancy losses (N=5).

At the time of the interviews, seven participants were on a methadone maintenance program for treatment for their addictions. One participant was not on methadone and described a continuous struggle with her drug use. Two of the seven methadone-maintained mothers began the program prior to pregnancy, and one participant started after she had her baby. The remaining participants initiated methadone once they found out they were pregnant.

Most infants with symptoms of NAS were born at full term while two infants were born prematurely by one-two weeks. At the time of the interviews, the children with NAS ranged in age from two months-six years. Infants were hospitalized with symptoms of NAS ranging from one week-one month, with the average length of stay being 16 days. One woman was unsure of the length of her son’s hospitalization as she discharged herself from the hospital only hours after she gave birth. See Table I and II.
Table I

*Maternal Characteristics*

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Current Age</th>
<th>Maternal Age at Delivery</th>
<th>Socioeconomic Status</th>
<th>Marital Status</th>
<th>Education Level</th>
<th>First Nations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Madison</td>
<td>35</td>
<td>33</td>
<td>$20,000-$39,999</td>
<td>Common Law</td>
<td>High School</td>
<td>Yes</td>
</tr>
<tr>
<td>Carol</td>
<td>40</td>
<td>39</td>
<td>$0-$19,999</td>
<td>Single</td>
<td>Elementary School</td>
<td>No</td>
</tr>
<tr>
<td>Shelley</td>
<td>29</td>
<td>29</td>
<td>$0-$19,999</td>
<td>Single</td>
<td>Elementary School</td>
<td>Non-Status – Father First Nations, Mother Was Not</td>
</tr>
<tr>
<td>Emily</td>
<td>22</td>
<td>19</td>
<td>$0-$19,999</td>
<td>Common Law</td>
<td>High school</td>
<td>No</td>
</tr>
<tr>
<td>Yolanda</td>
<td>26</td>
<td>22</td>
<td>$20,000-$39,999</td>
<td>Single</td>
<td>Elementary School</td>
<td>Yes</td>
</tr>
<tr>
<td>Chris</td>
<td>30</td>
<td>24</td>
<td>$0-$19,999</td>
<td>Common Law</td>
<td>Elementary School – Some Grade 9</td>
<td>Yes</td>
</tr>
<tr>
<td>Beth</td>
<td>29</td>
<td>26</td>
<td>$0-$19,999</td>
<td>Common Law</td>
<td>High School</td>
<td>Yes</td>
</tr>
<tr>
<td>Mary</td>
<td>26</td>
<td>25</td>
<td>$0-$19,999</td>
<td>Common Law</td>
<td>Elementary School</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Table II

*Neonatal Characteristics*

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Gestational Age at Birth</th>
<th>Number of Children</th>
<th>Number of Pregnancies</th>
<th>Current Age of the Child</th>
<th>Length of Hospital Stay with NAS</th>
<th>Additional Health Concerns at Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Madison</td>
<td>41 weeks</td>
<td>6</td>
<td>7</td>
<td>22 Months</td>
<td>23 days</td>
<td>None</td>
</tr>
<tr>
<td>Carol</td>
<td>37 weeks</td>
<td>4</td>
<td>6</td>
<td>8 Months</td>
<td>1 week</td>
<td>None</td>
</tr>
<tr>
<td>Shelley</td>
<td>36 weeks</td>
<td>2</td>
<td>6</td>
<td>2 Months</td>
<td>3 weeks</td>
<td>Premature</td>
</tr>
<tr>
<td>Emily</td>
<td>39 weeks</td>
<td>3</td>
<td>6</td>
<td>2 Years</td>
<td>1 month</td>
<td>Seizures</td>
</tr>
<tr>
<td>Yolanda</td>
<td>40 weeks</td>
<td>2</td>
<td>5</td>
<td>3 Years</td>
<td>24 days</td>
<td>None</td>
</tr>
<tr>
<td>Chris</td>
<td>40 weeks</td>
<td>8</td>
<td>8</td>
<td>6 Years</td>
<td>Unknown</td>
<td>Unknown</td>
</tr>
<tr>
<td>Beth</td>
<td>40 weeks</td>
<td>6</td>
<td>6</td>
<td>4 Years</td>
<td>2 weeks</td>
<td>None</td>
</tr>
<tr>
<td>Mary</td>
<td>35 weeks</td>
<td>6</td>
<td>6</td>
<td>1 Year</td>
<td>2 weeks</td>
<td>Premature</td>
</tr>
</tbody>
</table>

**Data Collection**

Data was collected through face-to-face semi-structured interviews. Consistent with Dukes (1984), it was anticipated that prolonged and extensive engagement with participants over 2-3 interviews would be required to sufficiently capture the true essence of the experience for birth mothers. Most mothers were interviewed on two separate occasions for approximately one hour each, while two participants were only interviewed once. One of the single-interview participants...
scheduled multiple follow-up interviews and expressed a desire to continue the dialogue, but after multiple missed meetings I chose to continue with other participant interviews rather than contact her to schedule another time. The second of the single interview participants was a woman who expressed a desire for a follow-up interview, and contacted the researcher to arrange one. However, when she failed to arrive for the interview, and when the researcher made a follow-up call her telephone had been disconnected.

The initial interview for all participants began with a review of the purpose of the research, its voluntary nature, the ability for the participant to withdraw at any time, and a full review of all issues addressed in the letter of informed consent. All participants were invited to pose questions to the researcher prior to signing the consent form, but there were no questions. All participants signed the consent form and were provided with a photocopy of it. Participants were then invited to choose a pseudonym that would represent them throughout the written and spoken presentation of the research. This task proved to be a useful ice-breaker component of the process as participants found humour in choosing a name that they had always wanted to be called.

In an effort to allow participants time for reflection, at the outset of the interview, participants were provided the broad areas of interest for the interview, such as pregnancy, birth of the baby, period of newborn withdrawal (hospitalization), as well as the early years of their life. Although interviews were semi-structured in terms of general areas of interest, the direction of the interviews was largely self-determined by participants to allow for the emergence of data relevant to each individual’s experience. For example, in addition to the primary research question, participants were instructed, “Tell me what it was like to be pregnant” and “Tell me what it was like when your baby was withdrawing.” This semi-structured approach revealed the
essential components of the experience as the participants saw it (Lopez & Willis, 2004). Sub-questions related to issues such as support or interaction with health care providers also emerged from the data, but these areas were determined only as interviews progressed. Through semi-structured interviews and probing techniques such as silence, reflective and empathic listening, and non-verbal attending skills (Douglas, 2004), participants were engaged to encourage further dialogue about their experiences. These interviews were tape recorded and transcribed verbatim for analysis by the researcher.

The initial interview included the collection of descriptive data about the sample as documented in Table I and II. Participants were invited to express their experiences as they related to the infant with NAS that was born within the sampling timeframe. However, while we spoke of the experience in question, it was possible that mothers had other children that were born with NAS outside of the sampling frame. Although each interview’s general direction was determined by the participant with guidance from the researcher to topic areas of interest, each initial interview began with, “Tell me what it was like for you on the day you found out you were pregnant.” Dialogue flowed freely through the interviews, and while initial conversations reflected pregnancy-related issues, issues surrounding drug use were a natural progression from the initial dialogue. Further questions were asked, paraphrasing of responses garnered further disclosures, and probing techniques were used to elicit understanding and depth in the response.

My experience in the use of basic and fundamental social work skills of reflective, empathic and active listening, paraphrasing and summarizing, open-ended questioning, and probing technique, proved useful in attending to the participants’ stories. According to Patton (2002), qualitative research allows participants to demonstrate a depth of emotion that reflects their innermost thoughts and feelings. Consistent with this, interviews progressed naturally and reflected deep
emotional pain, unwavering commitment, and personal thoughts, feelings and experiences as identified by each participant.

Given that many of the women in the research struggled with poverty and addictions, I suspected that contacting them could be challenging due to lack of access to a phone or transience in residence. As such, the initial interviews were purposefully broad in scope, inquiring when possible into each of the areas of interest. The initial interview was guided by the participant, as open-ended questions allowed for them to identify areas of experience that were salient to them. This approach helped build a rapport by offering participants self-determination of disclosure. I was struck by the willingness of participants to share the intimate details of their lives.

Following each initial interview with participants, audiotapes and transcribed notes were carefully reviewed by the researcher. Areas where further probes may have been useful were identified and documented in the field notes. Any gaps in information were also identified and noted. As an example, in the initial interview, Shelley made several discrete references to her life without a mother but did not discuss this topic in depth. As she appeared through her body language to want to not to discuss this issue, I did not probe further during the initial interview. However, by the end of the first interview, it was clear that Shelley and I had established a comfort in talking together. This was indicated through her body language, facial expressions and openness throughout the interview. During the second interview with Shelley, I began by asking if she had further questions, and after she noted that she did not, I advised her that I had noticed a few areas about which I would like to gain more details. One area was the issue of motherhood. I advised Shelley that I had noticed that she spoke of losing her mother at some point in her childhood, and I asked if she was comfortable discussing this further. Shelley was
very open about issues with her mother and her perception of motherhood emerged through the dialogue.

Like Shelley’s second interview, all subsequent interviews were scheduled after a review of the audiotapes and transcribed notes, and after identifying areas requiring further exploration. These interviews were intended to clarify previous disclosures, share new information and fill in any existing gaps in the data. These second interviews started with a review of the previous interview and an invitation for the participants to share anything further that they wished to discuss. This often initiated further dialogue, but at times the interviews began with the researcher asking a question related to an identified gap in the data. As in the initial process, second interviews were audiotaped, transcribed and reviewed.

**Bracketing**

In light of the foundational literature on phenomenology and the importance of suspending beliefs as a means of remaining true to the participant’s accounts of their lives, a process of bracketing began while preparing the research design and continued until the completion of data analysis and writing of the dissertation. Gearing (2004) offers a typology of bracketing in research. While each typology reflects subtle differences in the approach, the one that resonated most for me was the descriptive eidetic method due to its more practical application and less rigid structure. Gearing argues that the eidetic approach not only sets aside personal assumptions, but also sets aside presumptions related to the external phenomena. Complete suspension of beliefs and assumptions of the larger social and cultural elements of the world may not be removed entirely from consciousness, however, reflective awareness is essential.

It is noteworthy that as a researcher, the importance of presuppositions, knowledge and
beliefs are essential ingredients in directing a researcher to uncover gaps in literature and research, in choosing a research question, and in the design of a research proposal. Nevertheless, consistent with the phenomenological approach, the process of bracketing began once the research was being designed.

Ahern (1999) outlines a number of strategies for reflexive bracketing. These strategies provided the researcher with some guidance in the reflexive process that was undertaken in this study. Consistent with Ahern’s approach and in an effort to remain true to uncovering the essential essence of experience as perceived by the participants, several steps were undertaken throughout this study. As a first step, I approached the directors of the recruitment sites to review the background, purpose and informed consent letter for the study. I spoke in depth with them about my intentions for the research, as well as what I hoped to personally gain through the process (a PhD degree and potentially publication of findings), and what I hoped to disseminate in terms of participants’ stories of experience. I asked the directors to bring this information to potential recruiters from the agencies in an effort to minimize any type of bias or influence that I might exert in identifying particular types of participants. In this regard, individuals were approached to participate in this study by recruiters and not by the researcher.

From the outset, my personal intentions were stated and reflected upon. Through this research, I had much to gain as a researcher, most notably the potential to gain a doctorate. This fact was identified, stated in the ethics forms, discussed openly with agency directors and discussed openly with participants. I was concerned that my personal need for achievement could influence the drive to complete the data collection process quickly and haphazardly. However, upon reflection and after discussing with my supervisor, I was able to appreciate that the degree is not contingent on the content of the data, but rather on the process of the design, data
collection and analysis, and a commitment to the process. With this identified and noted early in the process, I was able to move forward with the research with an emphasis on the process rather than the end goal.

One of the primary bracketing techniques used throughout this study was self-reflection and questioning in an effort to uncover personal issues that could potentially influence the research. Given my background prior to the outset of the study, I engaged in quiet reflection on what brought me to this research question. Through this process, I recognized the experiences and beliefs in my own life that had developed my interest and understanding of mothers of infants with NAS. These included early career work with mothers of affected infants, a close friend with addiction issues, feelings of injustice and a desire to pursue social justice, knowledge of the literature, experience caring for babies with NAS, and so on. I recorded these reflections in a journal and often reflected on them throughout the process by asking questions such as “Am I assuming that drug use had a hold on women because I have heard this from women in the past, or is this what is being presented in the interview?” and “If I believe it is being presented in the interview and not from my forethought, is it apparent because of the type of question I asked of participants or did it emerge naturally through the process?” This process of continuous questioning helped me ensure that I did not influence the findings in any way. The following is an excerpt from my initial reflections:

I attended a conference and heard a social worker speaking about working with women who have addictions and have had babies. She talked about harm reduction, empowering women, the role of child welfare. I recall her stating that not all women who use substances and have a baby require a child welfare worker and that if child protection is deemed necessary, medical social workers have an important role of providing a comprehensive
assessment that identifies strengths and collaboratively contacts child welfare with the
women for whom the call was made. That day, I can recall feeling that the presenter was
out of her mind. How could these women parent, after all, they put their needs before their
baby. How could I possibly disclose to the woman that I was calling CAS, and
furthermore, how could I do that with the woman present?

After a lot of reflection and really focusing on what the women were telling me, I
decided I had nothing to lose by trying this approach with some of the substance using
women I was working with. To my complete surprise, the interactions went remarkably
well. Women disclosed a lot of painful experiences and I was able to empathize with them,
and acknowledge their strengths and love for their children. When child welfare was
involved, the dreaded calls were much smoother when they happened with the substance
using women and when strengths were identified. I learned a tremendous amount through
this process, and through really listening to the full spectrum of issues that these women
were dealing with. This experience and my experiences in general in working with families
impacted with NAS brought me to the research question, but also contribute to my new
found impressions about their experiences. I will need to be conscious of this as I question
participants and approach the analysis. (Jodie)

In addition to the personal reflections from my experiences as a clinician and friend, I also
reflected on knowledge I had gained as a researcher in this field. While there is an absence of
literature on mothers, I am well versed in the literature of NAS and have also conducted research
on nurses’ experiences, which required reflection to ensure that this previous knowledge did not
overshadow the findings through this process.

Another strategy to bracket was to set the research timeline outside of any clinical work I
had done in the area. The timeline of September 2007 to June 2011 was consciously chosen because I was a practicing social worker in the NICU until July 2007. I wanted to ensure that I would have no prior knowledge of their stories should potential participants come forward to be a part of the process. As such, the research began after my direct involvement with potential participants had concluded. Despite efforts to control the timeframe of the research, recruitment remained a challenge within the research. Because NAS is a very personal and difficult experience for women to talk openly about, recruiting women to tell their stories did not reveal an abundance of potential participants. I considered adding methadone clinics as recruitment sites midway through the recruitment efforts (following ethics approval). However, before doing this, I asked myself, “Why would you go to the methadone clinics?” and “What do you have to gain and what will it add to the study?” Upon reflection, I realized that by adding methadone clinics, I would likely gain more participants because of their stage in recovery and willingness to share their experiences. However, I believe this approach would have fulfilled my own need for more subjects rather than genuinely contributed to the research. I also suspected that by adding a methadone clinic, I would greatly influence the type of sample used in the research. Despite the fact that many of the participants in the research acknowledged their involvement with methadone maintenance, these participants emerged naturally through recruitment rather than being directly recruited from a methadone program. In the end, I made the decision not to include methadone clinics and remain true to the original intent of the design.

One of the assurances that bracketing was successful emerged through the interview process, as I identified many findings that even through initial reflection I did not anticipate in any way. A couple of examples included abandonment, “liquid handcuffs,” and the meaning of motherhood. The fact that these issues were entirely unexpected demonstrates my ability to stay
connected to the experiences as individuals perceived them and to avoid leading the discussing towards my preconceived notions, as I had no previous thoughts on these issues.

Another strategy for bracketing involved assurances of multiple voices from participants. To ensure I was not gravitating toward one participant over another to serve my own agenda, I sought out subsequent interviews for all research participants in the event that they may have more information to impart. In this respect, I was conscious not limit follow-up interviews to a particular individual who was more articulate than the others. In addition, through the written component of the analysis, I frequently reviewed the quotes that represented the themes to ensure that I was not using one respondent’s data consistently in the absence of the others. Quotes representing the themes were garnered from multiple voices and all participants contributed to the findings.

On a more personal level, the use of a reflective journal assisted in ongoing attentiveness to bracketing. Reflective journals are useful in processing presuppositions and reflections in a mindful way. By using a journal as a tool, bracketing pre-action in-action and on-action allowed me to maintain reflection throughout the process, (Wall, Glenn, Mitchinson, & Poole, 2004). Before interviews, I spent time reflecting on how I could approach participants in an open way. I was cognizant of the need to ensure that leading questions were not used, and I used a broad range of open-ended questions. Consistent with Hamill (2010), as themes began to emerge, I would reflect on how themes were emerging and whether the themes were important to me or participants. Following interviews, I typically left every encounter and immediately wrote my initial thoughts about the interview in the journal. I reflected on what I had heard, what surprised me, how I felt, what was difficult to hear, and/or what I felt the participant was attempting to convey. I also documented in the journal after review of the transcripts with particular attention
to gaps in the transcripts or any concerns or questions I had. I wrote about the impact the process had on me as an individual and any emerging themes to which I was attuned. This journal was reflected upon before each interview to bring issues into focus and set them aside so that I could approach the next interview with a clean slate.

Bracketing also included ongoing dialogue with my supervisor and on occasion with my mentor, who is also an academic in the field. These individuals acted as bracketing facilitators (Drew, 2004) and they provided assistance throughout the process by asking critical questions that prompted reflective thought and adherence to the data. Supervision was used to ensure the data could be observed by another individual (Hamill, 2010).

And as a final step in the comprehensive bracketing process, careful attention was taken when reviewing the transcripts. As I analyzed the transcripts, I often questioned, “Did I lead this interview in any way?” and “What is she trying to tell me and am I seeing something outside of the actual text in front of me?” These questions revealed only one occasion where I could identify that my prior knowledge had influenced the process. In an interview with Madison, I specifically asked about negative experiences with the nurses, despite her telling me that her experience with staff was fairly positive. Through a review of the transcripts, this finding was consistent with a previous nurses’ study that I had completed. To resolve this conflict, Madison’s data regarding the negative experience with nurses was not the subject of analysis.

LeVasseur (2003) stated:

In some essential way, we do bracket prior understanding when we become curious. That is, we have to assume that we do not know or understand something in order to attain the philosophical attitude. When we begin to inquire in this way, we no longer assume that we understand fully, and the effect is a questioning of prior knowledge. (p. 417)
While maintaining a curiosity about the research question and subsequent findings, the strategies noted above assisted in maintaining a bracketing state of mind (Drew, 2004). This approach enabled me to understand and position my own beliefs, experiences and knowledge as it related to the current research.

Data Analysis

Consistent with Lincoln and Guba (1985), data analysis emerged through the exploratory process of gathering and reviewing participant responses. As I interviewed participants with attentiveness to active listening, paraphrasing and probing techniques, each participant’s stories were uncovered. While the interview process was the data-gathering stage of the research, it should be noted that it was also the starting point for data analysis. Patton (2002) indicates that making sense of the data occurs while in the field through the process of field notes. As a researcher, following each individual interview, I recorded analytic insights and further questions in a journal. This process enabled initial insights to contribute to the analysis without leading to premature conclusions. The field journal was the first step in the analytic process in that it uncovered immediate reactions to the data that were aligned directly with participants’ accounts and unaltered by my own preconceived notions of findings. The following is an excerpt from my field notes and it demonstrates the initial stage of analysis while maintaining the participant’s voice:

Interview with Betsy: It was clear that her history and family issues were in the forefront of her mind…I found it interesting how much someone’s past could haunt them and impact them to the point of never seeing her children again. She lived a life of loneliness, yet perseveres with very little support and almost no hope.
Colaizzi’s (1978) phenomenological analytic method was used as a means of organizing and analyzing data. Colaizzi’s method involves seven steps in a process of uncovering the essence of the phenomenological experience across participants. Colaizzi identifies the first step in the process of “Read[ing] all of the subjects descriptions…in order to acquire a feeling for them” (p. 59). As a first step in this method following the brief field analysis and in an effort to become familiar with each individual’s experience, all recorded interviews were listened to and transcribed verbatim. This process enabled the researched to engage with the data. In order to identify any gaps in the data or any missed opportunities for further probing, I read each individual transcript and identified any areas for further exploration or possible ambiguities. These findings were recorded in the field notes and served the dual purpose of initial analysis and acting as a means of adhering to the bracketing process to ensure commitment to each participant’s account.

In an effort to be comprehensive and to make sense of an abundance of data, each individual participant’s response was reflected on and initially coded along temporal lines. These lines included family of origin, pregnancy, newborn, and hospitalization. In a reflective process, I asked myself, “What period of time does this statement refer to?” When a statement crossed multiple time periods, responses were copied and placed in each of the temporal categories. When the response referred to an issue that could not be categorized on temporal lines, it became its own category. For example, the issue of drug use was developed as a separate category.

Patton (2002) indicates that developing a manageable classification or coding scheme is the first step of analysis. Given that there was a copious amount of data, this initial process of organizing the data proved useful in sorting the data into a manageable framework.
In the second step of Colaizzi’s (1978) method of analysis, he suggests that researchers must “Return to each protocol and extract from them phrases or sentences that directly pertain to the investigated phenomenon; this is known as extracting significant statements” (p. 59). To be consistent with Colaizzi’s method of analysis, each transcribed interview was read on multiple occasions. Significant statements were highlighted in the transcripts. As an example, in Emily’s transcript, the statement, “I got molested. That’s how I got pregnant” was highlighted as a significant statement. In addition, I identified significant statements related to fear, guilt, drug use, etc., and highlighted them within the text.

The third step in the process required that I engage in a reflective process in which questioning the data helped meaning emerge. Patton (2002) states that being reflexive involves self-questioning and self-understanding, while Colaizzi (1978) identifies the use of “creative insight” as a means of formulating meanings within the significant statements (p. 59). As such, in a process of uncovering the meanings in the identified significant statements, I reflected upon each statement and asked myself, “What is this participant trying to say to me? What does this really mean to them?” As an example of this process, upon review of Emily’s statement, I reflected on the statement and recorded “trauma?” in the margin of the transcript. In addition to facilitating this process for each significant statement, the same process was undertaken following each participant response to make sure that no significant patterns were missed in the analysis. This process revealed insights regarding more broad-based categories such as resilience that may have otherwise been overlooked.

The fourth step in Colaizzi’s (1978) method involves the development of “clusters of themes” (p. 59). To maintain consistency with this approach, I documented each of the meaning clusters created from individual participant responses. Patton (2002) suggests that initial focus of
analysis begins with a full understanding of each individual case before subjecting independent cases to cross-case analysis. As such, I compared the individually identified themes to those identified in other participants’ accounts. Through a continuous process of checking and rechecking thematic findings, cross-case themes further developed and sub themes were identified. Where themes were obviously connected through similar meaning or description (e.g., experiences with drug use), these themes were grouped together across participants and checked against each other to identify trends in the expressed nature of the themes. Where themes were less obvious, I subjected those themes to further analysis and reflection to identify any commonalities and disparities among them. For example, while all participants spoke of their involvement with nursing staff at the hospital, their experience varied from positive to negative encounters. However, the question I posed to myself through reflection was, “What features of the experience with nursing staff do these responses have in common?” Through this process, I uncovered an underlying link between the experiences with nurses and the maternal role. Similarly, upon evaluating mothers’ experiences with child welfare, I uncovered a link with the impact of external forces on the maternal role. This lead to an important thematic finding related to the ambiguity of motherhood, with nurses and child welfare evolving as sub-themes.

Further to the comparative analysis noted above, in an effort to become more immersed in each individual’s story, I wrote independent participant summaries. This description was a useful validation tool used to compare the shared meaning clusters to each individual participant experience to check for consistencies in the independent participant summaries. Once I identified the themes across participants, each theme was referred back to individual participant summaries as a means of validating that the identified theme was consistent to each individual. In addition, I reviewed individual transcripts again in an effort to identify any missed data that was not
accounted for in the thematic clusters. This process yielded no discrepancies in lack of representation of the findings, though it should be noted that the theme of “trauma, abandonment, and loss” was created as a broad category that represented the multitude of experiences sharing the feature of deep emotional pain.

Upon completion of the constant comparative method used to align thematic clusters with shared meanings, I began a comprehensive and exhaustive description of the findings in accordance with the fifth step in the method. As such, I recorded participant quotes that reflected each identified theme and copied them under the heading of the theme. Each theme was described in written form through a documented convergence of participant description and supporting quoted statements. This lead to the development of an exhaustive description of the fundamental structure of the phenomenon, (Colaizzi, 1978) Once I wrote the description of each theme and supported the findings with direct participant quotes identifying the experience, all themes were reviewed and re-read on multiple occasions in an effort to identify the underlying structure of the experience. The underlying issue of motherhood permeated each of the themes and lead me as the researcher to uncover the essence of the experiences of mothers of infants with NAS.

**Trustworthiness**

As researchers, we are privileged to be welcomed into the lives of those who have lived experiences about which we seek further knowledge. This opportunity is one of tremendous responsibility to ensure that we are not voyeuristic and self-serving in our quest for a particular type of knowledge, but rather seek knowledge through honest exploration, sincerity, openness and fidelity.
The quantitative paradigm focuses on truth in research, its validity and reliability, and clear measures that indicate if the research is true and replicable to others. However, when researching the human element, truth is a matter of perspective. Finlay (2006) states, “qualitative research does not seek to be consistent or to gain consistent results; rather, it seeks to elicit the responses of a participant or researcher at a specific time and place and in a specific interpersonal context” (p. 320) As such, the value of contextually relevant and richly described data in a qualitative research study is of critical importance as the trustworthiness of the study is explored.

Lincoln and Guba (1985) proposed four criteria for ensuring the trustworthiness of naturalistic research: credibility, transferability, dependability, and confirmability. These criteria, although different than the quantitative approach, were aligned with the criteria in the positivistic paradigm to ensure the quality of the research. Although qualitative researchers continue to utilize Lincoln and Guba’s strategies, Tracy et al. (2010) add that “values for quality, like all social knowledge, are ever changing and situated within local contexts, and current conversations” (p.837). Nevertheless, regardless of the particular approach employed, addressing the quality and rigour of a research study is an important step in the research process. Lincoln and Guba (1985) indicate that the basic premise of trustworthiness is simple: “How can an inquirer persuade his or her audiences (including self) that the findings of an inquiry are worth paying attention to, worth taking account of? What arguments can be mounted, what criteria invoked, what questions asked, what would be persuasive on this issue?” (p. 290)

The trustworthiness of this research was an important and critical element for me, and I found that I was ever conscious of it throughout the process. As the researcher, I felt that my responsibility to be true to participants, to the data they shared with me, to their experiences and to the topic itself was a responsibility that I could not take lightly. As such, I employed several
strategies throughout the process to ensure that the quality of the research was rigorously
evaluated from the outset to its conclusion.

**Credibility.** As a first step in establishing the trustworthiness of this research, careful
consideration was given to choosing a methodology that would best answer the research
question. Deciding on a method to use within a research study was a task than cannot be taken
lightly, and it must fit with the paradigm of inquiry. With multiple methods to choose from,
evaluating each method in relation to the purpose of the study and the research question, as well
as intended outcomes (e.g., description or theory) strengthens the trustworthiness of a particular
piece of research (Starks & Trinidad, 2007). I engaged in an evaluation of the suitability of other
methods, including case study, grounded theory and hermeneutic phenomenology, to answer the
research question and establish a rigorous methodological process. The choice of descriptive
phenomenology appeared to be the best fit for the research question.

Further establishing credibility within this research began in the early phases through the
process of bracketing and reflexivity to identify any biases and prior knowledge and experience
that I as the researcher have had that may cloud my perspective in observing and hearing the
direct accounts of participants. Bracketing throughout the research gave me time to reflect, make
notes in a journal, and approach the participants with an open mind and perspective. This process
allowed me to listen attentively to reveal the salient issues as participants’ identified them.

The informed consent letter to participants also provided credibility of the research. The
informed consent was clear about what participants could expect, outlined issues of
confidentiality, and noted what was being asked of them. At the outset of each interview, the
consent was provided in written form and orally discussed to ensure that participants’ understood
the intent of the research and were fully aware of the process and their ability to withdraw. This process established the foundation of honesty, sincerity and trust as rapport was established.

According to Lincoln and Guba (1985), prolonged engagement in the field is essential to establishing trust and open dialogue. The definition of prolonged engagement is relative to the situation and context, but for the purposes of this research, prolonged engagement was established through the interview process. Most interviews were approximately an hour long and involved open-ended and iterative questioning as well as probing techniques to reveal the experiences of participants. Because there was no pre-determined set of questions, the length of the interview was largely determined by the amount of disclosure and comfort level of participants in the research. As such, a lengthy interview combined with most women returning for a subsequent interview is an example of the credibility of the approach, the central position of participants’ voices, and the establishment of a trusting interaction that enabled subsequent interviews.

To ensure consistently accurate information as it was presented, I reviewed the electronic tapes of interviews after each encounter, read transcribed notes on multiple occasions to establish a feel for the data, and audited the accuracy of transcriptions through a comparison of transcribed interviews and electronic recordings. I also reviewed initial interviews with participants during subsequent interviews, and began second interviews by inquiring if there was anything further they wanted to add before proceeding. These steps provided a sense of confidence in the accuracy of the participant accounts.

Triangulation is the process of utilizing multiple sources to verify the data and the analysis as it is presented (Lincoln & Guba, 1985). As an initial step in this process, “site triangulation” (Shenton, 2004) was employed by seeking participants from both a prenatal clinic
and a community support program. In this respect, although participants all met the research’s inclusion criteria, they were recruited from very different venues to ensure that the characteristics of and interactions within each individual recruitment site were not overrepresented in the responses. Triangulation of data sources was also used as a strategy to establish trustworthiness in the research. The process of thematic analysis helped establish themes based on representation across participants and the voices of each of the eight individual participants are represented in the various themes, ensuring that one dominant voice is not overrepresented in the data. Thematic findings were reported through rich description directly from participants themselves. The richness of the data combined with multiple voices across themes contributed to the depth of description within each theme.

To further establish credibility of the findings, I began by writing an account of each participant’s story or profile to establish experiences in their lives in a narrative form. These profiles were used as a means of verifying themes that were shared across participants. Once the thematic analysis was completed, the themes were checked by returning to the individual profiles and reflecting on the questions, “Does this theme make sense for this individual? Can I see this theme in her story?” This verification technique allowed me to ensure that what was revealed in the final analysis did not veer from the independent analysis of each participant.

External and internal debriefing was used as a means of verifying and staying true to participants’ accounts. From an internal debriefing perspective, as the researcher, I engaged in constant reflection to ensure my biases did not enter the process or the analysis, and I also used a field journal prior to every interview and following every interview to write down insights, questions, concerns, impressions and biases. The journal helped me monitor my own reactions and ensured I stayed true to the data as it was presented. External debriefing included continuous
dialogue with my supervisor to review the evolving process and any biases, and acted as a way to challenge assumptions. In addition, I often consulted with a close friend who is also an academic and who did not have direct knowledge of the data. These debriefing processes proved invaluable by providing poignant questions that challenged my decisions, my interpretations of the findings, and my openness. Additionally, the peer debriefing assisted in establishing credible research by ensuring that I was always aware of my decisions and my presentation of the findings.

**Member checking.** Hamill (2010) suggest that data should be evaluated by participants for accuracy in interpretation as opposed to accuracy of transcripts. It is suggested that the process of returning to participants is useful in evaluating whether the information that was provided has been interpreted correctly and if the description is consistent with participant’s understanding of it. Consistent with Hamill (2010) it was my intention to return to participants with a summary of the thematic findings and description of the essence of the experience as written in the findings. However, after multiple attempts to reach participants, I was unable to make contact with any of the mothers. Of the eight women in the research, six phones were disconnected or out of service, and of the two remaining, despite multiple attempts to reach them, there was no answer. The inability to connect with mothers is an unfortunate limitation in the research as participants were unable to comment on the accuracy of the interpretation. It is also indicative of the hardships that were faced by this sample of women. Financial constraints to cover the costs of the phone and residence transience are potential reasons for the disconnection of participants’ phones. Nevertheless, while I could not return to participants, I did return to the audiotapes of their interviews and used a reflective process to compare the dialogue to the
findings to ensure nothing misrepresented through analysis. Although this does not replace participant endorsement, it was an additional step to ensure the accuracy of the themes.

**Transferability.** Lincoln and Guba (1985) state that transferability is established through rich description that would enable another to apply the findings to other situations. Furthermore, Shenton (2004) draws attention to various issues that strengthen the description thereby increasing the probability of the transferability of the research. In the present research, I described in detail the recruitment organizations (Hope Place and the Maternity Centre), the inclusion and exclusion criteria for study participants, the number of participants and description of the sample, the data collection methods (interviews and field notes), and the number and length of data collection sessions. Through this information, I hope to impart the ability to transfer the approach and the findings to other situations.

**Ethical Considerations**

The researcher is the primary instrument in any qualitative research study (Lincoln & Guba, 1985; Patton, 2002), and as such, careful attentiveness is essential to ensure that no harm or coercion is done to research participants. Given that qualitative research uncovers the firsthand accounts and often personal life stories of participants in the research, adherence to strict ethical conduct inevitably protects the dignity and privacy of participants and the integrity of the researcher. Ethics approval for the current research was attained from both the University of Calgary Research Ethics Board and the Research Ethics Board for Thunder Bay Regional Health Sciences Centre. Additionally, while a formal ethics board is not a component of the program at Hope Place, the executive of Hope Place reviewed the research proposal and University of Calgary ethics approval prior to allowing access to program participants.
One area of concern involved my position as the coordinator of the Maternity Centre. Given this role’s power differential, I was concerned about the potential for the perception of coercion from a nurse practitioner and participants. However, in my role at the Centre, I do not have patient contact. The reason for using the Maternity Centre as a recruitment site and a nurse practitioner (NP) and social worker as potential recruiters is that the NP cares for the highest proportion of substance-using pregnant women in the relatively small city. The social worker is also involved with many pregnant women who use substances, though she does not directly report to me in her daily employment. In addition, almost all pregnant women in Thunder Bay receive at least a portion of their prenatal care at the Maternity Centre. I explained verbally and in writing that the NP’s involvement in recruitment would not affect her performance appraisals in any way and that her involvement in recruiting participants is not a requirement of her job, it is voluntary, and she can withdraw from this responsibility at any time. As a safeguard, I signed an agreement outlining these issues and had the NP also sign that she understands these issues. Participants were informed that their role in the research process would not affect their care in any way at the Maternity Centre and that the data they provide during the interviews will not be shared with the staff at the Maternity Centre.

In an effort to protect the confidentiality of participants, several safeguards were implemented at the outset of the research. As a first step, distance from the researcher was built into the recruitment process to ensure potential participants did not feel pressured to participate. To facilitate this, I asked the respective directors of the recruitment sites to disseminate the study information to the program coordinator at Hope Place and to the NP and social worker from the Maternity Centre, and asked them to orally provide brief information and the informed consent letter to potential participants who met the inclusion criteria. Potential participants wishing more
information provided their consent to release their name and phone number to the researcher. Once this information was received, I subsequently contacted individuals with expressed interest and reviewed the informed consent letter. This distance during recruitment served as a safeguard for coercion.

The informed consent document was as a critical tool in the safeguarding participant confidentiality and providing detailed information about the research and participants’ rights and resources. In the initial interview with participants, a copy of the informed consent form was provided to them before the researcher read it aloud. After reading the document with the participants, opportunity for questions was provided and participants were encouraged to reflect on the document prior to signing. Very few questions emerged, and all participants signed the consent forms prior before beginning the interview. The following issues were addressed in the informed consent:

1. A review of the purpose of the research and the inclusion criteria of being the biological mother of an infant who had NAS in the past three years.

2. Expectations including one to three face-to-face interviews of approximately an hour in length, in a private meeting space that is mutually agreeable and may include the Maternity Centre or Hope Place meeting room. Open-ended questions are used as a means of allowing participants to self-direct disclosures. A review of the type of information to be collected from descriptive information to areas of interest such as pregnancy, birth of the newborn, during newborn’s hospitalization, and the family of origin.

3. Interviews would be audiotaped and transcribed.
4. Involvement in the research is voluntary and participants can withdraw at any time by simply contacting the researcher. A phone number was provided. All information collected up to the point of withdrawal will be used in the final analysis unless participants indicate that the information cannot be used. Access to the final research report is still maintained despite withdrawal from the research.

5. Participants were also advised that their involvement or lack of involvement will not impact the care that they receive at Hope Place or Maternity Centre in any way.

6. A summary of the final themes identified will be provided to participants and feedback would be gathered within two weeks. Lack of feedback within two weeks will indicate approval of themes as is, but any suggested changes or additions to the data will be subjected to analysis and included in the final report.

7. The risk of emotional reaction due to recall of difficult memories was outlined in the consent form. Participants were advised of the availability of Hope Place, Maternity Centre, The Counseling Centre and a crisis line phone number for support should these feelings present themselves. There was no specific rescue plan for different cultural groups as the plan for emotional and psychosocial support was to re-connect women to the programs where they already accessed support. This approach was intended to increase the probability that women would reach out for support if necessary. This rescue plan was approved by two research ethics boards.

8. Limits to confidentiality were outlined. These included the researcher contacting 911 in the event of disclosure of thoughts of self-harm or thoughts of harm to another person. Expression of abuse or neglect of a child would also precipitate a limit to confidentiality and child welfare would be notified.
9. A pseudonym will be identified and used to represent participants in the final results. Only the researcher and supervisory committee will have access to the interviews.

10. The tapes with the interviews on them will be destroyed once the interviews have been transcribed, and the transcribed data will be kept in the researcher’s locked office on a password-protected computer. Hard copies of transcripts and any notes taken during the research process will be kept in a locked filing cabinet in the researcher’s office for seven years. At that time, all electronic data will be erased and hard copy data will be shredded.

11. Benefits to both participants and researchers were also addressed

Despite the safeguards for emotional reaction as well as for thoughts of harm, the established rescue plans were not required by any participant. While interviews were very emotional for many of the participants, and interviews were at times paused to inquire if support was required, participants identified that memories were painful, but expressed a desire to continue without intervention of any kind. I asked one participant if she had thoughts of self-harm due to the expression of overwhelming emotion through a tearful dialogue. The participant denied such thoughts and wished to carry on with the interview, stating that it felt good to talk about it and share her story.

Although there were no identified ethical issues related to emotional pain or thoughts of harm, there were a couple of ethical dilemmas that appeared throughout the research. One such dilemma included participant recruitment. I received a call from Chris following a brief presentation of the purpose of my research at Hope Place. Although I outlined the inclusion criteria in the presentation and over the phone, it became apparent only through the course of the initial interview that Chris’s infant was born prior to the inclusion criteria timeline of 2007 (Chris’s baby was born in 2004). While screening Chris for inclusion over the telephone, she
identified verbally that she met the inclusion criteria and wanted to participate. Given that the nature of the active interview was emotionally charged and highly sensitive, I made an on-the-spot decision to continue with the interview. I did not feel that it would be fair to Chris to stop the interview while she was disclosing such information, and Chris expressed a very keen desire to have her story told. Following the interview, I consulted with my supervisor and the decision was made to retain Chris’s data given her strong wish to be a part of the research (this can be heard on the audiotape). To support this decision, I returned to my rationale for the initial timeline. I developed the timeline based on my previous role as a social worker and the potential that I may have had direct contact with women prior to 2007. However, Chris was unknown to me at the time of the interview and I was not in a therapeutic relationship with her or her baby.

Another ethical dilemma with recruitment arose when a ninth participant contacted me to take part in the research. Again, I outlined inclusion criteria over the phone prior to establishing a meeting time. During the course of the interview, it became evident that the baby was born with withdrawal but did not have NAS as the withdrawal was from an antidepressant and not an opiate. During the course of the interview, it was unclear to me what to do in this situation. As a result, I continued through to the end of the interview. However, upon reflection after the interview, I made the decision to eliminate the participant from the dataset given that the issue of NAS was the phenomenon of interest, and I was not examining the broader issue of withdrawal in general. The audiotape of this participant was deleted and the interview was not transcribed or used in the analysis.

An additional ethical issue presented through an unexpected opportunity that arose. During the data collection and analysis, I was contacted by two separate journalists, one from CBC Radio, and another from a local newspaper. Each of these journalists had read some of my
previous research on NAS and requested an interview to shed light on the issue for the local and larger community. This was a challenging dilemma on many counts. First, the opportunity to provide this much-needed information to the community was both professionally beneficial in terms of work recognition, and beneficial in the ability to inform the public. In addition, I was concerned that failing to provide information to journalists could be perceived as hiding my previous research in some way. However, after careful reflection, I made the decision not to participate in these interviews for fear that the research participants in my current study may regard the dialogue as a breach of their information. Although I would not have spoken directly about the current project, I feared that women would draw inferences from the dialogue, and the data collection and analysis was not yet complete. This decision posed an ethical challenge and was reviewed with my supervisor in order to gain clarity on the issue.

Summary

This chapter has reviewed the qualitative tradition of inquiry and provided rationale for using descriptive phenomenology as the method that best represents the research question. Descriptive phenomenology was explored in the context of NAS and the examination included issues such as bracketing and Colaizzi’s model of thematic analysis. Participant summaries were provided and the trustworthiness of the research was explored. These elements outline the important process decisions undertaken for the completion of the current research.

The next chapter is a thematic presentation of the findings as reported from mothers of newborns with NAS. This thematic reflection provides data relevant to the essence of the experiences of mothers of infants with NAS.
CHAPTER 4: PARTICIPANT SUMMARIES:

THE VOICES AND EXPERIENCES OF BIRTH MOTHERS OF CHILDREN DIAGNOSED WITH NEONATAL ABSTINENCE SYNDROME

In this appendix, the individual voices of each of the eight participants are described through firsthand accounts of their experiences of having a baby with NAS. Each of the women spoke candidly about their uniqueness and the issues that were most important to them. This section was completed prior to the thematic analysis and I feel it is imperative to include in the findings. Although there were multiple experiences that were shared among each participant, telling the story and the nuances of each woman’s voice is equally important. With this in mind, to do justice to the overall findings of the research, the following presentation outlines the individual experiences of mothers. These experiences were used to validate the thematic descriptions. The themes are evident in the stories, but the uniqueness of each individual is not lost as their voices are represented.

Madison

Madison was recruited through the nurse practitioner at the Maternity Centre. I was provided with her phone number and told that she wanted to be involved in the study. I contacted Madison by phone and explained the purpose of the research and that it would include up to a few interviews to review her experiences surrounding the pregnancy and birth of her newborn with NAS. Madison expressed her interest and we set a time to meet for the following day. Madison was the first woman I interviewed as part of the study. I found myself very nervous as I prepared for our meeting. Despite my history as a clinician, I hadn’t conducted an interview in quite some time and I found myself overly focused on what I needed to do and say, the tone of my voice, and the ability to consciously follow Madison’s lead. We met at the Maternity Centre,
and after spending a short time with Madison, my focus on my own process quickly changed to focus on Madison’s experience. She had such an ease about her and was very talkative about her life experiences around the time her newborn had NAS.

Madison presented as a very timid and shy First Nations woman. She came from what she describes as a very good upbringing with a supportive family, but she also identified the presence of alcohol in her family life from a very young age because of her father and other relatives. Although she found her family very supportive of her, it was clear that the presence of this substance in her life had caused her a considerable amount of grief due to the alcohol-related deaths of many of her relatives. Madison describes the pattern of substance use in her family:

Like my grandpa drank and he died because of drinking. He got hit from a drunk driver, but he was drunk, too. And also my brother died. My older brother died from ODing on alcohol. And I also have uncles that have died from having too high sugar levels from alcohol. (Madison)

Yet, as her family struggled with alcohol, Madison observed her father overcome his addiction through treatment, and I wondered how much of an impact that had on Madison’s own life. Madison began using Percocets that were prescribed as a result of a back injury, but didn’t become addicted to them until many years later when she used OxyContin as “an alternative to alcohol” when dealing with pain and grief stemming from the betrayal in a trusted relationship with her partner. Madison described grief and sadness following the loss of that relationship and that drug use was a means of making her feel happy again:

I felt like “Well, he didn’t care anyway about me” Or “He doesn’t love me no more.”

….To me it was like, hey, I’m going to feel high and get even with him or not feel the
hurt that he’s given me and without drinking. Instead of going to the bottle, I was going
to get stoned, right? So, that’s how I felt and that’s why I did it. (Madison)

Madison carried a lot of guilt during her pregnancy and after her son was born. She
stated, “How did I end up getting like this?” She did not plan for the presence of drugs in her life,
but following a deep hurt and taking one OxyContin, she described a path that spiralled out of
control and lead her into feelings of unhappiness in her life. She cried often and struggled with
what she had done to her children:

   It was hard emotionally, too, ’cause I did a lot of crying. Mostly because I was ... most of
   the time ’cause I was mad about [son] having to go through that because he’s in there
   because of me, because of what I did when I used. (Madison)

As a single parent to her children, Madison lacked resources and lived in extreme
poverty. Her drug habit was consuming all of her financial resources and contributing to her
feelings of dissatisfaction with herself and struggles to financially maintain her household. Yet
despite the lack of resources, Madison exhibited an immense inner strength and determination to
do better for her kids. Throughout the interviews, Madison’s commitment to and determination
for the sake of her children had a central place in the discussion. Madison explains her
commitment to her son following a judgemental experience with a nurse: “I was just there for my
boy and knew I was there for him and him only. I just let it go, I guess.”

She independently accessed MMT and counselling, and connected with a supportive
partner (her partner and father of her baby). Throughout her pregnancy she worried about the
outcome for her baby and found herself crying often out of fear for him. However, she
maintained her connection to her baby during pregnancy and through her experience in the
hospital. Despite multiple commitments and responsibilities at home with her other children,
with the support of her partner, Madison was able to balance a number of things in her life to make her son her priority. She described a positive hospital experience that I wondered may have something to do with her internal capacity and commitment despite the odds. She disclosed having to balance her home life, financial hardships and parenting all while maintaining her involvement at the hospital several times throughout the day and late into the evening.

It struck me that Madison was so far from the stereotypical image of a drug-using mother that is depicted in the media. From the beginning to the end of the interviews, Madison’s focus never wavered from her children, and despite her involvement with drugs, it was clear that being an involved mother was very important to her and she cherished that role above anything else.

Carol

I first met Carol after she was recruited from the Maternity Centre through the social worker. Following a phone call to explain the nature of the study, a meeting was scheduled for a few days later. Carol arrived with two of her children because she had no child care for them. Prior to reviewing the research and signing the consent, I asked Carol if she felt comfortable discussing the issues in front of her children and gave her the opportunity to reschedule if necessary. She chose to continue with the interview, taking time to tuck her baby into the stroller for a nap and setting her older son up with a video game.

Carol was raised alone in a home with her grandparents while her other siblings remained with her mother. She moved in with her grandparents at the age of four or five and has no recollection of why she began living with them. She was visibly distressed talking about her early childhood, and reflected on a very distant relationship with her mother who she saw only at Christmas and birthdays. She did not elaborate on the separation from her family, however, when she spoke of this time in her life, her eyes welled up with tears and her pain was clearly evident.
Carol described her childhood as difficult but stated that her grandparents gave her everything. Her father was not part of her life but she stated that she knew he was an alcoholic and abusive to her mother. She believes that one potential reason she was placed with her grandparents was because she got in the middle of her parents’ fights.

Carol described a history of sexual abuse as a child, but she had blocked out many of the memories related to that abuse. She spoke highly of her grandparents’ treatment of her, and she sincerely struggled with anguish over the way she treated them. She recalls being very verbally and physically abusive towards her grandparents and stated that she had never forgiven herself for that. She described her memories of her childhood and how they impacted her life:

I used to chase my grandma around the table and I would hit her. Ew. I hate that. I never forgave myself for that. That’s why I stayed in this relationship, I think. ’Cause not only in this relationship – every relationship I’ve got into was abuse and I think I stayed in the abuse because I feel I deserved it because of what I did to my grandparents. (Carol)

The abuse was significant to Carol and she was even blamed by a relative for her grandfather’s death. Her presentation and body language, combined with her tears during the conversation, indicated that her childhood was turbulent and painful for her. I wondered what it would take for Carol to forgive herself for this time in her life.

After leaving her grandparents’ home, Carol was in a series of abusive relationships, from verbal and emotional abuse to serious physical abuse that caused her many injuries. It seemed to me that although she did not specifically discuss the pain of separating from her mother’s home, this hardship was evident in her face as she spoke of it. Carol eventually ended up in a long-term relationship with the father of her children who she describes as an alcoholic and abusive towards her throughout their 12-year relationship. While she was with her partner,
she drank alcohol with him but did not take any drugs despite having access to them while her grandfather was sick.

Her drug use began as a result of pain from jaw surgery resulting from being punched and kicked in the face by her partner. When she took Percocet and OxyContin, she indicated feeling really good, with lots of energy, and that she had feelings of happiness. Because she struggled with depression, Carol described the use of narcotics as a “depression pill.” Perhaps for the first time, Carol had the energy she needed to function:

Because I suffer from chronic depression, so when I would snort that Oxy, it’d give me the energy. It made me happy. It made me feel good. It gave me that boost that I needed, otherwise I just laid around. I didn’t do nothing, you know what I mean? And I was using that. And I said to the psychiatrist, I told people – at that time – that’s what they should prescribe people who have depression, because that’s a wonder... that’s a happy pill, you know? So, I was using it just to get along with life, right? (Carol)

The use of OxyContin and Percocet quickly spiralled into addiction and she felt that she needed the drugs just to get up in the morning and continue with daily living and looking after her kids. She describes not feeling good about what she did to support her habit. She stole and pawned and sold things just to have the money for her drugs. If she didn’t take drugs, she felt very sick and wasn’t able to care for her children. She described her drug use as a constant struggle. Because of her addiction, she lost her children to her abusive ex-partner.

When Carol became pregnant, she struggled even more with her addiction and expressed an extreme feeling of self-loathing because of what she was doing to her baby. She wanted to stop using drugs more than anything and tried unsuccessfully several times. She did not want to hurt her baby but feared that discontinuing her use could cause her baby harm. The drug’s hold
on her was very powerful and her sickness when she didn’t take the pill was unmanageable. Consequently, Carol had an extreme sense of guilt and fear that her baby would not be okay:

Oh, it was so hard! It was very hard. Because, like, you know, you’re sick. You’re not feeling well and then you’re pregnant with this baby in you and you didn’t want this baby to, you know, be retarded or withdrawing, because he wasn’t asked to be put here. And then he’s going to be born with an addiction and he’s going to be sick. So, it was really hard. Like, I loved being pregnant but I hated what I was doing. (Carol)

She kept her drug use a secret from both child welfare and her physician during her pregnancy until she felt she could no longer carry the secret out of fear that she was causing harm to her baby. Although Carol lacked support in her life, her oldest daughter encouraged her to “come clean” and Carol was able to turn to her physician for help. She continued with an immense feeling of self-loathing and guilt after this disclosure, but was supported by the physician to go on the methadone program.

Carol described the methadone program as very difficult. Although she recognized she needed it to keep herself and her baby from being sick, she did not want to replace one drug with another. She fought her addiction for the sake of her children and it was clear through our conversations that she loved her children very much. It seemed like her children were the reason she was able to persevere through all of her challenges in life. Carol described breaking her silence of addiction and her motivation to be on the methadone program:

It was relief that finally it’s over [her secret of her addiction], that I’m going to do something that I might not get my baby taken away. The whole thing was that baby… That baby. That baby…I was scared of them coming in and taking my baby. That I did not want to happen. (Carol)
Carol feared for her baby’s well-being and struggled with watching her baby go through withdrawal. There was a desperation in her descriptions of the time spent in the hospital when she did everything she could to ensure she was not separated from her baby while he went through the withdrawal. With every symptom in her newborn, Carol’s guilt and shame were reinforced, but she maintained an unwavering commitment to her baby and stayed with him as she felt that this was part of her role as a mother. Carol described the first time she witnessed her baby’s withdrawal:

Oh my God. See what I done? And I cried. I held him. I’m like “What did I do to you? You didn’t ask this. You didn’t ask to hurt.” 'Cause you think, when you’re pill-sick, how do you feel and then you got a little baby there, sick. And you know you could have prevented that. It kills me. (Carol)

Carol spoke of her feelings of motherhood and she expressed a love for her children that surpassed the hold of the addiction and the feelings of guilt and shame. Throughout my interview with Carol, I found myself feeling sorry for her. She did not label her experience as abandonment, though it was clear to me that she didn’t seem to have anyone on her side. It seemed to me that she always had to look after herself, and even when drug use took over her life she only found the strength to fight it because of the love of her children.

Carol spoke of motherhood as well as her hopes and aspirations for her children. Contrary to stereotypes of mothers who use substances, Carol demonstrated that drug use does not define you as a bad mother. She described her thoughts for her children and her desire to break the cycle:

You know what, I want to do better. I want my children to be proud. And I want them to be a better mother and father. I want them to be good, to treat their kids good and have a
good opportunity. You know? I don’t want them to end up…I want them to grow up and have a job and education. So, they can be good for their kids. (Carol)

Emily

I was approached by Emily following a presentation at Hope Place. She appeared very light-hearted and sure of herself, and she expressed that she had a newborn with NAS and was eager to share her story. I discussed the purpose of the research and that it would entail meeting a few times to review aspects of her pregnancy, the birth of her child, and issues about her family. We made an appointment for a few days later. Emily asked if I would meet with her in her apartment because of issues with transportation and child care. I explained that due to ethics limitations, while I could not meet with her in her home, I could come to the Single Parent’s Program where she lives and meet in a meeting room that allowed for sufficient privacy. Emily was pleased with this option because transportation was such a stress for her. She made arrangements with the program coordinators and we met a few days later.

Although I had passed the apartment building several times in my day-to-day activities, I had never been in the building and when I arrived to meet Emily, due to construction around the building, I parked on the opposite side of the entrance. To get to the entrance I had to walk through a narrow alley. I recall my heart beating quickly as I walked through the alley, wondering who might be nearby. The Single Parent’s Program is in a rough end of the city, and I wondered how Emily and other women felt living in such a space while trying to be safe and care for their children. Was she uneasy like I felt in the alley?

I was greeted at the door by Emily who appeared distressed and quickly expressed that she was having a very bad day. Given that it was only 10:30 in the morning and Emily was still in her pajamas, I wondered what could have possibly gone so wrong so early in the day. Emily
stated that she had an argument with her partner and he choked her. She said that she “kicked him out” and didn’t know where he was. In light of the circumstances of the day, I offered to meet with Emily another time, but she was eager to tell her story and asked me to stay.

From the outset of the interview, the rawness of Emily’s emotion was evident through a very tearful report of her circumstances during her pregnancy and the birth of her newborn with NAS. The first question I asked was in regards to her pregnancy, and the first statement Emily shared through intense sobbing was “I got molested. That’s how I got pregnant.” This type of emotional exchange continued throughout the interview and I was very concerned that perhaps the questions were causing Emily undue stress. I checked in with her several times throughout the interview, and every time she indicated she was “OK but didn’t realize it would be so hard” and wanted to continue.

Emily reported a very traumatic history with a significant pattern of abuse both in her childhood from a family member and from her partner during pregnancy. The abuse inflicted on Emily appeared to have a strong link to her substance use. Emily explained this when she spoke about her family of origin:

My stepdad sexually abused me since I was 6 years old, up until my 14th birthday. That’s when I got hard into drugs. And even when I found out I was pregnant, I just...I think I just wanted to use just to get rid of it. Do you know what I mean? (Emily)

She further explained the relationship between abuse and substance use in her life when she disclosed memories of her previous relationship:

It’s, like, even if I didn’t want to use, I had to because (name of partner) was there. He’d push and push and if you didn’t do what he wanted...he would never do anything by
himself. That’s why, if he wanted to get high, I had to get high or else I got beat up.

(Emily)
The trauma of Emily’s relationships with men in her life was profound, and I found myself surprised that despite my many years as a clinician, Emily’s story and the rawness of her emotion really affected me. I struggled in hearing her account to find a balance between clinician and researcher.

Emily was explicit about her own family and indicated that she didn’t have an easy upbringing. She described her entire family as “addicts,” her father as a “needle junkie,” her mother as someone who “uses men for money” and her stepfather as “sexually abusive.” She was the first person to get clean in her family.

Her support system was severely lacking, with no support from family, and the only friends she had were others with whom she used drugs. Therefore, when she had her baby and he was born with many health issues, she had no one to turn to, ended up isolating herself further and didn’t visit the hospital to see her son for quite some time.

Emily went on to report a long history with drugs and alcohol, and a self-loathing and unhappiness in her life. She described a life of fear, as well as and fear and emotional pain during her pregnancy and after she had her baby. Emily did not find out she was pregnant right away, and when she did, she describes not being in a good place emotionally: “I didn’t know I was pregnant until I was, like, 4 months pregnant but then after I didn’t really care. I was just at the stage that I just didn’t care about anything.”

Despite numerous hardships in her life, she was able to overcome many obstacles and is now on a methadone maintenance program and is parenting a child from a subsequent
pregnancy. In describing her experience with her son who had NAS, Emily expressed a strong connection to him after holding him for the first time in the hospital:

Emily: ’Cause that one time I held him. It made me just feel differently…It’s just people always say when you hold your baby for the first time you get that motherly instinct.

Interviewer: Did you have it?

Emily: I think so…Once I held him, that’s when I put myself into the women’s shelter thing again and I wanted to get clean. They put me on a safety withdrawal program and it took me a month but I got clean.

Because of that experience, Emily stopped using drugs. She had to make very difficult decisions, including placing her newborn up for adoption, to ensure that he was well cared for and had a better life. Despite Emily’s difficult lifestyle, she maintained a commitment to her children above herself.

Despite the positive outcomes from MMT, Emily expressed a struggle with the methadone program, as she felt she needed to stay on it to avoid her former life of street drug use but wanted to get off the program because it made her feel like she still needed drugs just to get by. She just wanted to be “normal.”

After meeting with Emily for almost an hour and observing her struggles as she cried through her gruelling account of her story, I was left with so many questions that I wanted to ask her the next time we met. I asked Emily if we could meet again and she agreed. I made an appointment with her for a few days later, but she wasn’t there when I arrived. When I contacted Emily, she said that she really wanted to talk to me again, and in five subsequent instances we made an appointment to meet and Emily failed to show up. I explained to Emily each time on the phone that she didn’t have to continue in the research, but she continuously acknowledged
wanting to participate. Prior to the last time I spoke to Emily, I ran into her at a mall a couple of days before our scheduled meeting. She introduced me to her partner and child and stated that she was looking forward to meeting with me on Monday to tell me more of her story. However, Monday came and went and Emily did not attend our meeting. I had so many unanswered questions, but I felt that enough attempts were made to connect, and despite Emily’s espoused desire to meet I did not continue to call her to reschedule and there was no additional interview. I wondered if the failure to have a second meeting was a reflection of the pain she experienced in recalling her experience during the initial interview, or if it was perhaps a reflection of the tumultuous nature of her lifestyle.

Beth

I received a call from Beth after she learned of the study through the Maternity Centre. After describing the purpose of the research, we set a time to meet the following day at the Maternity Centre. Beth was a very shy, pleasant woman with six children. She described herself as a “tomboy” growing up and said she never intended to have children of her own.

Beth was raised by her father and was very close to her aunts. Beth’s mother used drugs and alcohol until she passed away when Beth was only nine years old. This loss was very traumatic for her. Although she did not speak in great detail about her mother’s death, she did state that her mother died from consuming a mixture of alcohol and sleeping pills. I wondered if this death was accidental or if her mother had committed suicide. This was not an area that was explored in depth as it was clear from Beth’s response that this was a private issue in her life. In addition, Beth’s memories from her childhood were scarce, and she stated that there were a lot of things from her past that she “blocked out.” Nevertheless, losing her mother at a young age had significantly impacted Beth. She spoke about the pain caused by her mother’s death, and how it
impacted the emotional support from her father. In the following exchange, Beth described her blocked memories from childhood:

Beth: Like, I’ve blocked everything out. I only have certain images of my mom. And the last one that I can remember is her laying in bed for three days and then my aunt coming over saying “You better call 911.”

…

Beth: My kids now, like, they can remember stuff from when they were babies and they ask me, like, how come you don’t remember anything. I don’t know what to tell them. I blocked everything out.

Interviewer: Why do you think you did that?

Beth: Too painful.

Interviewer: So, remembering it just brings back all that emotion.

Beth: Wishing I had her.

Interviewer: Your mom?

Beth: She missed out on a lot of things. And then he would always tell me…I wish he would have took me and left her.

Beth went to live with her father and stepmother and felt like an outsider in her new home. She spoke of how her stepmother was just another woman in the house and her step-siblings were treated differently than her and her brother. As a result, she predominately cared for her brother on her own and essentially took on a mothering role at a very young age. This was difficult for her, but it was something she accepted once her mother passed.

Beth later became involved with her partner several years before the birth of her child. They worked together to establish a business that required them to work night shift. While
pursuing this dream, they found staying awake at night very difficult and a friend suggested that they take a pill (OxyContin) that would help them stay awake. Although Beth smoked marijuana from the young age of 15, she was not otherwise a drug user and felt that taking the pill was only to assist her and her partner through their work.

Beth described using OxyContin for the first time by stating that she felt “normal.” She said, “Like I couldn’t function properly until I got it.” It allowed her to function in a way that she wasn’t used to, and all of a sudden she was able to cook, clean and maintain her home. However, she realized she became addicted to the drug when she required it to feel normal and to avoid the sickness caused by withdrawal. Her and her partner realized they needed help when they were in debt more than $25,000, and they lost their company as a result of the financial struggles and issues related to their use. She subsequently began the methadone program three years prior to having her newborn. Beth struggled with methadone, and although she knew she needed it to stop her addiction, it continued to cause her considerable stress, particularly when she was pregnant. She spoke about her struggles with methadone:

I thought of coming down but then she started taking more of it, so I had to come up and then I also wanted to just quit. Like, when I found out that I was pregnant again. But then the doctors said that would probably do more harm to the baby than it would to me. So, I just more or less had no choice to stay on it. (Beth)

Beth spoke about an instant connection to her baby on the day she found out she was pregnant, and this was strengthened by the first ultrasound. Her battle with methadone and concern for her developing fetus made Beth consider her options regarding her pregnancy, but the growing love she had for her infant helped her commit to treatment: “I thought of adopting it
out but once you carry something inside you for so long, you get attached to it and it’s hard to give something away you’ve got a bond with, you know?” (Beth).

Beth experienced a flood of emotions on the day she learned of her pregnancy. Although she did not want to have children, she was overwhelmed with an immediate connection and bond to the baby growing inside of her. She had a tremendous sense of worry and fear that her use and her methadone treatment would cause her baby distress and health problems. She continued to worry throughout her pregnancy until the day she gave birth to her daughter:

...And then once the baby did start taking my methadone, then I started withdrawing. I kind of got scared because they said “If you withdraw, there’s a chance that the baby could die.” And then I was also scared of going up more and thinking that the baby was going to be getting more, like, than what it should be. (Beth)

Although Beth felt that the methadone was helping her with her cravings and her quality of life, she struggled with remaining on methadone as she felt it was causing her baby harm. She described feeling trapped between remaining on methadone in order to prevent her baby from being harmed in utero from stopping the drug quickly, and discontinuing her treatment in order for her baby not to be exposed to the drug at all. This struggle with methadone was a predominant issue for Beth as she described the impact of methadone on her life.

When her daughter was born, Beth recalls a sense of worry for her baby’s health. Though she had family supporting her at the time, she found it extremely emotional to watch her baby go through withdrawal. She expressed a constant concern for how her baby was feeling and wanted to know if her baby was in pain from withdrawal. She found it very difficult when the nurses took her daughter to the NICU, and Beth described feeling very lonely without her. Although it was difficult to watch her baby withdraw, she travelled back and forth to the NICU several times
a day to be with her baby. For someone who did not plan on being a mother, it was clear through the interview that Beth stepped into the maternal role with ease and would do whatever it takes to ensure that her baby was well cared for.

**Chris**

I first came in contact with Chris at Hope Place during a presentation on my intended research. I did not speak to Chris that day, however, she phoned a few days later asking to participate in the study. I explained the purpose of the study over the phone and advised her of what to expect. I asked if she had a child with NAS born within the last four years, and she stated that she did. An interview date and time was set for two days later. The following day, I received a call from someone who introduced himself as Chris’s partner. He was very polite and asked if the appointment could be rescheduled to Monday (it was Thursday). I was very careful not to give this individual any information, but stated that if Chris would like to talk to me on Monday I would be available. The implication in his voice was that he would be joining her. I carefully told him that the meeting could only be between Chris and myself. He accepted that answer and seemed fine with the new arrangement.

The next morning, I received a call from Chris asking if we could meet that day. She did not want to wait until Monday and told me that she would be bringing her children with her because she had no one to watch them as her partner was in jail. She told me that they had an altercation the day prior, and the police took him to jail at that time. Chris was used to depending on him for things like transportation, child care and money. There was an urgency in her voice to meet with me on that day and she said that she really wanted to do the interview. Although she requested that I meet with her in her home due to transportation and child care issues, I advised
Chris that independent homes were not an approved meeting space under the study’s ethics agreement.

Having conducted an interview where there was a child in the room, I told Chris that her children were welcome but she may find it difficult to focus on the conversation as she attended to her children. We agreed that I would attempt to find temporary child care at Hope Place where we would have our initial meeting. Child care was arranged as it is a component of Hope Place, and Chris and I met there for our initial interview.

At the outset of the meeting, Chris was very emotional and almost appeared as if she was “somewhere else” as she stared at the floor, clearly reflecting on her past. Despite having introduced details of the study at Hope Place and screened for inclusion criteria during our phone conversation, midway through the interview it became clear that Chris’s newborn with NAS was born prior to the inclusion date. Because the interview was raw with emotion and Chris expressed that she wanted her story heard, I felt it would be inappropriate to stop the interview for fear that Chris would feel that her voice was not worthy of being heard through this process. This was an ethical dilemma for me at the time, but I relied on judgement to dictate my initial actions, and after the interview I discussed the issue with my supervisor to ensure I had made the right decision. My supervisor supported the decision to keep Chris’ interview included in the research and he advised not to remove her interview from the dissertation. I did not speak to Chris about the inclusion issue at that time as I felt it was important for her to feel that her story and experiences were important.

Chris came from a very large family. She was the oldest of 14 siblings but became separated from many of them throughout her life. She didn’t appear to know much about her parents, where they were, or why she wasn’t with them, but it was clear from her body language
and a quick change in the subject that this was an area she was interested in elaborating on. I wondered if this was painful for her or if it was simply a chapter of her life that she didn’t wish to dwell on.

Between the ages of one and four, Chris was in the foster care system and vividly recalls experiencing sexual abuse from her foster parents. She was later moved to her grandmother’s home where she lived with her grandmother and her grandmother’s boyfriend. Despite the initial traumatic experience in foster care, Chris described her childhood as “awesome” and attributes that fact to her grandmother and her partner, who she now refers to as “dad.” When talking about her family, it was clear that Chris had a closeness with her caregivers and she remarked that her grandmother’s boyfriend was the first man she ever trusted. After his death, Chris struggled with the loss and experienced additional painful losses in her life due to severed relationships with her sisters.

Chris began using drugs and alcohol at the age of 12 because of peer pressure and a desire to fit in, but she described this use as experimental and her addiction to drugs did not begin until later. She described a very significant dependency on drugs ranging from alcohol and marijuana to OxyContin, morphine, Ritalin, Percocet and intravenous cocaine. She used drugs and alcohol up until the day she delivered her baby, and continued to struggle with her use during the time of the interview.

Chris’s serious drug use began following a traumatic event in her life when she was falsely accused of using intravenous drugs and her children were apprehended by child welfare. Chris had not been using at that time, but the pain of losing her children and the depression that resulted from that loss were the impetus for her using substances. She reflected on the many losses she had at that time:
I was depressed. I was contemplating suicide. I lost my house. I lost my kids. I lost my old man. Well, the kids’ dad. My daughters’ dad. I lost my self-respect. I lost everything. I lost hope. (Chris)

Chris was very depressed and suicidal, and she stated that the drugs made her feel good and numbed her pain. She described the power of cocaine in her life: “It made me feel really good. It made me feel powerful, like nothing could hurt me. It made me feel like I was on top of the world” (Chris).

Throughout her drug use, Chris was open about working for drug dealers and she had access to many substances through her “job,” which was intimidating and “hurting” people, and collecting money owed to dealers. Chris explained her life on the streets and the lengths she would go to in order to access her drugs:

I loved it. It was awesome. I worked – I wasn’t a street person. I collected money for people and I got into fights. I hurt people for my drugs. I pretty much got paid drugs to do something that I enjoyed doing…To go and collect money. Or go and scare somebody or go and do something…It gave me a sense of empowerment. It gave me a rush. It gave me adrenaline. It’s ’cause I’d been picked on my whole life as a child or I always felt that I wasn’t good enough for anything or anybody. So, doing that made me feel powerful.

(Chris)

I don’t think Chris realized it when she spoke of it, but it appears that even her enjoyment of working for drug dealers was connected to deep personal pain and loneliness. As she spoke of this lifestyle, I couldn’t help but think of how scary it must have been to resort to violence in order to support her drug use. However, Chris surprisingly indicated that she loved this time in her life, as she felt empowered when she hurt other people and secured drugs for herself.
Of all of the participants in this research, Chris was the only woman who was not on a methadone program at the time of the interview. Chris talked about her constant struggle with drugs, and as I watched her talking about her experience I became concerned that I was triggering something that would push her to use again. When the tapes stopped rolling, Chris and I talked about it and she was clear that although she had cravings, she did not intend to use and would speak to counsellors for support. She declined my offer to discuss her issues with the counsellor at Hope Place, opting instead to contact them on her own.

When Chris learned of her pregnancy, she was drinking and using drugs. She did not have any support and was living with an abusive partner who was telling her that she had to abort the baby. What struck me most about Chris is that although she stated that she did not connect with her baby while pregnant, she made many conscious and difficult choices that would indicate that on some level there was in fact some sort of connection present. During her pregnancy, Chris spoke of making a choice not to use weed (although she used other substances) because she could feel the baby’s movements and knew he did not like it. She also made the very difficult decision for her baby to be adopted because she felt she was not in a position to care for him. She also describes feelings of guilt and a conscious effort to disconnect from her baby in utero as a survival mechanism to cope with that guilt:

…I felt somewhat connected but not the way I do with my normal pregnancies. Um…I think I disconnected myself. I didn’t hate the baby or I didn’t not want the baby, it’s just I knew I was doing wrong to this child… (Chris)

However, Chris felt an immediate connection when her son was born, and although she had very limited time with him after giving birth, she describes a heartfelt moment the two of them shared. Due to feelings of guilt and shame for what she “had done to him,” Chris told the
nurses to take him out of her room because the pain was too much to bear. She has not seen her son since, and the pain is evident in her eyes as she speaks of the day he was born.

Chris recalls hearing others talk about her son’s withdrawal while she was in the hospital, but she indicates that she did not see it because she believes she disconnected from the experience as a means of coping. She spoke further about leaving the hospital only hours after she had her son. She had taken many drugs that day, and despite what she had already been through, she travelled directly to a bar to drink in an effort to numb the pain of knowing what she had caused her son. She stayed drunk for many days, fearing that if she stopped drinking she would begin to feel these negative emotions again. Chris disclosed the events that occurred hours after her son was born:

I didn’t even care about using. I just wanted to get drunk. I don’t even think I used for a couple of days. I just stayed drunk…Because when you use, when you come down you get really depressed and it’s like you want to kill yourself and I knew that feeling would come if I didn’t have any drugs and if I had to work hard to get it. And I knew if I stayed drunk I would not feel or think. So, I just stayed drunk. (Chris)

Despite attempts not to think about her son, Chris found herself thinking of him often, and would inject herself with cocaine every time he came into her mind in order not to feel the pain, guilt and shame.

Although she describes a disconnected pregnancy, her natural protective instinct was revealed in the interview. She protected herself from pain by disengaging, and she also protected her son by giving him a better life. She describes the decision to place her son for adoption as “the first right decision I have ever made in my life.”
Chris appeared to be the least stable of the study’s participants from a drug use perspective. The fact that she was at Hope Place indicates that she is trying to overcome addiction, but Chris continues to struggle and lacks support to help her through her sobriety.

I had many questions for Chris following our first meeting, and a second interview was scheduled. Chris called the morning of our meeting and asked to move the meeting to the afternoon. She had been hit by a car the night before and needed medical attention. Although Chris took the initiative to schedule another appointment with me, she did not attend the meeting and I have not heard from her since.

Chris struck me as someone who was very tough and who had a protective instinct that seemed to be a defence mechanism. She had clearly done many things in her life as a means of survival, but it was clear that Chris’s children had changed her. She loved them and they loved her, and she would continue to fight for their sake. Chris sums it up nicely when she describes her children:

That’s my new empowerment. I feel powerful. I feel loved and I feel wanted and needed and accepted. Unconditional love. That’s what I get from my kids and that’s what I’ve always looked for. (Chris)

Yolanda

Yolanda was recruited to participate in this study through Hope Place. When I first met her and throughout the interviews, Yolanda as appeared to be a very confident and self-assured woman who seemed to have her children’s interests in the front of her mind at all times.

Yolanda grew up in a remote community with her father and grandmother. Her parents separated when she was three, and she lived with her father’s side of the family because of her mother’s issues with alcohol. She described herself as having two very different lives as a child.
Her father’s family was very structured and had clear boundaries and a strict parenting style, while her mother’s family struggled with addictions. When Yolanda remained with her father, she recalls a positive lifestyle, receiving straight A’s in school and staying away from “trouble.” By the time she was 11, she made a conscious decision to move in with her mother. Because she had not been exposed to a lifestyle of drinking and drug use, Yolanda became fearful in her mother’s home and took it upon herself to contact child welfare for help. This call changed her life in many ways. She was in and out of foster care, and relocated to many different foster homes in different communities in north-western Ontario. These relocations contributed to the sense of loneliness and isolation that was growing in her:

In the time that I was in [the child welfare agency], I was moved to [names different communities], where I knew nobody… I was the only Native and I went through a lot of racism and, like, not fitting it over there. And so, like, I hitchhiked back myself. I was only… I was in grade 6. (Yolanda)

While Yolanda struggled with being away from her family and her community, and having no interpersonal connections in the places she was living, she began a life of experimenting with substances such as alcohol and marijuana, and became involved in undesirable teenage behaviours that landed her in jail many times as a teen. She remained in care from the age of 13 to 18, and describes this time in her life as very lonely. She was very depressed at the time, and as she went back and forth between her mother’s home and foster care, she never felt like she fit in anywhere. This was a very emotional moment for Yolanda during the interview as she described a dark time in her life that she felt was the impetus for her drug use:
[crying] I felt like nobody wanted me. Like, my mom wouldn’t quit drinking and then I had options to go with my dad’s family but by then they thought I was, I don’t know, bad, I guess. Because I was already drinking and hanging around with the bad kids. So, like, that’s where I didn’t fit in. I didn’t feel like nobody wanted me…. It [the drug use] impacted big time because I felt good. I fit in with the people I was using drugs with and drinking with. (Yolanda)

Yolanda began drinking and using marijuana at the young age of 11 or 12. Her mother would often give her money and Yolanda felt that her mother was fine with how she was spending it. Drugs and alcohol were a normal part of her life. When she turned 18, Yolanda’s drug habit became progressively worse, beginning with weekend drug use at parties but growing into an addiction to cocaine, Ritalin, morphine and OxyContin. She recalls feeling more energized and happy once she began to use drugs. She described her use and stated that the drugs “caught me so fast.” Her use of painkillers began as a result of wanting to fit in. She recalls frequenting the drug house and being unable to “bang” herself so she had other people injecting her. She knew she was addicted when she found herself alone in the drug house putting a needle into her own arm:

There was needles, but I couldn’t even stick ’em in my arm and put the drugs in. ’Cause there’s a certain way you’ve got to do it, right? So, I didn’t get into it. Everybody always had to get me high. Like, stick a needle in me. And then I knew I was addicted when nobody was around and I just did it on my own. That’s how I first started the banging.

(Yolanda)

Her drug habit was profound, and included multiple substances, injections three to five times daily, panhandling, stealing and bumming money from whomever she could get it from to
support her habit. This lifestyle was far from her norm. She regularly banged drugs with her partner and her mother, and she lacked positive support in her life. Her drug use cost her all of her possessions and eventually her home. Once homeless and living on the streets in the cold winters of Northern Ontario, she became progressively more depressed and stressed and had thoughts of suicide as she struggled with the addiction and feeling like she had nowhere to turn.

Although Yolanda hadn’t planned on having children, the day she found out she was pregnant, her life changed in a different direction. She was homeless and struggling with her addiction when she went to see her doctor for an unrelated issue. When she was told of her pregnancy, she felt an instant connection to her baby and adopted the role of mother almost immediately. She recalls feeling very unhappy and terrified for her baby on that day as she knew how significant her drug use was, and how impossible it had been for her to get clean despite multiple attempts in the past. Yolanda expressed her thoughts when she learned of her pregnancy:

Oh, when I found out I was pregnant? I wasn’t happy. My initial…when the doctor told me, I just bursted out crying because I was such in a bad place…Oh, I was feeling scared. More scared than anything. Like, what am I going to do? I don’t have a place to live? I don’t have any income. Like, what am I going to do? (Yolanda)

Yolanda had no natural support at that time in her life, and had distanced herself from her father’s side of the family. However, on the day she discovered she was pregnant, she accessed a number of community supports, and by the end of the day she had an appointment to begin MMT. She had attempted the methadone program in the past but was unable to tolerate the cravings during the stabilization period. However, Yolanda attributes her newfound success with methadone to the baby growing inside of her. I believe that her success was attributed to both her
commitment to her baby, and her strength and resilience as a person. Yolanda stated that for the first time in her life she felt committed to getting clean for the sake of another person.

Yolanda felt a tremendous sense of guilt and shame throughout her pregnancy and thought of the baby daily. She stressed about the health outcomes for her newborn and was mad at herself for causing him pain. Yolanda expressed her concerns during her pregnancy, demonstrating that the bond between her and her child was developing early:

Every time I went to my ultrasound. Like, I would always be asking the ultrasound, like “How’s my baby? Does the baby look fine? Is it normal?” I’m like “Can you see any deformalities?” I was really thinking that…’Cause I seen people have kids drinking and drug-using and all that throughout their pregnancy and you can just look at them and tell. You know? ’Cause they have a disability or something. That’s what I was always afraid of. (Yolanda)

When her son was born, although she was happy and relieved that he was okay, she struggled with her own emotions of shame and guilt. She also described watching her newborn’s withdrawal and crying as she grieved for what she had done to her baby. She knew what withdrawal felt like and found it difficult to watch in a baby. Yolanda expressed seeing signs of withdrawal in her baby for the first time:

But his whole body would shake. Not just a little shake, it would be like a whole body shake. His little hands would go like this and I was thinking “Oh my gosh! What am I doing? Like, look at my kids. They’re going through this because I wanted to feel good.” You know what I mean? So, that was a lot of guilt I felt, when I seen my son go through withdrawal. (Yolanda)
However, Yolanda’s emotions and her struggles with seeing the withdrawal in her newborn did not stop her from taking on her role as mother. She stayed with her son around the clock. Although she states that she knew people were talking negatively about her and what she had “caused” in her infant, she didn’t care and remained committed only to doing what she could for her baby. Yolanda’s attitude and commitment consequently gave her a positive experience in the hospital. Unlike some of the other women in the study, Yolanda felt very supported in the NICU where she grew into her new role as a mother. She states, “having kids changed my life.”

Yolanda spoke about her hopes for her children and how they have kept her on a more healthy path:

I haven’t done any drugs since I got pregnant. Well, I did drugs once but I never did them when I was pregnant. I did the methadone. I knew I wanted a stable life. I knew that I wanted to be there for my kids. I knew I wanted them to have a safe environment.

(Yolanda)

Shelley

Shelley was recruited through the social worker at the Maternity Centre. After I contacted Shelley and explained the purpose of the research and what it would entail in terms of interviews, we set a time for our initial meeting. Despite a very harsh life and extreme drug addiction, Shelley was one of the most considerate people I have met. Prior to our initial meeting, she contacted me to tell me she would be late, and despite living in extreme poverty and having yet to meet me, Shelley asked me if she could bring me a cup of coffee. I was struck by that and have since learned that it is a true reflection of Shelley’s character. She is someone who has been labelled in many ways and fits the stereotypical depiction of a drug-addicted woman,
but upon getting to know Shelley, it is easy to see that she is a woman with a very big heart. She is full of compassion for all people and has a protective instinct that I’m sure has served her well. 

Shelley appeared for the interview looking very tired and sweaty, and although she was similar in age to me, she walked with a cane. She was quick to explain the reason for “the sweats,” stating that she hadn’t taken her methadone yet that day because she wanted to be focused and present for the interview. Despite all of this, she was dressed as if she was on her way to an important job interview—in a blazer, high heels and lots of jewellery. While in the grand scheme of things her appearance is irrelevant, it is something that stood out for me because it was clear that Shelley took pride in her appearance and the way she presented herself to others. 

She described a very turbulent childhood that was marked by her father taking her away from her mother, who struggled with alcohol, at a young age. Her mother later died when Shelley was 19 years old. She did not have much contact with her mother throughout her childhood and felt very alone because of it. Shelley spoke of her relationship with her mother:

Well, I talked to her. I met her when I was younger, like, twice and for a couple days each time. And she called maybe once every couple years and that really messed with my head. You know? That was like “Why don’t you come and get me? Why don’t you come and move up here? I miss you. I need a mom.” (Shelley)

Shelley had several brothers and sisters throughout Canada, many of whom she had not met. She lived with one sister and her father on a reserve, but her sister was removed from the home because she was violent toward Shelley. Shelley’s sense of abandonment and having no one to support her was heightened when her sister was gone.

Shelley reported starting to use drugs and alcohol at the early age of eight years old following a sexual assault from a trusted family friend. This assault was significant in Shelley’s
life and may have been the impetus for the onset of her drug use. Shelley described the impact of the sexual assault:

Like, he was having sex with me…I guess he only, like, penetrated me once. I was half asleep and I grabbed the knife and I was going to kill him. I kept thinking, as a child, I was like “I’m going to go to jail!” Like, I know now…if I knew I would have got away with it, I would have killed him…And then after that I really felt like I was abandoned. (Shelley)

She further described the impact of the assault on her interactions with other men:

And then after that I started having sex with guys. At 8 years old, 9 years old, I had an 18-year-old boyfriend…Because it already happened to me. I didn’t even care, you know? Do it again, do it again. Like, who cares, you know? I already got raped. Like, who cares? With virginity, who cares? You know, I didn’t really care at all. (Shelley)

Promiscuous at the age of 9, she moved out of her father’s home and lived with a “drug dealer” boyfriend at the age of 16. She disclosed that her drug use became much worse at that time and she became involved in criminal activity and fraud to support her drug habit.

Shelley grew up in extreme poverty and did not have the financial means as a child for food, blankets or a bed to sleep in. Leaving her family home gave her opportunities to have certain things for the first time and this contributed to her involvement with her partner, who was dealing and using drugs, and to her own drug use that was quickly becoming out of control:

I got into drugs with him and it was like he was just feeding me drugs constantly. And I thought “Oh, he’s taking care of me. He’s buying me stuff. Taking me out in a nice car, nice motorcycle.” I wasn’t used to that. My own father couldn’t even give me that. So, from him…it was like “Oh, I love this guy!”…When we started getting really bad, it’s
not two grand anymore it’s more like we’ll do anything for an 8-ball, then anything for a gram. And that’s when it all ended… (Shelley)

Later on in life, Shelley’s drug habit grew to include a lifestyle of drug use ranging from cocaine to morphine, OxyContin and Percocet. She worked as an escort to support her drug habit. She had a history of abuse from her partner and multiple losses in her life through miscarriages, the loss of her child to his father, the loss of her mother in death, and the loss of her sister to the system. She experienced further loss when child welfare placed her second son with his father after deeming Shelley to be unable to care for him without supervision.

Shelley struggled throughout life with self-loathing, depression and multiple suicide attempts. She described herself as very apathetic toward life, saying she used drugs because “who cares.” Shelley described herself as “very apathetic towards life” and explained how she felt about getting clean from the multiple substances she was using:

After a while I just figured, you know what, I’m a junkie. No one cares. I don’t care. I wish I was dead. You know, like, who cares if I get high? Who cares if I don’t get high? It was just that…So, when I’m using, it’s like every day would be like “Okay, I’m not going to use.” But then, throughout the day I would be, like “Screw this, man. You know what? Who cares?” (Shelley)

There were many times during my interviews with Shelley when I was struck by the fact that she had a big heart and compassion for other people but truly lacked a sense of self-worth. I wondered how she had come to have so many protective instincts and resilient qualities but was unable to internalize those to her sense of her own value.

Going through the interview with Shelley, she appeared so self-assured with a lot of insight into issues such as methadone, life in general, and what others thought about her, but
there was an inability to overcome many of the injustices and pain she had experienced, and she frequently indicated that she had “given up.”

Although her pregnancy was unplanned, Shelley was very dedicated to her baby in utero. She began methadone maintenance just before learning of her pregnancy and stated that the only reason she stayed on methadone and remained clean was for her baby. She shared with me that had she not been pregnant, she wouldn’t have stopped using drugs because she simply didn’t care anymore. However, it is evident from the transcripts that Shelley loves her children above all else and would do anything for them. Shelley discussed how her baby made her stick to getting clean:

I knew I’d quit using before I had the baby but I was wondering is methadone going to hurt my baby? Like, it did, to a point, but I hurt my baby more. You know? If I knew I was going to be getting pregnant, I would have stopped. I would have went through it for a baby. Of course I would have gone through the pain. But when it was just me, I didn’t care. (Shelley)

In a sense, she was sacrificing herself by being on the methadone program, and it appears as though she was simultaneously saved by her pregnancy.

Shelley faced many judgements while she was pregnant and when her baby was born. Despite her negative view of herself, Shelley was resilient through the difficult time when her baby was born. She continued to try to get well from her addiction to avoid having her children removed from her care, and to be a good mother to her son. Although she did not have her mother as a role model, Shelley had a clear conception of what it meant to be a mother, and she strove to ensure that she could meet her own expectations.
When Shelley’s son was hospitalized for NAS, she struggled with judgement from nurses, her own feelings of guilt, and the lack of a support system to help her cope with her baby’s withdrawal and hospitalization. She describes feeling a loss of control as a mother when she became a powerless observer as nurses cared for her baby. Shelley spoke about her feelings of when she was in the hospital with her son:

I felt like nobody was on my side…I think they judged me just because I…I’m a bad mom because I was on methadone. The poor baby, like. No one thinks, “Oh, the poor mom has to watch her baby go through this.” It’s always like “Oh, the nurses have to watch the baby go through this. It’s like, that’s my baby.” (Shelley)

Despite Shelley’s ability to speak up, she felt silenced when her son was in the hospital as she tried to balance her role as her baby’s mother while trying to avoid any reason for child welfare to apprehend her baby. Shelley was committed to doing whatever was necessary to ensure that she could be an active mother to her son and provide him with the necessities of life.

The interview with Shelley took a path that I wasn’t anticipating. Although we spoke of her pregnancy and the birth of her baby, it was quite clear that some of the salient issues in Shelley’s life that continue to affect her now stem from her family of origin and her childhood in general. Hearing the stories of abuse, sexual assault, promiscuity and drug use at such an early age angered me as I wondered who was looking after this child. As I have children of my own who are that age, this interview was close to home. It amazed me to see how much resilience one individual can have despite having never had a role model or family member to care for her.

**Mary**

Mary was the last participant I interviewed for this research, and her story was perhaps the most tragic. I received a call from Mary after she saw a poster for the research at the
Counselling Centre, which is a program attached to Hope Place. When I first spoke to her over the phone, she seemed urgent to meet and a time was set for Friday night at her request. However, Mary did not attend the scheduled meeting. After speaking with her, another appointment was set at her request, and although she called to arrange it and chose the time, she did not arrive for the appointment, nor did she come to two subsequent appointments that she had arranged with me. I attempted to contact her following the last no-show but her phone was disconnected, and I assumed that was the last I would hear from her. A month and a half later, Mary called from her hospital room. She had just had another baby only hours earlier. Because I had no previous contact with her, I did not know that she was pregnant at the time and I found it unusual that she was in touch with me at such an intimate time in her life. I wondered if the previous sense of urgency was triggered by the knowledge that she would be experiencing NAS all over again in the near future.

Although Mary requested that I meet with her that day, I opted to wait until the following day given that she had just given birth. The following day, I met with Mary in her hospital room. She was in an isolation room due to potential exposure to a transmittable infection. I found myself in an unusual situation: I was wearing a hospital gown and gloves conducting an interview in which she disclosed very personal and traumatic details of her life. The interview began like the rest with a question about the day she found out she was pregnant. We spoke very little on the first day about her pregnancy or her newborn, as the initial conversation moved quickly into a discussion of her drug use and her past.

Mary disclosed that she grew up on a reserve with her family and eight siblings. Her parents were still together but her siblings lived in various places. For a period of time in her childhood, she lived with her grandparents and her aunties. She described being fearful all the
time as she never knew what she would do that would “piss them off.” Mary experienced verbal and physical abuse from her family as a young child and described herself as always depressed and lonely. She stated, “It’s just I felt like I was always so alone. I mean, even though I had people around me, I felt alone.”

Very early in our interview, Mary described her sense of loneliness and depression, and asked to tell me about what happened to her. She began a vivid description of an event that changed her life in many ways. She stated that when she was a young teenager, she watched her sister being severely beaten by her partner. She described the violence in great detail and believed that her sister was dead, as she was unconscious and bleeding in the corner of a room while her partner sat on top of her and continued to assault her. Mary tried to stop the violence by screaming for help, intervening herself, and calling police but that only succeed in turning the assaulter on her as well. As she tried to help her sister, Mary ended up killing the perpetrator of the violence. She was only 14. I thought about myself at her age and the different experiences I had in my life. How can such a young child bear witness to something so violent? As a result of this event she was removed from her community and her family home, and was not permitted to talk to anyone as she moved from one detention home to another. Mary described the lack of support she had in her life:

The only person I ever had contact with was my worker and she wasn’t very much help because she never listened and she just kept sending me away just so she wouldn’t have to deal with me or anything. It was really hard. I felt like…I don’t know. I just felt like I was…I don’t know…like I wasn’t even a real person anymore or something…Like I didn’t matter. (Mary)
She describes a profound sense of loneliness and depression, and she believes these feelings contributed to her substance use.

She began using Tylenol 3s on a prescription basis as a result of a physical ailment and describes that she lost control and became addicted. She began taking increasing amounts of the painkiller and didn’t realize until much later that she was actually misusing it. Soon after her misuse of prescription drugs became apparent to her, Mary began purchasing OxyContin and Percocet off the street and stated that the feeling was like no feeling she had ever felt before. For the first time, Mary recalled feeling relaxed and happy. She talked about her feelings of loneliness and how the use of drugs helped changed the way she felt. She described her initial use and how it evolved into addiction:

I think it [the drugs] was, like, the first time that I’ve ever felt…um…I guess, happy. I’ve never, ever felt that happy before…After a while it was like I needed it just to feel normal. Just to be able to live life, I guess. You know, get up and do everyday things.

Because without it I was very sick. (Mary)

However, the elation that Mary felt quickly became a sickness whenever she didn’t taken the drug, and a need so strong that the pill no longer made her happy and was needed simply for survival. Mary described another incident that significantly impacted her. She lived in subsidized housing with her children. One night, she left her children at home with her sister while she went out. The children were left unattended and were apprehended into the care of child welfare. Mary thought she had made the appropriate arrangements for her kids, but when child welfare arrived the kids were alone and the condition of Mary’s home (as a result of her inability to do much due to the “dope sickness”) was unacceptable. Mary described feeling like she failed her children and
missed them terribly while they were in care. She became more depressed without her children and turned to alcohol to cope.

When Mary became pregnant again, she turned to the methadone program in order to avoid the sickness from her addiction to Oxys. Although the methadone program offered her hope for the first time, she described the treatment as a double-edged sword in that she was happy to be on it but the daily regimen of receiving her dose caused considerable stress.

Mary and I did not speak much about her pregnancy and her baby until the second interview. It was clear that there were things about her past that she felt she needed to state and that those events had a major impact on her. When we did speak of her children, Mary described feeling connected to her baby as soon as she found out she was pregnant. Although she longed to meet her baby for the first time, she expressed a tremendous sense of guilt for her substance use and methadone treatment, and worried daily about her daughter’s well-being. She feared child welfare and was concerned that her newborn would be apprehended at birth. She did not have support at the time and was in an abusive relationship.

When Mary’s daughter was born, she recalled feeling happy but very worried at the same time. She knew immediately that her daughter started withdrawing and she worried about her well-being. She expressed a tremendous sense of guilt when she saw her daughter withdraw for the first time:

Just knowing that she was withdrawing because I…you know…I was a drug addict and I couldn’t stop using when I was carrying her and just seeing her. Like, actually seeing her go through that sickness and that pain. I felt awful. I felt like I didn’t even deserve to be her mother. (Mary)
Mary stayed with her daughter as much as possible while she was in the hospital but struggled with her guilt for “causing” her daughter’s suffering. She said she never really overcame the guilt she felt, but she forgave herself a little because she knew she could have been doing a lot worse:

I still do feel bad. But I guess I just…I guess I sort of forgive myself a little bit, just not entirely. I don’t know how to explain that…Well, I just thought about…you know, I could have just kept using and everything. I could have been using a lot more. There were so many bad things. Like, I could have done things that were a lot worse and at least I tried, even though it wasn’t very much, I tried to find help. I tried. (Mary)

This statement speaks to the strength she had. Mary had so many challenges in her life, combined with a lifetime of depression and loneliness, as well as no support from anyone around her, and yet she was able to rise above the challenge and be there for her newborn. Mary’s life and her strength through adversity were memorable throughout the interviews.

Although she experienced judgement from the nursing staff, Mary expressed feeling relief when her daughter was finally treated with morphine and was cared for by the nurses that Mary perceived had been negative toward her. It is evident that she was able to put her own feelings of hurt aside in order to ensure that her daughter received the best care possible. I wondered how difficult this must have been for her as she sat quietly in the chair next to the isolette while she felt judged.

While we sat in the isolation room with a newborn baby in the isolette beside the two of us, I found it interesting that Mary appeared to be on autopilot. I watched her new baby withdraw next to us and her mother, with a stoic face and a timid and quiet voice, told her tragic story to a stranger while tending to her baby’s every need like a professional who had done this a thousand
times. She knew this newborn would not be going home with her. We spoke very little of that, but it was a shared knowledge between the two of us. Despite this knowledge, Mary was the mom she wanted to be in that moment, tending to her newborn and showing her love. I left her room with a sinking feeling. Just when you think life is tough, you meet someone like Mary and you become grateful.
CHAPTER 5: FINDINGS – A THEMATIC ANALYSIS OF THE EXPERIENCES OF MOTHERS OF INFANTS WITH NEONATAL ABSTINENCE SYNDROME

In this chapter, participants’ thematic reflections will be explored. Given the semi-structured nature of the qualitative design, the inductive process uncovered issues that were salient to participants rather than ones that fit a pre-determined set of criteria. Women’s heartfelt accounts of their lives were analyzed thematically and the corresponding findings are descriptions of the issues relevant to multiple participants. They reveal the underlying essence of the participants as observed through the data. The findings explore early issues such as trauma, abandonment and loss, drug use, pregnancy, birth, resilience, and motherhood. These findings serve to create an alternate discourse of the experiences of mothers of infants with NAS.

Pre-Motherhood: Background Context

Participants in the research disclosed personal accounts of their lives from their early years through to their experiences following the birth of their baby. Unfortunate experiences with trauma, abandonment and loss, depression and drug use were forces present in women’s lives beginning in the early years and progressing into adulthood. Although the early experiences occurred prior to having a newborn with NAS, all of the women felt it was important to provide some context to their backgrounds. They revealed these backgrounds as frames for their experiences with having a newborn withdrawing from opiates. It was clear through conversations that the participants’ early experiences prior to having children were critical moments that could not be isolated from their current experience of being a mother of an affected infant. In their words, the early experiences influenced their current experiences and could not be removed from the discourse of their lives relative to NAS.
**Trauma, abandonment and loss.** The lives of the women in this study were marked by a history of trauma, abandonment and loss that resulted in significant impact on their well-being and involvement with substance use. The women disclosed heartfelt stories of experiences both as children and as adults. Issues that were discussed included verbal, emotional, physical, and sexual abuse; separation from their families, particularly their mothers; the death of close relatives as a result of drug use; loss of trusted relationships; and multiple pregnancy losses through miscarriages and therapeutic abortions. Throughout the interviews, it was evident that these issues were very painful for participants, but that they also marked an important point in their journey. Their initiation of substance use represented a means of coping with the pain. Unbeknownst to the women at the time, beginning to use substances influenced their life well into the time period when their children were born with NAS.

When I interviewed Mary for the first time, she asked if she could begin her story by telling me about something that had happened to her as a child that had a great impact on her life in terms of loss of family, community, friendships and her youth. Mary felt that she could not talk about her experience with her infant until she could express her experience as a child, as it framed her current experiences. Therefore, Mary’s interview began with an account of an early experience of significance for her. In a very timid voice, Mary described the event:

When I was a teenager, I actually ended up killing a guy through self-defence. A man. He was a really abusive man. He used to beat up my sister all the time and I had been living with them. It was just this one time…well, the last time…it was like he was going to kill her and yeah, I had to stop him….I tried pretty much everything. I tried calling the cops. I tried doing this and that and the guys that were in there wouldn’t help me. He was so bad. Like nothing could stop him…I thought he was going to kill her, so I ended up stabbing
him. They sent me away and they kept putting me in these detention type of homes…I had nobody to turn to. I had nobody to talk to…It was really hard. I felt like…I don’t know…like I wasn’t even a real person anymore or something. (Mary)

We spoke at length about this event in Mary’s life, which I am certain she would change if she could. However, this traumatic event signifies the types of hardships that she faced at a young age. She wasn’t living in her family’s home, and she was surrounded with abuse and fear. Mary links the trauma that she faced with a profound sense of loneliness that she associates with her use of drugs and alcohol (It should be noted that child welfare was involved with Mary and her baby and they had just been to see her in the hospital moments before the interview. With this known, a report to child welfare regarding active substance use was not necessary).

Mary was not the only participant who was separated from her family at an early age. Seven of the eight participants in the research indicated that they were separated in one way or another from their mothers. Although they never labelled it as such, there was a sense of abandonment in their stories that contributed to feelings of responsibility for parenting themselves and their siblings. The women spoke of either being separated from their mothers by being placed in foster care, living with their fathers due to their mothers’ unstable lifestyles, or by losing their mothers at a young age through death. Regardless of the way in which the separation occurred, it was apparent through tearful accounts of their stories that the loss of their mothers had a dramatic impact on their upbringing and sense of loneliness. Shelley was removed from her mother’s home by her father when she was very young (before the age of seven). She described the sense of loss that she felt throughout her childhood because she did not have her mother around her:
I met her [mom] when I was younger, like twice and for a couple days each time. And she called maybe once every couple years and that really messed with my head. You know? That was like “why don’t you come and get me? Why don’t you come and move up here? I miss you. I need a mom”…’cause everybody had a mom, you know.

Everybody had a mom. Except for me. And it just sucked. (Shelley)

Shelley’s mother died when she was 19 years old, and she expressed a sense of loss at not having the opportunity to know her. Growing up without a mother framed Shelley’s experiences in life in that she became independent early on and always felt alone with no one to turn to. In a sense, she had to learn to fend for herself because she did not have her mother’s guidance or support.

Like Shelley, Beth recounted a similar story of pain through the loss of her own mother at a young age. When talking about her mother, Beth became emotional as she recounted that particular time in her life:

My mom died when I was nine years old…I think it was alcohol and sleeping pills I’m pretty sure. I’ve blocked everything out. I only have certain images of my mom. And the last one I can remember is her laying in bed for three days and then my aunt coming over saying “You better call 911.” (Beth)

Beth spoke of how this loss impacted her life and how she really wished she had a mother around to help her through some difficult times. She expressed that her mother had missed out on a lot of things, and she subsequently became the caregiver to her sibling. This sense of loss was profound for Beth as it changed life as she knew it.

Many of the participants in the research grew up without their mother in their home. It is remarkable that this pattern appeared to be consistent in the lives of those who participated in the research. Yolanda was also separated from her mother at a critical time in her development. She
spoke openly about having two lives—her life with her dad was more stable, whereas her mother’s home was less stable and consisted of constant partying and alcohol and drug use. When Yolanda moved from her father’s home to live with her mother, she was not accustomed to her mother’s lifestyle and recalled being fearful of the substance use, partying and many strangers in her home. As a result of this fear, Yolanda contacted child welfare and was subsequently taken into care where she remained from the age of 11-18. She recalls living in several different foster homes and feeling like she did not fit anywhere. Yolanda described her time in care:

I went into foster care, I didn’t like foster care. I wanted to go back to my mom’s. And so that’s what I ended up doing. I just took off and I would always go back to my mom. And then that’s how I got involved with drugs and drinking, through my mom’s friends’ kids.

(Yolanda)

Yolanda further described how her experience in foster care and separation from her family impacted her emotionally:

I felt like nobody wanted me. Like, my mom wouldn’t quit drinking and then I had options to go with my dad’s family but by then they thought I was, I don’t know, bad, I guess…So like, that’s where I didn’t fit in. I didn’t feel like nobody wanted me.

(Yolanda)

Although Yolanda did not call this abandonment, it was evident through the dialogue that there was a clear disconnect from her mother who was unable to care for her and her father who did not reach out to her to take her into his home. This left her with a sense of isolation throughout her teenage years.
Like Yolanda, Chris was separated from both her mother and father through placement in the child welfare system. She expressed a difficult start to her life between the ages of one and four when she was sexually abused by a couple while she was in care. Despite her young age at the time of the abuse, Chris recalls every detail, and it was clear that discussing the abuse brought her back to a dark time. Chris told her story while staring fixidly at the floor, and later told me that she did so because it put her right back to the place of all her memories—it seemed as if she could see everything happening in the present. I was concerned for Chris throughout the interview because from a drug use perspective, she appeared to be the least stable of the participants in her recovery. We spoke of the interview as a possible trigger, but Chris wanted to continue. She did not have memories of her parents or of the reasons that she went into care. When Chris was four years old, she moved from foster care to her grandmother’s home. She described the impact of her trauma during the first bath she had in her grandmother’s home:

I remember my first bath there. Granny told me to tell dad [grandmother’s boyfriend] — I call him dad — to come and get me when I’m done. I wasn’t calling him. I was too scared. I was thinking, “Why would I do that? Why would I call him?” You know? So I sat in that tub and I was cold and I remember having wrinkly hands and shivering and I was crying and then he came in and I just started screaming and screaming and he held out the towel and says “Come here.” He said “No one’s going to hurt you anymore.” (Chris)

The experience of sexual abuse as a child had a significant impact on Chris and she expressed a lot of deep emotional pain resulting from her start to life. Like Chris, Emily experienced sexual abuse as a child and it had a major impact on her life. She expressed the emotional scars of that abuse in her life:
Like, my stepdad sexually abused me since I was six years old, up until my fourteenth birthday. That’s when I got hard into drugs.” (Emily)

Shelley also described a history and pattern of abusive relationships and expressed not feeling loved by her partner. She described her relationship as a constant struggle. However, in addition to the trauma she experienced through abusive adult relationships, an event that occurred when Shelley was eight had a profound impact on her emotionally. She described an incident of child sexual abuse that triggered a lifestyle that included drugs and alcohol at a young age:

Well, I was eight. I guess that’s when I started doing drugs and stuff….This guy, he came to work up on the reserve for my dad…When I went to sleep one night and he was babysitting, I begged my dad. I’m like, “Daddy, please don’t leave me with him. I don’t trust him. Please don’t leave.” And me and my sister were there and we had bunk beds and I don’t know how we ended up in his room. Like, he must have carried me, but I was sleeping and I woke up and he was like, behind me and he was like bothering me and I freaked out…Like, he was having sex with me…I guess he only penetrated me once. That’s why I screamed. (Shelley)

For other women in the study, the experience of abuse did not occur in childhood but began as they developed relationships with men in their lives. It appears that the abuse occurred for most women in relationships that ultimately contributed to feelings of depression and isolation. Carol expressed a tremendous guilt for the abuse that she inflicted on her grandparents when she lived in their home. Subsequent to those early years, Carol described a pattern of abuse in her adult relationships. She spoke of her experience of abuse throughout her life with both the
father of her children and other partners, and how she felt that tied into her own history of violence toward her grandparents:

He was emotionally, physically, verbally abusive, everything…Like, every relationship was abusive…’cause not only in this relationship – every relationship I’ve got into was abuse and I think I stayed in the abuse because I feel I deserved it because of what I did to my grandparents. (Carol)

Emily revealed a pattern of abuse from partners and friends of her partner. Emily’s interview was very emotional and she spoke in her interviews about the traumatic experiences she had with men throughout her life. In fact, when I arrived to Emily’s apartment complex, she reported an encounter with her partner who choked and threatened her that day. From the outset of Emily’s interview, she described the pattern of abuse in her opening sentence she stated: “I got molested. That’s how I got pregnant…I ended up getting tied to a bed with duct tape.” (Emily)

Following this sexual assault, Emily became involved with a man who she reported continuously abused her verbally, emotionally, physically and sexually, and was immensely controlling of her:

[Name of partner] ended up throwing me through the window. He used to do needles and he used to do it right in front of my baby….Then when I came home one time…there were three guys in my house and [partner] tied me up with a phone cord and then let the guys do what they want to me. (Emily)

Emily told further accounts of how her partner controlled her by making her use drugs with him and not allowing her to seek treatment. It was clear through her emotional account of her story that these events had severely impacted her sense of self and made her view the world with fear and skepticism.
Unlike most of the women, Madison had not been in an abusive relationship as an adult and described having had a positive childhood. However, like the other participants, she expressed multiple losses in her life which she suggested contributed to her initial use of substances. She recalled being in a trusted relationship with her partner for several years when she discovered that he was in a relationship with another woman. She was devastated by the betrayal and sense of loss, and stated that she turned to drugs as a means of coping. Madison described her grief:

I was really heartbroken when I found out he was with someone else and I was still grieving… I was chatting with him online or whatever and he keeps writing to me, wanting to know about [child], right? That’s how he kept in contact with me, asking about [child]. Over and over again I would feel that griefness for him. (Madison)

It was clear from the interviews that experiences with trauma, loss and abandonment, as well as severed relationships, had a profound impact on the women who participated in this study. Many women expressed the connection of their experiences of trauma and their use of substances as a means of concealing deep emotional pain. Although most of these accounts occurred prior to having a newborn with NAS, women expressed a strong need to tell these aspects of their life story in an effort to better understand their full experience leading to having a newborn with NAS, and how their current situation is a product of their background and interpersonal relationships.

**The Cyclical Nature of Depression**

The experience of depression permeated all of the interviews with participants. (In all instances throughout the dissertation, the term depression is self-defined by the women
themselves and does not reflect the formal DSM diagnosis). The issue of extreme sadness, self-loathing and loneliness intersected with all other topics of discussion during the interviews, including experiences with family, drug use, treatment, pregnancy and when the baby was born. Although it is unclear if participants were diagnosed and treated with clinical depression, depression was a self-applied term the women used to identify their experiences and how they felt at different times in their lives. As such, to represent the terminology that women used to define their experience, the term depression is used to capture women’s experiences related to sadness, self-loathing and generalized depressive feelings. Although it seems that for most, these feelings began in their early childhood and were connected to both their experiences in their own families and early trauma, the feeling of depression appeared to become more pervasive when women began using substances. With this in mind, it is difficult to discern whether depression contributed to substance use or whether substance use contributed to depression. For the participants, it appears that depression or sadness existed in a cycle in which using substances initially helped the women feel less alone, less depressed and more energetic, but once they became addicted the women reported feeling increasingly depressed and apathetic toward life.

Mary described how early experiences with abuse and trauma contributed to both loneliness and feelings of depression. Mary’s demeanour throughout the interviews was sombre. She spoke softly and slowly as she described her life and what she feels contributed to making her the person she is today. Mary outlined her perception of self throughout her life, beginning with the abuse she suffered from her relatives when she was a young girl:

It [abuse] was mostly, like, verbal, but there was times when there was physical…And so, I felt I’ve pretty much been depressed my whole life, I think…It was really hard. I felt
like….I don’t know. I just felt like I was…I don’t know…like I wasn’t even a real person anymore or something. (Mary)

Mary continued by disclosing that she attributes feelings of depression as the root cause of her decision to begin consuming alcohol. She stated that she drank to numb the pain she experienced from feeling lonely and depressed and described how the cycle of depression and substance use continued throughout her life. These feelings were shared by many of the women in this research. Many women reported that their depressed mood precipitated their use of substances.

Carol also lends support to the cyclical nature of depression and substance use. She disclosed feelings of depression throughout her life, connected to the pain she experienced in childhood, and the abuse she suffered in her teenage and adult years. This pain was difficult for Carol to cope with, and she attempted suicide on a number of occasions to break free of her internal pain. Carol discussed the power of OxyContin for someone suffering with depression, and how the cycle continued throughout her life:

I suffer from chronic depression, so when I would snort that Oxy, it’d give me the energy. It made me happy. It made me feel good. It gave me that boost that I needed, otherwise I just laid around. I didn’t do nothing, you know what I mean? And I was using that. And I said to the psychiatrist, I told people, at that time, that’s what they should prescribe people who have depression, because that’s a wonder…that’s a happy pill, you know? So I was using it just to get along with life, right... Like…I was using these pills just to cope with depression… I was sick of…like, I was mad at myself for what I’d become. Because I said I’d never become that person. (Carol)

Although many of the women spoke of feeling depressed, as noted by Carol in the above statement, the depression that she spoke of appeared to be combined with self-directed anger.
This anger embedded within the feeling of depression was not unique to Carol. Many women spoke of depression as an all encompassing term to define a general low mood and self-loathing related to their use of substances.

Chris also spoke of the cycle of depressive feelings in her life and its connection to her substance-use. She stated that she became addicted to substances to numb the pain of losing her children, but drug use only served to mitigate depressive symptoms for a short while and soon after initiation it perpetuated further emotional pain:

My biggest challenge was to try not to feel as much pain as I did. And in order not to feel the pain, I always had to have drugs or alcohol. That was the biggest problem was feeling pain. Emotional pain…I remember it being dark and it was winter and I was walking in the back alleys, just praying somebody would out and beat me up or something or just finish my pain. (Chris)

The pain led Chris down a path of progressive substance use. She recalls how she felt when she used drugs and alcohol to numb the pain she felt from depression:

I was depressed. I was contemplating suicide. I lost my house. I lost my kids. I lost my old man. Well, the kids’ dad. My daughter’s dad. I lost my self-respect. I lost everything. I lost hope. (Chris)

It appears that in the search for a cure for emotional pain, the feeling of instant gratification from increased energy, happiness and numbing quickly faded to an even deeper experience of depression or sadness for all of the women. While all participants recalled becoming highly addicted to substances at some point in their life, all of the women did not want to become an addict. Instead, substances were used as a means of mitigating feelings of sadness or escaping
the harsh realities of their lives. Unfortunately for all of them, addiction led to new challenges that were equally difficult to manage emotionally.

Shelley also expressed reflections on her lifestyle while she attempted to get clean from street drugs. Similar to Madison, she could not understand how she had let herself get so far. For Shelley, the deep emotional pain began in early childhood, continued through adolescence, and substance use made her feel more energetic and carefree until addiction set in. At that point, her depression became even more profound as she struggled with the direction her life had taken and the hard work she had ahead of her as she maintained methadone treatment. However, as Shelley described her struggles with emotional pain and depression, her commitment to her baby served as a strong motivator for her to forge ahead to get well:

You know, trying to stay clean while I was pregnant was really hard, you know. Considering how depressed I was. You know, I just felt horrible. I wanted to die half the time, you know. Like, I was suicidal while I was pregnant but I kept alive for the baby, you know. I kept saying, “I want to die but the baby doesn’t deserve to die. I got him this far, I’ve got to get him out and save him.” (Shelley)

**Self-directed anger.** Embedded in the dialogue regarding depression, many of the participants appeared to link the feeling of depression with a sense of self-loathing due to their addiction to illicit substances. Yolanda identified herself as having experienced depression and sadness during the time when she was using drugs. The emotional impact of drug use appeared to revolve for Yolanda and others around a reflection on how they had gotten to a point in their lives that was marked by multiple losses and a lifestyle they had not chosen. Like some of the other participants, Yolanda linked her feelings of anger toward herself with the experience of
depression. Yolanda discussed how she internalized the changes in her life that resulted from her drug use:

I was pretty mad at myself. Like, thinking I never planned it this way. Like, what the hell. Like, I never thought I would be a needle junkie and never thought I would be homeless. I was just more mad at myself, like, for falling into that way of life. I was pretty mad about it. And, by then I was only doing it so I can function, you know what I mean? (Yolanda)

Like Yolanda, Madison disclosed feeling emotional pain while she was using drugs and contemplating how she had come to a point in her life where addiction had a strong hold on her. As she sought methadone treatment, Madison reflected on her feelings:

I was very angry at home and frustrated with myself. I was crying a lot. Feeling sorry for myself when I didn’t get it [drugs] and also feeling sorry for myself ’cause I was trying to…even though I was trying to better myself when I went on methadone, I felt sorry for myself. ’Cause I allowed myself to get so far, I guess. Like, owing that much money.

How did I end up getting like this? (Madison)

The perception of depression combined with self-directed anger, touched every participant at some point in their lives. The experience of emotional pain coinciding with either a history or current experience of trauma, abandonment, loss or abuse seemed to influence the experience of depression for all participants in the research. It appears that depression was cyclical for the women in that their self-medication for depression through substance use was a temporary cure that quickly perpetuated further feelings of depression. Despite disclosures of a profound sense of sadness and emotional pain, each of the women continued trying to work
toward a more balanced life that’s free from drugs. For many of them, this ability to forge ahead through the constant struggle was attributed to the need to be in a better place for their baby.

**Drug Use**

**Exposure and initiation.** The issue of drug use was a pervasive theme throughout all of the interviews with participants. While it was clear that this issue would invariably present itself, it struck me that for many of the women, there was a salient need to discuss substance-related issues and how their use of drugs had a negative impact on their lives.

For all of the women, exposure to substances began in early childhood, despite the fact that for many of them, addiction did not occur until later in their life. However, many of the women discussed the “normalcy” of alcohol and drug use in their family of origin. This early exposure made experimenting with drugs and alcohol somewhat insignificant for them. Beth spoke of her early exposure to alcohol following her mother’s death when her father became an alcoholic:

> He [father] would go on binges off and on for like; three months and then he would sober up and go back to work…He would go on these binges for months. Wouldn’t shower. Wouldn’t shave. He’d watch the same movie over and over. Bang on the floor for me to come and rewind it. (Beth)

Beth spoke of how she took on the parenting role with respect to her father and had no one to parent her. She had many responsibilities, and as a consequence she and a relative began experimenting with marijuana at an early age.

The majority of the women reported experimenting with substances in their pre-teen years, with the earliest reported use of substances by Shelley following a sexual assault when she
was only eight years old. Shelley explains how she began the use of substances and how she interpreted her use at the time:

We started sniffing when I was eight or nine years old. We got into nail polish, that spray stuff – like, air freshener – sniffing that. I never sniffed gas…And then after that I was about maybe 11, 12, I started drinking heavily. I’d go to a party and everyone’s like “Hey!” Even though I’m 12, they don’t care. Like, 25 year olds giving me shots of rye. So, that’s just how I grew up. I thought it was normal. (Shelley)

Similar to Shelley, Emily began using drugs following a traumatic series of events in her life. She spoke openly about a history of sexual abuse from her step-father, and acknowledges the initiation of substance use at that difficult time in her life, saying, “Like, my stepdad sexually abused me since I was 6 years old, up until my 14th birthday. That’s when I got hard into drugs.” (Emily)

The initiation of substance use did not result in addiction at a young age. However, the participants spoke of the connection between their early experiences with drugs and alcohol and the decreased novelty of substances at a later stage in their life. Many of the women reported heavy drinking and/or drug use by at least one of their parents. The single woman interviewed who did not identify coming from a family with alcohol or drugs addiction issues noted substance use issues in her community and stated, “I’ve always had some kind of drug in my life. Always. Whether it was just marijuana or just the booze.”

For Yolanda, her initial use of substances began when she was a pre-teen. She recalled that her mother often drank and “partied” in her home, leaving Yolanda so scared that she contacted child welfare for help. Consequently she was taken from her mother’s home and
placed in foster care at age 13. Yolanda describes her easy access to drugs and alcohol, and her subsequent initiation of substance use:

I didn’t like foster care. I wanted to go back to my mom’s…And then that’s how I got involved with the drugs and the drinking, through my mom’s friends’ kids. You know, my mom’s best friend, like, me and her daughter were best friends and, you know, they were drinking and we would steal booze and…you know? Then there were people doing drugs and then we would steal the drugs and you know, just experiment with it. I feel I was trying to fit in, you know what I mean? Like, my mom was OK with it. (Yolanda)

Despite early exposure and experimenting with drugs and alcohol, participants did not identify themselves as addicted to substances at a young age. Addictions began later in their lives. For some women, drug use resulting in addiction began with a prescription for narcotics to deal with pain. For others, addiction began while trying to fit in with a social group, and for some, drugs were used to numb deep emotional pain in their lives. Regardless of the initial reasons for drug use, the commonality among participants is that women did not choose to become addicted to drugs. For most, the addiction set in without conscious realization. Mary outlines how her addiction began and how things veered out of her control very slowly:

It actually just came on so slowly. Like, I didn’t even notice it until I actually really thought about it. The first time I started using, it was actually just…I was prescribed Tylenol #3s [for medical reason] and I didn’t realize it at the time but I had started abusing it….I didn’t notice it at the time, but I was starting to use more amounts, like more than I was prescribed to, and I didn’t know what was going on…I didn’t know I was abusing it. I don’t know how many years it was like that for. It wasn’t until later, when I wanted to get high I finally noticed what was going on there. (Mary)
Unlike Mary’s slow process toward addiction, Chris’s addiction began quickly following the loss of her kids to the child welfare system. Chris describes emotional pain that she could only numb through the use of drugs and alcohol:

I had my sister and her boyfriend staying with me and my partner…I knew they were shooting up in my basement and I had my kids and I told them “You can’t be doing that.” I said, “I got kids here.” I kicked them out eventually and I was separated with…I have two daughters with their father and I had him come over to watch the kids while I went out and he found a strap in the basement and he automatically assumed that I was doing it, so he called [child protective services] and got my kids apprehended because of the drug use…I wasn’t using at the time. And then finally I lost my kids and that was it. I went downhill from there and that’s when I started to use. It was numbing the pain of not having my kids with me. (Chris)

The need to numb the pain was consistent for many of the women, whether it was physical pain or emotional turmoil. Carol’s addiction to drugs began following her use of Percocet for physical pain that was a result of physical abuse from her partner. She experienced abuse within her relationship for many years resulting in significant injuries that required hospitalization. Carol suffered from severe chronic headaches and jaw pain when her partner assaulted her and broke her jaw. While she waited for a specialist appointment with a physician, a friend introduced her to Percocet, and upon her initial use of the drug she noticed relief for the first time:

That’s when the control started. And that’s when I started getting headaches and jaw pain. So, then that’s when I started…my friend showed me the Percocet and that’s how the pills started. I tried that, and it helped me right? Helped my headaches. ’Cause it was
severe pain I was getting. But meanwhile here I was buying Percocets, now, because they helped the pain and they made me feel better. Right? I started getting energy! And then I started buying them more… (Carol)

The feelings associated with drug use. Regardless of the timing or type of substance that participants began using, the feelings associated with the drug use were profound and extremely difficult for the women to disengage from. Participants spoke of lives full of loneliness, trauma, abandonment, isolation, and sadness or depression. However, when the issue of substance use presented itself in the conversation, participants consistently spoke positively about the feelings that came over them when they began to use. Those who were lonely felt that they finally fit in with a social group, those who were sad reported feeling good for the first time, and those who were struggling with trauma and abuse felt more relaxed and happier. Perhaps the most consistent emotion reported by participants was the sense that they had more energy than they had ever had before, and because of that energy, they were able to function in what they called a “normal” life. Yolanda struggled with loneliness and isolation, and spoke about how she felt when she began using substances with a group of other substance users in her community:

They [the drugs] made me feel good. Yeah. Really good. Physically, emotionally, everything. It made me feel good. Like, I had energy and I didn’t think about how sad I was. I didn’t care. I just felt OK. (Yolanda)

Carol’s addiction to Percocet came on very subconsciously for her. However, she recalls the feelings that the substance use gave her and how it contributed to her becoming an addict:

Now I’m doing it [Percocet] because they made me feel better. Like, I had more energy. I was cleaning the house. Then I realized if I didn’t have them I was tired. So, now I’m
taking them just to have the energy. Now I realize I’m an addict. I’m hooked at that time.

(Carl)

Mary’s struggle with addiction was linked to the feelings that came from her use of OxyContin. Mary had experienced a significant trauma in her life that very much defined her early years and had a profound impact on the person she is today. Because of the trauma, she experienced a deep and intense sense of loneliness that is difficult to capture in words. This loneliness led to depression, and Mary described how the use of OxyContin helped her with the overwhelming negative feelings she had at that time:

It’s just I felt like I was always so alone. I mean, even though I had people around me, I felt alone…[using drugs] I think it was, like, the first time that I’ve ever felt…um…I guess, happy. I’ve never, ever felt that happy before…I think I just felt relaxed. (Mary)

Chris identified feeling depressed when she lost her children to the system and how she began using opiates to numb the pain. Her feelings when she began using drugs were similar to those of Mary following a traumatic event, saying, “It made me feel really good. It made me feel powerful, like nothing could hurt me. It made me feel like I was on top of the world” (Chris).

While the effects of drug use resulted in positive feelings, it was interesting that each participant in the research self-identified that the use of substances was in some way linked to the pain they experienced in their life. Beth was the only participant who did not directly express a link between drug use and previous abandonment and loss issues. However, she spoke openly about the hardships in her past and I wondered if this link could be made for her as well. Nevertheless, the positive feelings, both emotionally and physically, that resulted from substance use were difficult for participants to walk away from.
**The hold of the drug.** Although the initial use of drugs and alcohol did not start with addiction, all of the participants in the research became addicted to substances. Although unplanned, the drug use became paramount in their lives. They spoke of thinking about drugs constantly, feeling a need for them just to get out of bed in the morning, and using increasing amounts just to feel “normal”. Yolanda described how her substance use spiralled out of control:

First it was drinking, then I started marijuana, and then it was, like, acid and mushrooms. I remember one time, like for a phase, it was Gravol. Like me and my friends would pop Gravol all the time. And then it was Percs for a couple years and then once I got older it was Oxyx and morphine and then it was, like snorting it and popping them. And then it turned into banging. [injecting drugs] Banging drugs. And cocaine. Cocaine too. There was cocaine in the banging too. (Yolanda)

This sense of using one drug to replace another and using one method of administration to progressively move toward a route of administration that produced a faster uptake was common among the women. It seemed that a tolerance for one substance led to the need for multiple other substances as time progressed. Yolanda further described her experience with the increasing role of substances in her life:

It was like, four or five different times a day. And it wasn’t all pills. It’d be coke. It would be Ritalin, morphine, Oxyx. It was always something. And I just didn’t believe how fast I got addicted to it…It’d be the first thing I thought of when I’d wake up and it’d be the last thing I thought of before I go to bed. And in between… (Yolanda)

Carol was overwhelmed by the feeling of addiction to substances and the need to constantly have some type of drug. Like Yolanda, Carol was consumed by the need to find and use drugs in an effort just to feel normal in her day to day life. Carol spoke of the hold of the
drug: “It was awful! I woke up thinking about pills. I went to bed thinking about pills. Constantly. It took over my whole life.” Similarly, Beth described the hold of the addiction:

I had a constant need to find it. It became a routine. I’d do one in the morning, do one at lunch and then at bedtime…I guess when I was addicted to it I didn’t think it was a problem. I didn’t think it was…I don’t know…such a bad thing. But then I’d say to myself “Oh it’ll just be two weeks trying to get off.” But those two weeks…you know, I don’t know. It’s really bad, the withdrawal. You can’t sleep. You’re fidgety. You toss and turn. You have hot and cold sweats. (Beth)

The participants spoke of the drugs’ hold over their lives, and the multiple attempts to try to stop using. Women in the study described how the use of substances changed their way of life, led to inner struggles with their lifestyle and how they felt they had become an entirely different person. They reported that drugs led to addiction and the addiction prompted numerous consequences. The consequences of the addiction included adopting a position of constant lying to protect themselves, abusive and unsupportive relationships, stealing, prostitution, pawning their possessions, panhandling and hurting others. All of these things led to multiple losses in their lives, which created a “vicious cycle” of desiring more frequent and varied drug use to conceal the pain of loss. Chris expressed the impact of her addiction: “You lose everything. You lose your self-respect. You lose your family, your kids, your home, your husband. You’ll be filthy dirty. You won’t have a place to live or eat. You’re going to lose everything.”

Shelley also spoke of the multiple losses she experienced when her lifestyle changed because of the seriousness of her drug use. Consequently, Shelley began escorting to support her habit and described her struggles:
I guess just because I never had money. So, the minute somebody said I could make $50 an hour I was like, “What??” It was a goldmine you know? But with the money comes the drugs. With the drugs comes the hell. With the hell comes the cops. It’s a trail.

(Shelley)

However, despite the disgust women expressed with their lifestyle, the drugs’ hold made stopping their substance use seem impossible. All of the participants expressed repeated attempts at a sober life that were not successful. Chris expressed her fears regarding her drug use when she learned she was pregnant: “I felt afraid because I knew there’s no way I’m going to stop the drugs. I was too far into it.”

Emily also shared her experience of attempting to stop using drugs and being unable to do so:

I tried to get into treatment four times and then I tried to do it on my own. I locked myself in my room I think for three weeks. I couldn’t do it either….I’d get really sore. If I’d go through any withdrawal, I’d just go do it. (Emily)

All of the participants made multiple attempts to stop using drugs and alcohol because of the negative impact substance use had on their lives, their finances, and their ability to have a “normal” life. However, participants said they were unable to stop their use because of the sickness they felt from withdrawal symptoms. They continued to try to work through the pain of withdrawal, but in the end the drugs won the battle and participants knew they could end their pain by taking just one pill. Carol described the struggle:

That pill made you feel better. When you didn’t have it, you’re sick. And your brain’s only focussed on that. Like, you know when you love something and you’d do anything for it? Well, my love was for that fricking Oxy. And I hated it but I needed to take it so I
felt better and just to go on. Because if I didn’t have it I was sick in bed. I was sick and I
didn’t want my daughter to see me sick. And that’s how it is. (Carol)

Yolanda described the withdrawal she felt when she tried to stop using, and how that withdrawal
held her back from stopping her drug use on her own:

Because the first maybe, month or two…it’s good. You know, you’re getting your high
and you’re all good. But then after that you start to get sick and then you’re sick as a dog
and then you get you’re pill and you’re OK. You’re just normal. You’re not high, you’re
just not sick anymore. So, you’re just chasing that high and that’s what I did for like, a
year. I just chased my high. And I hated it. (Yolanda)

**Becoming a Mother: Pregnancy**

Participants’ described their pregnancies as a turning point in their lives. Although this
does not necessarily only relate to sobriety, it also pertains to a time in their lives when they were
forced to focus on another human being. Although none of the participants planned their
pregnancies, for each woman, the pregnancy evoked feelings that made them commit to
maintaining the pregnancy. Because of the nature of the methodology, this inquiry had the
potential to take many different directions. In an effort to create a shared starting point, each
interview began asking about the day women found out they were pregnant. This question
appeared to bring participants back to a time that was filled with a feeling of ambiguity of
emotion. The question also served as an icebreaker that built rapport and assisted participants in
recalling an intimate time in their lives.

As a result of the unplanned nature of their pregnancies, the majority of participants
reported learning of their pregnancy either late in the first trimester or early in the second
trimester. At that time, most women were still actively using substances, with the exception of
two women who had begun a methadone maintenance program. Knowledge of their substance use created a sense of overwhelming emotion for women when they found out that they were pregnant. While it is presumed that many new families are overwhelmed by the life change of becoming parents, the women in this research not only possessed the common feelings associated with pregnancy, but also the ever-present knowledge of their substance use and its potential impacts on their pregnancy. Yolanda was using IV drugs on the day she went to see a physician for an unrelated problem. She described her experience when she was told of her pregnancy:

I got up and did my needle. Like, I had my shower and got high, then I was OK to go about my day. And then when he told me I was pregnant, that was just the worst day…I wasn’t happy, I just bursted out crying because I was such in a bad place. (Yolanda)

The sense of worry and fear that Yolanda experienced was not unique. Although most of the women reported feeling happy and excited to be having a baby, these emotions were challenged with fear for the baby and knowledge that their drug use was beyond their control. Mary found out she was pregnant in the emergency room when she saw a physician for what she later found out was morning sickness. Her initial reaction was one of happiness but this was quickly overshadowed with fear and worry when she reflected on her lifestyle and her drug use:

“Yeah. I was both happy and kind of worried and scared because of this situation I was in, being a drug addict.” (Mary)

Chris also expressed her fears when she found out she was pregnant. She described that at the time she felt very isolated with little to no supports and was with a partner who was not there for her. Chris recalled feeling like she needed to talk to someone, but thought her family would not understand. Although she had a positive relationship in childhood with her grandmother, she did not turn to her to support her during her pregnancy as she felt her grandmother would not
want her to keep the baby. Chris’ decision to avoid her grandmother may indicate that she was developing a connection with her baby almost immediately. Chris described the day she learned of her pregnancy: “I was drunk and using drugs and I told the father that I was pregnant and he wanted me to abort him. That was the day I found out…It was scary. I didn’t have anybody there for me.”

Chris found out she was pregnant late into the pregnancy when she was over four months along. She was conscious that her use of substances had likely already caused harm to her baby and she feared for her infant’s well-being.

Despite these feelings of fear and anxiety, participants spoke of the connection they felt almost immediately with the baby they were carrying. This connection surprised them, and it acted as a strong motivator to mobilize support and find help for their addictions. For those who had already sought out methadone treatment, they felt a renewed commitment to maintain their treatment to help their baby have a better outcome. It is apparent that the moment when many of the participants discovered they were pregnant was a moment of opportunity for change.

Yolanda spoke at length about the day she found out she was pregnant. It progressed from a normal day that began with an injection of drugs, to finding out she was pregnant, securing resources for her addiction and prenatal care, and moving forward. When describing the changes she made on the day she found out she was pregnant, Yolanda expressed her thoughts for the future:

Just the fact that I was having a baby. I didn’t want to be a drug addict anymore. I wanted to clean up and be ready for my baby when the baby came. I wanted to be stable. Like, I wanted to have a home…I knew what kind of mother I didn’t want to be. I know what
kind of mother I wanted to be. I knew everything. I knew what I wanted and that’s the way it’s been ever since. (Yolanda)

Like Yolanda, Mary also spoke of an immediate connection to her baby once she found out she was pregnant. She explains the connection that she feels motivated her toward methadone treatment for her addictions:

I don’t know how to explain it. It was just, I guess, realizing that I’m going to be having her and that she’s going to be there and that she was already there. Just feeling her live inside me…I was collecting all the stuff for the baby. I was even…I quilted a blanket for her as well. I just really enjoyed it. (Mary)

Only two of the women in the study indicated they didn’t feel a strong connection to the baby when they found out they were pregnant. They acknowledged feeling aware of their pregnancies, but the connection for them didn’t begin until after the baby was born. Interestingly, the two participants who did not feel an immediate connection were both women who continued to struggle the most with their addictions during their pregnancies, and who were unable to seek treatment and become sober until after their babies were born. These two, Chris and Emily, acknowledged feeling connected to their baby when they held him for the first time. It was after that moment that both sought treatment for their addictions. Chris spoke of the lack of connection to her baby in pregnancy as a means of coping:

Um…I don’t know if I…I felt somewhat connected but not the way I do with my normal pregnancies. Um…I think I disconnected myself. I didn’t hate the baby or I didn’t not want the baby, it’s just I knew I was doing wrong to this child and…. (Chris)
However, although Chris stated that she was disconnected from her baby in pregnancy, she told a story of her drug use that may indicate some type of subconscious early connection while she was pregnant:

I didn’t feel the baby when I did cocaine. I never felt him, like, move around a lot or anything different. When I smoked weed, he would move around a lot. I didn’t like the feeling, so I avoided weed for a long time….Because I knew it was discomforting him. I could tell. I could feel the discomfort, the way he was moving in my belly…I knew it [cocaine] would harm him, but I just didn’t feel the feeling, so I just kept doing it. (Chris)

The connection that participants felt not only served as a motivator to change their drug use, but also precipitated feelings of guilt and fear regarding the impact of substance use on the developing fetus. Women expressed feeling ashamed that they caused harm to their baby. They also expressed fear for their baby’s health and fear of the child welfare system. This served as a constant threat to their ability to fulfill their roles as active mothers in the lives of their children.

Carol struggled immense feelings of guilt throughout her pregnancy. She described being highly addicted to narcotics, and despite several attempts to quit, Carol stated that she was unable to attain sobriety until she started the methadone maintenance program during her pregnancy. In a tearful voice, Carol described her feelings during her pregnancy:

Even when I went for an ultrasound, I’m like “How does he look? Is his heart OK? Is he growing?” “Oh yeah, he’s big and he’s growing”, and then I’d get pictures and I’m thinking “You stupid bitch! What are you doing? You’re doing those pills, still!”… I was scared. I was ashamed. I felt like I was a junkie. I was disgusted. (Carol)

Participants spoke of multiple daily thoughts about the harm they were doing to their baby and their inability to stop using drugs. They expressed feeling fearful and constantly
worrying about the well-being of their baby. Shelley described daily thoughts of her baby and the
difficulties she had in her pregnancy because of the guilt she experienced:

   It [the pregnancy] was horrible. Horrible, depressing, scary, painful, I dunno. Just not
good. Not like my first pregnancy at all…I cared about the baby but then I’m like, “Is he
going to live? Is he going to be messed up? Why did I do this? I’m such a bad person and
my baby is gonna be on methadone till he’s born. (Shelley)

   Many of the participants created opportunities to reassure themselves that everything
would be OK. Although they frequently worried that their baby would be “retarded,” would
experience withdrawal or would die, participants attempted to reassure themselves. Beth
described the fear she felt for her unborn baby as a result of the methadone:

   I would always be like, holding my belly. And then I would get worried. I would tell [my
husband], “[h]ere, hold this side and I’m going to hold this side, and you tell me if you
feel something”. ’Cause, like, I’d get worried if I don’t feel her moving. (Beth)

   Carol described her fear and guilt as she struggled with drug use, methadone maintenance and
the impending birth of her baby:

   …I was scared. ’Cause the pills. I was scared the whole thing of my baby being a drug
baby. You know, withdrawing. The baby doesn’t deserve that right? He didn’t have a
choice. So, I was upset…I thought, maybe this is the way God is saying to get off the
pills. Like, this is a blessing right? And I’m fighting with it because I didn’t want

   Children’s Aid to know. You know, I was scared that they’re taking the baby. (Carol)

   Like Carol, Yolanda’s thoughts regarding her baby’s outcomes were a regular mental intrusion.
She expressed a sense of shame in what she had “caused” and a constant sense of fear for her
baby. Yolanda described some of her worries and fears during her pregnancy:
Every time I went to my ultrasound, like, I would always be asking the ultrasound, like “How’s my baby? Does the baby look fine? Is it normal? Can you see any deformalities? I was really thinking that…’cause I seen people have kids, drinking and drug using and all that throughout their pregnancy and you can just look at them and you can tell. You know? ’Cause they have a disability or something. That’s what I was always afraid of.

(Yolanda)

The feelings of guilt and shame combined with fear and anxiety were even more problematic due to the lack of support in the participants’ lives. For many of the women, there was a distance from their own family of origin, either resulting from a traumatic history or because of the participants’ own involvement with drugs and alcohol, which isolated them away from their kin. This sense of isolation was confounded by a loss of friendships and other relationships due to their drug use. For most of the women, their only interpersonal contacts were others who used substances with them, including their partners. Therefore, as participants learned of their pregnancies and felt compelled to at least pause to consider their lifestyle and their future, the only people they felt they could relate to were other individuals who were using drugs and who were often not in a position to provide positive reinforcement to become sober.

During Shelley’s pregnancy, the father of her baby was also using substances and was abusive towards her. She struggled with the lack of support while she tried to get clean on methadone for the sake of her baby. Shelley described her support system and the difficulties she had in navigating her relationships when she began the methadone treatment program:

…I was in an abusive relationship, too. And that didn’t help matters. And I didn’t feel loved and, you know, I don’t have family and friends to support me while I was pregnant.
No friends. I mean, that’s the hardest thing. My baby’s dad was still using Oxys when I was pregnant and that was very difficult for me. (Shelley)

Shelley continues by explaining the differences in her relationships once she began methadone:

That changed big time. ’Cause everybody’s…you know. I wasn’t sharing with them no more, you know? I wasn’t getting them high. I wasn’t getting high with them and it would be like, “Oh, can you hook me up?” And I’m like, “No man. I’m frickin’ pregnant. Leave me alone. Like, get lost.” But I’d be like, “Hey you wanna hang or something?” But they’d just be like “Oh! I’m so sick!” Like, I don’t want to listen to that, you know?…They didn’t want to hang out with me because I was straightening up and I didn’t want to hang out with them because they were always hurting for a pill and when I see them…It still bothers me when I see someone jonesing [craving drugs]. It pisses me off ’cause it’s like, “Don’t jones in front of me, man.” (Shelley)

Emily also struggled with support during her pregnancy. Emily’s parents and siblings were addicts and so was her partner. The people that Emily spent her time with were all other drug users. She spoke of the support system she had during pregnancy and after she took her baby home from the hospital and tried to adhere to methadone maintenance:

All my friends were just people I used with. Because we just lived in a small town. Everybody knew everybody. But, like, the only people that I talked to was the people that used to come to my house to get high with us. But then when [name of baby] got out of the hospital, I didn’t talk to nobody. I just kind of barricaded myself and him in my house and I didn’t want nobody to associate with me. I think I was scared that I was going to use again. (Emily)
While the pregnancy seemed to be a motivator to change and lead more sober lives, it clearly came at a cost to the women. Making changes to their substance use also meant accepting a different lifestyle and isolation from their peer group. For women who already struggled with a sense of loneliness, this isolation was a barrier to their sobriety that they needed to continue to fight to overcome. Even when support was available to them, they had isolated themselves from that support while they were using and found it difficult to re-engage. Mary described this struggle:

Well, I think I just made myself feel like that [scared] because I didn’t want to be a …like, I didn’t want to bother anybody. I didn’t want to bother my family. And also, my friend. I didn’t want to have to bug anybody to help me but they were…you know…they were just really offering and…you know…practically grab my hand and take me home, kind of thing. I don’t know. (Mary)

For others, the support they had in their life were not always the most ideal but they were often the only option. Chris described having no one to support her during her pregnancy, and she was unable to gain sobriety while she was carrying her baby inside of her. She had a very significant drug problem, was in an abusive and unsupportive relationship, and only associated with others who used substances. This made her pregnancy seem daunting to her. During her pregnancy, Chris turned to her sister for support, knowing that although she felt less alone, it wasn’t the kind of support that she needed in order to make changes in her life:

Well, she [my sister] always stayed with me you know? And when I was hungry she would feed me. Like, we were street girls. We lived on the streets. Every time I was hungry I would always come first, and every time I needed a fix, she would give me a fix.

(Chris)
The lack of support in these women’s lives was profound. At a time marked by worry and fear, many of them had no one to turn to for support. Six of the eight women were in abusive relationships that exacerbated stress during their pregnancies. Emily described a lifetime of abuse and trauma that continued into her pregnancy. Her partner’s control of her also contributed to her drug use. She described her pregnancy in the context of her relationship:

It was bad. I dunno. It’s hard to explain I guess. It’s like, even if I didn’t want to use, I had to because [name of partner] was there. He’d push and push and if you didn’t do what he wanted…he would never do anything by himself. That’s why, if he wanted to get high, I had to get high or else I got beat up…But when I came home one time from [name of partner] mom’s house, there was three guys in my house and [name of partner] tied me up with a phone cord and then let the guys do what they want to me. (Emily)

With significant abuse a common feature in their relationships, the fears associated with pregnancy and the struggle to have a better life for the sake of the baby were excessively difficult to deal with. However, for some women, a single moment in time appeared to make all of the difference to them. When women sought methadone treatment and had practical assistance from an individual whom they could rely upon, they appeared to be able to mobilize external support to aid them in their path toward healing for themselves and their baby. Yolanda described in great detail the day she found out she was pregnant, and the difference that a single intervention made for her in gaining sobriety. Yolanda had no intention of going on methadone on the day she arrived at her doctor’s appointment, but she stated that she knew exactly what she needed to do as soon as she found out she was going to be a mother. It took the support of a concerned community worker to give Yolanda the confidence to forge ahead and maintain treatment from
that day forward. She spoke of the day she disclosed her use to the worker after discovering she was pregnant:

I was like, “Well, I don’t have money.” And they’re like, “Well, what the hell are we going to do?” So, this one guy from Superior Points, he gave me $50 and he says, “Well, here’s something for today. We’re going to have to figure something else out for you.” And I thought that was really weird. But he goes, “I don’t want to see you in withdrawal,” he says, “Especially now that you’re carrying a baby.” So, they called my doctor and when I left here at 5 o’clock, they sent me in a cab to Shoppers Drug Mart and they told my doctor my situation, so he had prescribed me Oxys twice a day ’til I got on methadone, to keep me from withdrawing. And I was thinking, “Holy crap!” And it made me feel really good at that time because I was an addict, I thought, “Okay, I don’t have to worry about drugs till I get on methadone.” So, I knew I was OK. But then again, I thought, “Oh my gosh. I don’t even know these people and they’re doing this all for me.” Like, you know what I mean? (Yolanda)

For all of the participants, ceasing their drug use was not at the forefront of their minds until they either found out they were pregnant or actually gave birth to their newborn. The constant struggle with addiction appeared insurmountable. However, the women spoke of how they were able to make changes in their life for the sake of their newborn, not necessarily for themselves. Shelley expressed regret in not learning of her pregnancy until she was a few months along. Reflecting back, Shelley describes what she feels would have made a difference to her ability to maintain sobriety:

If I found out I was pregnant before I got the methadone, I would have stopped Oxys. Like, just like that. If I did know. So…like, I would have went for help. I would have
went to the hospital. I would have been like, “Okay. Hook me up. I’m going to get off this shit. Just don’t let my baby die.” That’s what they told me, though; I can’t do that. I have to go on methadone because I was using an 80 a day. And I’m like “Well other people quit. Well, yeah, but they weren’t pregnant.” So, I’m like, I did quit for the baby. I honestly wouldn’t have quit. If I was on methadone and not pregnant, I’d still be using. I told them that. I said, “I’d still be using. I wouldn’t care.” (Shelley)

**Self-Sacrifice: The Paradox of Methadone Maintenance Treatment**

At the time of the interviews, most participants were on a methadone maintenance program as a treatment for their addiction to opiates. I wondered if willingness to participate in the research was perhaps due to the fact that women who are on a methadone maintenance program are in a different place in their addiction and recovery journey and can therefore express their story more openly.

Although several reasons for initiating methadone treatment were offered by women, the reasons typically fell into one of two categories. Women, in general, had reached a point in their addiction where the drug’s hold had created a lifestyle that they would not have readily chosen and the depletion of finances and recurrent “dope sickness” had created insurmountable barriers to what they would term a “normal life”. Secondly, the knowledge of their imminent responsibility for another human being was a motivator to either initiate or maintain treatment.

For Shelley, MMT appeared to be the last stop for her in a world of addiction that had spiralled out of control, with her resolving one addiction with the use of another substance only to find herself addicted to the new drug:

I was shooting up coke and heroin and I went on morphine and Oxys to get off the coke, which I did on my own. I started using pills to quit doing needles and then I got addicted
to the pills and then I tried to get off the pills and I eventually went to methadone to get off the pills. Now I’m on methadone and I’m trying to get off methadone right now.

(Shelley)

For others, the initiation of methadone therapy served a dual purpose. It resolved their ill feelings associated with withdrawal, and it also provided a better outcome for the baby. Mary described this when she spoke of initiating methadone treatment:

I just…I want to be able to get over this addiction. I want to be sober again someday.

And, I want to be able to be a mother again…I think I did it [methadone] for both of us.

But, mostly the baby. (Mary)

While illness and finances were mentioned consistently as motivators for receiving methadone treatment, the commonality among the participants remains the baby. Participants expressed that whether they initiated treatment for the baby or maintained the treatment, what kept them faithful to the methadone treatment regimen was a quest for a better outcome and better lifestyle for their baby. Yolanda described her conviction to maintain methadone treatment despite having tried it and failed only years earlier: “I didn’t want to be a drug addict anymore. I wanted to clean up and be ready for my baby when the baby came. I wanted to be stable” (Yolanda).

Having been addicted to substances for several years, Yolanda described being unable to sustain treatment until she had someone else for whom she felt responsible. It seemed that she cared more for her baby, than she did for herself. The power of this growing relationship between mother and unborn child was a significant finding of this research. Carol described her commitment to getting herself in a more stable place on methadone in order to keep her baby and be a good mother:
The idea of giving birth to this baby and seeing Children’s Aid coming and taking him away and never seeing him again. That’s what would kill me because I’m having this baby inside me, growing inside me, and then all of a sudden never seeing that baby because it’s me that did it. I’m guilty. You know? Nobody else to blame. (Carol)

However, despite the motivation to be in a more stable place in order to provide and care for a baby, methadone maintenance was not easy for women, and all of them expressed a desire to be off of the program and completely clean from drugs. The consequences of methadone were unknown to the participants when they started the program, and they expressed some of the difficulties they had in sustaining the treatment program. Madison explains the struggle with methadone and the commitment and determination it takes to stay on the program:

The first week I still used real bad. Like, still felt like I needed to use but it wasn’t even working…Prior to…when you first get on methadone though, when you do your papers, it takes at least six to eight weeks to get on it. You have to go through four full weeks of urines [urine testing]. You’ve got to do two urines a week. Go there twice a week to methadone and do urines four weeks in a row. Then you’ve got to attend these two doctor’s appointments before they decide how much to put you on. (Madison)

Shelley further outlined the sense of failure that she had as she strived to receive a carry (a dose of methadone that can be self-administered at home) of methadone: “It’s hard to be straight for two months to get a carry. That’s impossible for drug addicts. It was for me until I seen my baby, right?” (Shelley)

The struggle did not stop with the original stabilization period. Madison, like many of the other women, continued to wrestle with frequent requests from child welfare for urine screenings and information about her adherence to the methadone program. Participants expressed the
difficulties they experienced because of judgement placed on them when others learned that they were on the methadone program and how those judgements negatively impacted them. Several participants stated that they had experienced judgement from health care professionals after revealing that they were on a methadone program when they arrived at the hospital to deliver their baby. For women who had sought out treatment in order to be in a better place in their lives for their baby, judgement from others was difficult to deal with.

Beyond judgement and struggles to stabilize, participants also noted the health consequences of their chosen treatment and the loss of friends who also used substances and no longer fit into the lifestyle of someone who was trying to get clean. However, despite these consequences, participants were able to identify several positive aspects of the methadone maintenance program, from better support and the ability to re-establish relationships with family to less secrecy, no cravings for drugs, no more pain, better focus, and perhaps most common across participants, the ability to keep their children or spend more quality time with them. Carol describes the benefits of methadone in her life:

I don’t like being on it, but it’s helped me to not use. I don’t think of using. It’s helped me. I got my children back. I can get up. I can focus better. I have money. And I just don’t crave or jones for those pills. I don’t even think about it. (Carol)

“Liquid handcuffs.” MMT and what it meant to the participants as a benefit and in terms of consequences was a predominant theme throughout the research, and participants focused on this as they described their experiences. It was interesting to me that many of them felt trapped on methadone. The stability in their lives resulting from their involvement in a methadone maintenance program allowed the participants to have clarity about their substance use and their goals. Surprisingly, although these women had independent meetings with me,
several used a similar phrase when they spoke of methadone treatment, referring to methadone as “a deal with the devil.” Similarly, Beth referred to methadone therapy as “liquid handcuffs.” She further described that methadone is something that an addict needs from a physiological perspective in order to stop craving and stop withdrawal symptoms:

Well, when you first get on, you can’t get carries until you have a certain amount of clean pees [urine tests]. So, you’re not allowed to go anywhere. You’re not allowed to leave for camping for the weekend or for a week. You’re not allowed to go anywhere unless you have another pharmacy at that place where you can go and they’ll take it. It’s like you need it. If you don’t have it you can’t sleep…I also wanted to just quit. But then the doctors said that would probably do more harm to the baby then it would to me. So, I just more or less had no choice but to stay on it. (Beth)

The daily regimen and the fact that methadone is one drug replacing another drug made Beth and many of the others in the study feel as if they were trapped. Emily described this feeling when she referred to methadone:

When I got on [methadone], they told me that it was a two to five year program and it’s just bothering me that I have to take something. Like, I want to be normal…It’s a drug making me normal. I think it’s just a drug switching for another drug. That’s how I feel. (Emily)

As methadone begins to stabilize cravings, the participants expressed feeling more stable in their lives but continued to have the sense that they were on a drug. In a way, methadone was a constant reminder to them of their drug-using past. Carol echoed Emily’s sentiments when she described her relationship with methadone:
I wish I wasn’t on methadone…Because, like, I don’t want to be dependent on pills. I don’t want to be dependent on alcohol. I just want to live life like other people. I don’t want to have to deal with life where I have to drink and bury how I feel, because I always did something not to feel, I guess, and just numb…I don’t want to be on it forever ’cause it is a drug. Like who wants to be on methadone? I want to accomplish and just live a clean life, you know? (Carol)

While MMT has many benefits to women, participants spoke of methadone’s hold due to their knowledge that it was the best chance for an improved outcome for their baby. The commitment to their baby and wanting to ensure that they could give their baby the best start possible made staying on the methadone program a certainty in their lives. Shelley spoke of this commitment to methadone for her baby, not herself, and described her conversation with the methadone clinic:

“[The physicians told me] Oh, by the way, you’re pregnant. But you still have to stay on the methadone. I was like “What?! Why?” Well, you’re baby is going to die if you don’t. And I was like, really? But I mean, who’s going to take that chance, right? So, I stayed on it and then it was like the worst thing in my life. (Shelley)

While MMT was accessed by the majority of the participants, it is clear from their responses that it was not easy to stay on the program and given the choice they would quit altogether. However, the common thread among the women in this study was a need for a more stable life and a commitment to ensure the best possible outcome for their unborn baby. Although they were unaware of some of the negative aspects of the treatment, women pursued it to ensure that they were doing all they could to increase the chances for their child.
Being a Mother: Experience with the Newborn

The experience of having a baby was monumental for participants. It was a time in their lives that was met with mixed emotions as they anticipated life with a new baby, and feared for their baby’s health and long-term outcomes. Like other women who prepare for the imminent birth of a child, the women reported a sense of excitement on the day they began their labour and happiness to finally meet the baby that was growing inside them. However, in addition to the excitement, participants expressed a sense of relief once the baby was born. Although concerns for the health of the newborn are common among expectant parents, the sense of relief may exemplify an exacerbated feeling of stress for women who used substances. Beth explained her sense of relief when she met her baby for the first time: “Thank God she’s healthy. She’s normal. Ten fingers, ten toes; a normal face.” (Beth)

While many women experience a sense of relief once their baby is born, the magnitude of the emotion for participants who used substances or were treated with opiates during their pregnancies paralleled their sense of worry for their babies’ outcomes following substance exposure. Mary described the same sense of relief when her baby was born: “I think I actually felt…I did feel really happy, even though I had all that other stuff, I just felt so happy. She was born. And she made it.” (Mary)

Yolanda also described a sense of relief as she finally held her baby in her arms for the first time, and reflected on how far her life had come since the day she found out she was pregnant: “I was relieved and I started crying even more because he was fine. There was no nothing. He [the physician] said there’s nothing that we can see. There’s nothing wrong with him. So, I was just relieved.” (Yolanda)
After months of worrying and waiting, giving birth was a pivotal moment for many of the women. They expressed a renewed sense of self in that they knew they had to get well and stay well for their baby’s sake. The moment the baby was born, a sense of being a mother came to life. Shelley described the moment she held her son for the first time:

I have a video of it. He was just so sweet and I just sat down and I held him and I cried. I sang to him and I rubbed his head. I still do that every day when I see him. I still do the same things. That’s how he knows it’s me. And I just stared at him you know? (Shelley)

Emily shared a renewed sense of wanting to move forward for her baby. She left the hospital and began a journey involving treatment, crisis homes, women’s shelters and counselling. Emily spoke about this change in her life:

’Cause that one time I held him…it made me just feel differently…Once I held him, that’s when I put myself into the women’s shelter thing again and I wanted to get clean. They put me on a safety withdrawal program and it took me a month, but I got clean…I’ve been clean ever since. (Emily)

Similar to Emily, Chris stated that she did not feel connected to her baby during her pregnancy. However, when her baby was born, Chris felt an overwhelming surge of emotion as her baby became real to her and she felt remorse, guilt, shame and pride. Chris spoke of feeling an instant connection to her baby when she saw him for the first time. However, she was keenly aware of the seriousness of her addiction and was confident in her decision to have her baby adopted. She described it as the “most right decision I’ve ever made in my life.” For Chris, the connection to her baby prompted her to make difficult decisions that she felt were in the best interest of her newborn.
**Fears and guilt.** Similar to the pregnancy, the day that the baby was born renewed feelings of fear and anxiety about the baby’s outcomes. The participants expressed that when they went into labour, while they were uneasy about the actual pain of labour itself, there was also a cloud of anxiety regarding the impact of their use on their baby. Many expressed concern about withdrawal while others expressed fears that the baby would be deformed, “retarded” or have major health concerns. In addition to outcomes for the baby’s health, there was an expressed worry regarding the presence of child welfare in their lives and a fear that their babies would be apprehended at birth because of what they had “caused” in their baby and their ability to provide care. When birth is overshadowed with uncertainty for health outcomes, the magnitude of the emotion changes and becomes more profound. Madison spoke about the moment her baby was born and the experience she had as she observed him transferred to the NICU:

> It just made me afraid. You know, is it going to happen to him? Is he going to end up in ICU? And, sure enough, he did… I was really… I was like, crying a lot. I was really scared that I was going to lose him. Like, I thought he was going to die because he was in ICU. (Madison)

Like Madison, Yolanda experienced fears when her baby was born. The imminence of the baby’s birth served as a reinforcement of all of the worries that she had during her pregnancy. Yolanda explained her immediate reaction when her infant was born:

> I was just crying, thinking… I remember crying. Like, you know, my gosh, something is going to be wrong with my baby. I kept thinking in my head, something is going to be wrong with him. I was really expecting something to be wrong with him. Like, how am I
Yolanda said, “going to live with a disabled baby? You know what I mean? Like, that’s going to be hard!”

Carol also had an overwhelming sense of fear when her baby was born. She was afraid that her baby could die because of what she had done while pregnant, but she also feared losing her newborn to the child welfare system. Like others in the research, Carol wanted to be a mother and knew that her substance use could impede her ability to be an effective parent. Carol’s fears were intricately intertwined with her sense of guilt. She described her thoughts and stress while she was in labour:

“So, I just did the gas [anesthetic] and I kept thinking, “Oh my God. Children’s Aid, don’t take my baby. Don’t take my baby.”…So I had him and I was like, “Oh my gosh.” I was overwhelmed. I was happy. I got to hold him. They let me hold him when he first came out. And I’m like, “How is he? Is he good? How is he?””

Carol was overcome with emotion as she spoke of the staff “letting” her hold her own baby. While speaking she didn’t seem to recognize the magnitude of her statement. She had carried a baby for nine months, had worried for his well-being on a daily basis, changed her life to include methadone treatment for the sake of her son, and she was overjoyed that someone “let” her hold her baby. The power imbalance in a birthing situation such as Carol’s was clearly apparent. Following her disclosure regarding her substance use, Carol’s baby, like many others, was taken from her care and transferred to an independent unit where infants are closely monitored and treated in an isolette. There are no spaces for mothers to overnight with their newborns, and instead they are able to sit in a rocking chair beside the isolette while the baby receives treatment, monitoring and temperature control in an isolette. Carol’s description of her first encounter with the NICU surprised herself. She described going

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to see her baby for the first time: “It felt like the hallway was so long. It was long. It felt like I was walking down the aisle of shame.” Carol achieved additional insight as she became more stabilized on methadone:

…I didn’t see it then. I didn’t see it. I didn’t see what…I had, like, even up to date, what impact I did to my kids. To my family…The idea of giving birth to this baby and seeing Children’s Aid coming and taking him away and never seeing him again. That’s what would kill me because I’m having this baby inside me, growing inside me and then all of a sudden never seeing that baby because it’s me that did it. I’m guilty. You know? Nobody else to blame. (Carol)

This reinforced guilt which occurred at the time of the baby’s birth was consistent across participants. For the most part, the guilt reflected their perceived failure to protect the baby. Emily also expressed guilt and shame when she had her son. She did not return to the hospital for two weeks after his birth because she felt so bad that she had caused him to be sick. When I asked what kept her from the hospital, she replied, “[j]ust the fact that I did something like that to a little baby.” However, Emily’s guilt extended beyond the baby. She expressed the guilt and fear she experienced related to herself, which further reinforced her guilt at not being more concerned for her baby:

I was just scared. I think I was scared more for me than I was for him. And that just makes me feel really bad. [crying]…’Cause I was just scared…I was just scared for more me because…I was young, I didn’t know if you’d get charged for hurting your kid and I just felt really bad. I pretty much killed my kid, if you thought about it. I made him have a bad life. (Emily)
Emily’s expression of the guilt she experienced is considerable. These feelings of guilt presented in varying degrees of severity among all participants. Although Yolanda was fortunate to find help on the day she discovered she was pregnant, she continued to express guilt about causing her baby distress through her use of drugs and methadone treatment:

I guess you could say it was guilt, I guess. I beat myself up real bad for that ’cause it’s hard to see your little babies go through withdrawal. And I felt like I did it to them because I wanted myself to feel better. That’s what I felt like. But I knew that I was going on methadone to kind of lower the chance of losing my children. Like, that’s why I went on it, so I wouldn’t lose the kids. Like, I wouldn’t lose my baby. ’Cause I wanted my babies. I knew I wanted to go through with these pregnancies and I knew I wanted to quit the drugs and be a good mom. But it was hard. Like I said, I beat myself up. (Yolanda)

Beth also expressed a sense of guilt, which for her was combined with a sense of frustration. She knew that methadone would impact her baby and she made several attempts to come off the methadone but was unable to do so, and this caused her guilt because she felt like she failed her baby:

I felt bad. Like, this is all my fault. I should have got off methadone. But I was trying, like, after I had the first baby on methadone, I started coming down and then I ended up pregnant again, so I had to go back up. And then after the second one was born, I tried coming back down again. Every time I went down to 40. And then I ended up getting pregnant again, so I ended up going up to 80. (Beth)

**The onset of symptoms.** While pregnancy and birth were times of anxiety because the participants were uncertain about their babies’ outcomes, the onset of withdrawal symptoms in newborns confirmed the women’s fears as they observed their babies experiencing the same type
of discomfort and pain they had frequently experienced themselves when withdrawing from opiates. This revelation of the similarities in the experience was too much for some of the women to bear, and they questioned how they were unable to attain sobriety by persevering through the withdrawal. It was immensely difficult to stand by and observe their newborns going through withdrawal in the first hours or days of life. Many women experienced confusion and disbelief as they struggled to interpret their newborns’ symptoms and questioned whether they were indicative of withdrawal or if they were being misdiagnosed due to judgement and stigma. Beth described her experience of confusion when she noticed withdrawal symptoms in her baby for the first time:

The sneezing. It would sneeze over and over. Like, ten times. What was the other one? I think it was the jitters that the one baby had. I think that was it. The yawning and the shaking. Like, when you would take the baby out of his clothes, out of the blanket…I guess it’s real. Like, the baby is withdrawing from this. A million things went through my head…I don’t know how to say it…babies all have different cries, and, I don’t know…you could say I was just thinking they were being mean to me just because they knew I was on methadone. (Beth)

For others, the symptoms of withdrawal were so familiar to them from their own experience there was no mistaking that their babies were experiencing withdrawal due to the participants’ substance use or methadone treatment during pregnancy. Many of the babies did not exhibit overt signs of withdrawal until a day and a half after birth. This time period allowed for the women to room with their babies and provide direct care to them before the infant was transferred to the NICU. This period of time was met with hypervigilance as they anticipated the onset of symptoms. Mary described when she noticed withdrawal symptoms for the first time:
I think it [the onset of withdrawal] took about a day. I noticed that she started to cry a lot and I just…I don’t know. I was expecting her to feel sick and I just kind of figured she was, when she started to cry a lot and she was jittery. Yeah, and I could feel that she was hot and just pretty much the same things that I would be feeling if I was withdrawing.

(Mary)

The sense of guilt resurfaced for Mary when the symptoms of withdrawal began. By recognizing the symptoms as mirroring symptoms she herself had experienced, Mary knew her baby required medical help, but she struggled with a sense of guilt reinforced by the baby’s symptoms:

I had a lot of guilt. I felt so awful. I kept crying and I kept telling the nurses that she was sick and when she finally scored high enough, the doctors sent her to the NICU. [The guilt was] just knowing that she was withdrawing because I…you know…I was a drug addict and I couldn’t stop using when I was carrying her and just seeing her. Like, actually seeing her go through that sickness and that pain. I felt awful. I felt like I didn’t even deserve to be her mother. I don’t know. (Mary)

Like Mary, Madison took a watch-and-wait approach while observing her baby in her hospital room. Unlike other diagnoses that typically require a physician’s assessment, the familiarity with the feelings associated with discontinuation of substances made the mothers experts in identification of symptoms of withdrawal. Although Madison was not surprised that withdrawal was beginning, she was overwhelmed when it started and recalls the experience as one filled with tears and sadness as she saw her baby exhibit symptoms;

I noticed it first. Like, I seen him getting sweats. Really sweaty. And finally told a nurse when they came and did their vitals. I told them, “He’s shaking and he also got, like,
sweats. Can you check him?” I told her. And, sure enough, she said, “OK, I’ll take him to the desk.” And, sure enough, he had withdrawal symptoms. (Madison)

Similar to the other participants, the withdrawal symptoms in the baby triggered a sense of guilt all over again for Madison. She described what was going through her mind as her baby experienced withdrawal;

Why is this happening to me? That’s what I was feeling. And I also was crying because I was blaming myself. Because I’m on the methadone, ’cause I did these pills, that’s why I’m here. That’s how I got here. You know, I was mad at myself. That’s how I felt. (Madison)

Carol recalled having her baby in her room with her for a day and a half before withdrawal started. She had worried throughout her pregnancy and continued to worry while she waited to see if symptoms would present themselves. Like many of the others, Carol expressed her sense of responsibility for the withdrawal symptoms in her newborn. Her commitment to her baby was unwavering despite the pain of seeing him go through something she struggled so hard to avoid in her own life:

They monitored him and then we stayed in the maternity and they kept an eye on him. The first day, I think was no withdrawals, and then it started coming. He started sneezing and…I didn’t let him go. I did not. I didn’t let him go at all. Those nurses, like, they took him one time just for me to have a break, but I was right there. You know what I mean? Then he started sneezing. I didn’t see it but they were noticing it. They were like, “Ya, we’ve got to take him. He’s getting withdrawals.” And I lost it. I just got so mad at myself. I’m like, “No way!” They go, “Ya ’cause he started getting the restlessness” and I said, “Oh my God! What am I going to do.” (Carol)
The baby’s withdrawal symptoms perpetuated Carol’s feelings of guilt and responsibility for the discomfort she believed she caused to her newborn. However, despite feeling responsible for the infant’s situation, Carol maintained her commitment to her baby. Like Carol, Chris also maintained a commitment to her baby, though her commitment did not involve staying by her baby’s side. For Chris, her substance use was far from controlled at the time she had her baby. She stated that on the day she delivered, she had approximately 200 Ritalin. During her pregnancy, Chris made the difficult decision to place her baby for adoption as she felt she would be unable to care for him due to her drug use. She was overcome with emotion when he was born, and stated that she had purposefully disconnected from her baby in order to survive her guilt. The ability to separate from the baby was so significant that Chris was unable to see or feel her baby’s symptoms as she held him in her arms:

I should have seen it [withdrawal], because I held on to him. I should have seen it because my family held on to him in front of me but, I don’t know, I was blocking it in my head but I didn’t see him shake. (Chris)

The experience of seeing withdrawal symptoms for the first time evoked an all too familiar sense of guilt for women, and it also paradoxically combined with a strong commitment to the baby. Yolanda recalled her mixed feelings when she observed withdrawal in her son:

His whole body would shake. Not just a little shake, it would be like a whole body shake. His little hands would go like this and I was thinking, “Oh my gosh! What am I doing? Like, look at my kids. They’re going through this because I wanted to feel good.” You know what I mean? So, that was a lot of guilt I felt, when I seen my son go through withdrawal…And that was scary because they left him with me right? Like, he was born and he stayed with me all day and then all night and he got to sleep with me. But, by six
o’clock the next morning, that’s when I could feel him and his body would go stiff and I would freak out and cry and then I would call the nurse. (Yolanda)

For all participants, the experience of observing the withdrawal symptoms in their newborns was profound and difficult to watch. However, what became apparent through the interviews was that despite these difficulties, all but one participant continued to be a presence and caregiver to the baby throughout the hospitalization. This commitment was evident for most, from the beginning of the pregnancy through to the discharge of the baby from the hospital.

As a standard of practice, babies who are scored eight or higher on the Finnegan’s tool for three consecutive scores are transferred from the mother’s room and placed in an incubator in a sterile NICU. In the hospital where participants had their babies, it’s an open-concept room and cannot accommodate a bed for the mother or a wall for privacy during visits. Transferring a baby from the mother’s care to a unit where care is provided by nursing staff was described as a traumatic time for participants. They struggled with separating from their babies, and knowing that the baby was experiencing pain and discomfort from opiate withdrawal. The separation of mom and baby contradicted their belief in their role as mothers and caregivers, and challenged their ability to provide care. However, Mary succinctly summed up the mix of emotion and unwavering commitment to her baby’s well-being as she explained seeing her baby taken from her care and placed with health care professionals who were essentially strangers to her: “I missed her very much but I think I was more concerned about the way she was feeling. Just knowing how bad it is to feel sick like that. I just wanted her to have some kind of relief.”

For Yolanda, the separation from her baby when he was transferred to the NICU was something she would not stand for in the hospital. She wanted her baby to get well, but she also felt that she needed to be the one to ensure he was getting the care he needed. Many of the
women I spoke to evoked the same assertiveness and conviction in their commitment and responsibility to their newborn. However, I couldn’t help but reflect on the fact that not all women in this vulnerable position are able to self-advocate. It is interesting that for many of the participants, the incentive to stay is preceded by a sense of guilt and responsibility. Yolanda described her commitment to stay with her baby:

’Cause, they just don’t have the time at the NICU to sit there all day with them. You know? He lays in his little bassinette and they check up on him once an hour, you know what I mean? When they do their rounds, or if he cries. And I thought like, it’s bad enough that he’s going through this you know? I want to be here with him. So, that’s what really made me stay with him because I felt like I did it to him, so I wanted to be there to help him the whole way through. (Yolanda)

Shelley also maintained her involvement with her baby while he was in the hospital. She struggled with the separation from her baby and experienced a loss of control. She wanted to be a mother and wanted her baby to be well, but like most women in this situation, Shelley found it necessary to rely heavily on nurses who were not always supportive to her. She felt like she was being a mother on the periphery, which contradicts many constructions of motherhood that place mothers at the centre of care to their babies. Shelley described her feelings when her baby began withdrawing:

I don’t think he was going through withdrawals. I think he just needed me to hold him more. He didn’t cry much. They said he was trembling. I don’t remember seeing him tremble at all…But had he been in my arms, I think I should have been able to make that choice for myself…I didn’t feel like I had no control over nothing. I had to feed my baby when they wanted me to feed him…It was hard in NICU, watching him in that tube, in
that thing…But giving him morphine, like seeing him totally unresponsive and that kind of bothered me, you know? Like, why is my baby on morphine? That’s what bothered me. (Shelley)

The experience of witnessing their baby’s withdrawal was profound for women. Watching their babies struggle with severe discomforting symptoms triggered a sense of responsibility and emotional pain. All of the women in this study experienced the pain of withdrawal themselves. This pain was unbearable for them and they began to use substances again. To see the symptoms in their babies was a reminder of their past and that their actions had caused their baby to suffer. Yolanda described her thoughts as she reflected on her own life through the thought of her baby’s withdrawal:

But even still now I think that I’m…like, how come I couldn’t go through withdrawal? If my little babies did it, how come I can’t do it? You know what I mean? ’Cause I’m still on methadone right now. And I’m like, “Well, if my babies can do it when they’re newborn, why can’t I?” You know? But it’s not that easy. You can’t just go to the hospital and say, “Okay, keep me here till I’m not withdrawing from methadone anymore,” you know? But I’m glad the kids had to be in there. (Yolanda)

When newborns experienced withdrawal, they were transferred to the NICU for monitoring and high-risk care delivery. The length of hospital stay for women was approximately two to three days, while the length of stay for newborns could be anywhere from a week to over a month depending on the severity of withdrawal. As a result, all of the participants were discharged from the hospital before their baby. This was a notable point for the women that challenged their sense of motherhood. Yolanda remained at the hospital because she felt it was important to be the one
caring for her son. She described being advised that she was being discharged from the hospital while her son remained in the NICU:

[name of baby] was so small. I didn’t want to leave him by himself there. You know, I’m his mom and I wanted to be the one to take care of him and I wanted him to be used to me. Like, I didn’t want to just go in there sporadically. Plus, I was breastfeeding too. That was another good reason to stay. (Yolanda)

Like Yolanda, Carol did not want to leave the hospital while her baby remained behind; she wanted to stay at the hospital to be as close to him as she could. She expressed her feelings when the nurses told her that she was being discharged:

Like, they kept me in, admitted for so long till they couldn’t keep me in there no more. They tried so hard. ‘Cause usually two days, you’re gone. Well, they kept me there. Because there was beds, they kept me. And then finally they said, “We’ve got to discharge you but we’re keeping the baby.” I’m like, “I don’t want to leave my baby.” “Well, you can come. You’ll go home at night time.” I’m like, “No, I don’t want to leave him. I don’t.” And I cried and I said, “I’m not leaving my baby. I don’t want to leave him.” Cause I was so scared that they were going to take him. (Carol)

Many of the women advocated remaining at the hospital in order to be with their babies. Like the others, Madison was also advised that she had to leave the hospital before her baby. She felt torn because she wanted to be the one to look after her son, but she also had other children at home. Madison was fortunate in that she had a supportive partner at home who she could trust to care for her other children while she stayed with her son through his fight with withdrawal. Although she initially followed the hospital’s direction and left, she was also able to come back to the
hospital and advocate for a space to stay for as long as she could. Madison described leaving the hospital and the struggle she felt that prompted her need to return:

[Upon leaving] I felt empty. I felt…I was actually feeling like lost without my baby. You know, you’re supposed to be going home with a baby and [name of other child] didn’t happen like that, so why was [name of this child] going like that? Is it ’cause he’s sick or…you know, that’s how I felt. And I got home and I just cried to everyone. The kids and [name of partner] they were all holding me in the kitchen. I even…Right away what I did is I unpacked my stuff and I started washing baby clothes, ’cause I missed him. And when I was doing baby clothes I was crying…Finally when I did stay in the parenting room I told [name of partner] I can’t go back and forth. I’m falling apart. I’m tired. You know, I was crying every time he would walk with me to the bus stop. He’d come with me to the bus stop and I’d tell him that I’m getting tired, can I stay over there [at the hospital]. And he said, “Yeah, go ahead.” So, I ended up staying over there for two weeks. (Madison)

While many of the women were able to stay at the hospital as a parent, not as an inpatient, the two women who were not stable with their substance use at the time of delivery were not able to stay with their babies. Both Chris and Emily were not on the methadone program at the time their babies were born. The guilt of seeing their babies withdraw was emotionally painful for them, and this pain triggered a strong need to bury their pain through the use of drugs. Emily explains leaving her baby at the hospital and trying to suppress her feelings:

I think I just didn’t want to think about anything. ’Cause usually when someone gets high it’s just because something is going wrong in their life. It’s just to hide everything, make it so you don’t think of anything. (Emily)
When Emily left her baby at the hospital, she went through a period of frequent drug use that she defined as a way to self-medicate. It wasn’t until she returned and held her baby that she was able to get on a path towards sobriety.

Like Emily, Chris also left her baby at the hospital, though she did not return. She described the day her baby was born and her very difficult decision to let him go. She knew she was unable to care for him in the way she hoped he could be cared for. Even at a time when she was using drugs, Chris was trying to make the best decisions she could to help her son. She explained the emotional pain of the day and her strength to maintain her commitment to her plan to place her baby with another family:

…And I held him and then I just gave him a hug and kissed him. I told him I loved him and that I was sorry. And then I let him go. I never seen him again [crying]…it all happened really quick. Like, he was born and they gave him to me after they said he was shaking and everything and I just held on to him and it was only five minutes he was in the room and I told them to get him out of here…Because it hurt me. It hurt me to give birth first to a sick child and he was so small and precious and cute and it hurt me. I was ashamed. I didn’t want to see. I couldn’t see him shaking but everybody said he was shaking and I couldn’t see it. I think my mind was like, playing tricks on me or something. I don’t know. But they said, “He’ll be outside of your room if you change your mind. We’ll leave him there.” And I never changed my mind and I just signed myself out and left. (Chris)

Chris’s drug use appeared to be the most problematic of all of the participants and she was unable to attain sobriety or methadone treatment. She felt an immense emotional pain from
leaving her baby and knowing that she had caused him pain. Chris took extreme measures just hours after leaving the hospital in an effort to avoid the painful feelings:

   I went to the bar and got drunk. I didn’t even care about using. I just wanted to get drunk. I don’t even think I used for a couple of days. I just stayed drunk…I couldn’t think about him, period. He was on my mind all the time but I couldn’t think about him. Like soon as he came to mind I would stick a needle in my arm. Or, as soon as he came to mind, I would shove a bottle down my throat. I even got to a point where I’d have to just shake my head like this in order just to get that thought away. (Chris)

It was clear through the interviews that whether women stayed with their baby through withdrawal or left the baby at the hospital, the experience of witnessing their newborn’s withdrawal and separation was very painful emotionally. However, this pain became a motivator to ensure that the baby was well cared for. For some, this meant advocating remaining with the baby as the primary caregiver, while for others it meant adhering to the care plan and leaving the baby to the medical team who could provide the care they felt was necessary to ensure the infant’s well-being.

   When the withdrawal had run its course and the babies were well enough for discharge, women expressed a feeling of relief and success that they had made it through the withdrawal period. They were overjoyed that their baby was well enough to go home, that they did not have to be away from their family or from their baby, and that they could finally introduce the baby to their loved ones. Madison summed up the experience of taking her baby home: “Bringing him home was really great. It was the best feeling, like a success feeling. We did it! We made it through this. Yeah baby, we’re going!”
Ambiguous Motherhood

Despite the desire to get well for the sake of the baby, mothers were faced with external forces that challenged their role as mothers. Whether positive or negative, interaction with health care providers had an impact on mothers’ involvement in caregiving toward their infant. When faced with negativity from hospital staff, women had difficulty engaging in care for their newborn. An additional challenge to their maternal role evolved from their interaction with the child welfare system. These experiences made the ambiguity of their maternal role apparent to them.

External providers: experience with nursing staff. Given that all of the babies born to women in this research were born in a hospital setting, the participants all had extensive involvement with nurses from the labour rooms, their postpartum unit care, and in the NICU. Although the women inevitably had to rely on nurses for their own medical care and for the care of their baby, they did so with a feeling of vulnerability that was compounded by their own guilt, the necessity of breaking the silence of their lifestyle and drug use, and vulnerability.

Interactions with the nursing staff affected the participants’ level of involvement with and commitment to the baby’s care. Although the majority of experiences with nursing staff were described by women as overwhelmingly negative, resulting in a perception of judgement and stigma, there were two women who disclosed positive encounters with the nursing staff who were tasked with providing care to the newborns. Despite the differing experiences, the commonality among the participants is that regardless of the type of experience, the perceived attitude and actual communication from the nursing staff had a dramatic impact on the level of involvement women had with their babies. Negative experiences yielded less involvement and
further distancing from the baby while positive experiences served as opportunities for engagement.

Although many of the women spoke of their experiences with the nurse, participants disclosed concerns regarding the care they received while in labour. Participants reported a sense of discomfort due to the judgement they faced from health care professionals. A number of women felt that nurses were purposefully withholding pain medication in labour once the knowledge of their substance use or methadone treatment was known among the health care team. The participants reported that this adversarial relationship with the nursing staff in the labour rooms prompted them to maintain silence on things such as their substance use history. Carol expressed a feeling of judgement from the nursing staff when she arrived at the hospital in labour:

I said, “Oh, can I get something for the pain?” And they’re like, “Well…” Thank goodness it was a girl that I knew I grew up with. But there was another, other nurses, right? You mention pills or methadone, you do get a different reaction from people…It was negative. Like, “Oh, yeah. Look. She’s only asking for pills because she needs a fix.”

(Carol)

It was important for the women to express that their history of substance use did not necessarily mean they were always seeking drugs. Each woman presented to the labour rooms for a medical reason that in many cases required pain medication. However, judgement from the nurses persisted and negatively impacted participants’ ability to become actively involved with their baby. Shelley expressed a tremendous amount of struggles with the nursing staff on all units in the hospital. She was dissatisfied with the care she was receiving but noted that because her baby needed to be cared for by the nurses and she felt she was needed to stay silent about the
care and treatment plan. Shelley expressed her frustrations with the nursing staff and how the judgemental responses of the nurses impacted her ability to provide care to her baby:

…They didn’t trust me at all with the judgement of my own child. They just…They kind of took over the parenting part and I was just, you know, the caregiver. I was the nanny for them, is what I felt like. You know, I’m not the mother. (Shelley)

Shelley offered insight into how the roles of nurse and mother had been reversed, as she felt like an observer rather than a parent. She expressed the difficulties she experienced when the nurses did not acknowledge her as her baby’s mother:

I’d been up for three days. Nurses weren’t helping me at all. They just put me in a room and they say, “If you need something, if you’re going to go out for a smoke, you can leave your baby at the front but don’t make a habit of it”…I think they judged me just because I…I’m a bad mom because I was on methadone. The poor baby, like, no one thinks, Oh the poor mom has to watch her baby go through this. It’s always like, “Oh the nurses have to watch the baby go through this.” It’s like, that’s my baby! (Shelley)

Like Shelley, Chris also experienced judgement from the nurses. She was not accustomed to opening up to others in her life and felt vulnerable in the hospital when she had to interact and rely on a nurse. She expressed her thoughts regarding the nursing staff:

[I felt] like I was a parasite or something. Like I was awful and dirty and they didn’t want nothing to do with me…I felt like I was a junkie and I was dirty and I shouldn’t be there and nobody wanted me there. Nobody cared I felt. (Chris)

The staff’s judgement of the mothers of these infants served as a barrier for many of the women when it came to offering direct care of their newborns, and in the feelings of comfort that a
woman needs throughout a baby’s admission in the hospital. Mary spoke of how the judgement she received from the nurses made it difficult for her to be with her baby,

> It [interaction with nurses] kind of sucked, I guess…I don’t know how to explain it but I could tell that some of them just really…I don’t know what it is…hated me or just disliked me. Just the way they would speak to me, the way they would treat me. I didn’t want to be there. I hated it. (Mary)

For some, the negative judgements from the nurses seemed to change once they began methadone treatment. It appeared to participants as though the compassionate assistance provided to mothers was conditional upon their stage in the journey toward sobriety. Emily struggled with the health care staff but noticed a change once she began methadone. The first impression with the staff made it difficult for Emily to be forthcoming with information about herself, choosing instead to guard her information and retreat from the care of her baby as she was unsure of her place and what she could do in her new role as a mother. Emily described the changes in treatment from staff:

> Like, there’s one nurse that kept telling me, “How could you do this to your baby?” And then that’s when they kept asking me if I was using. And then they’d just look at me and shake their head and walk away. It was just bad…I didn’t really talk to anybody unless it was just to ask questions about him. But then after I got clean and everything, everything was, like, fine. It was like nothing ever happened. (Emily)

Although there was certainly a perception of judgement from health care professionals towards new mothers in this study, not all women experienced the same pervasive judgement that others described. Yolanda and Madison spoke of the positive experiences they had with nursing staff. While they acknowledged negativity from “the odd nurse,” they stated that they predominantly
felt supported and cared for. Even for some of the women who expressed a tremendous amount of judgement from staff, there was a parallel experience of a positive experience with “the odd nurse.” In both situations, the attitude of health care professionals had a direct impact on the ability of women to participate in the care of their baby and feel a part of the care team. When women felt engaged and supported by staff, they took a more active role with the baby. Madison spoke of her response to the attitude of the nursing staff from both a negative and positive experience: “Um, she was really just sounding negative and being rude. ‘No, you can’t change him. I just changed him.’ Like really mean…I know one nurse did that to me once and I walked out crying, feeling really down.”

She further explained a more positive interaction:

Just that they [nurses] were nice to him [baby]. They took care of him really well and that they were very like, involving me in everything. They never left me out on anything. They were always happy to see me when I got there. You know, they were very…most of the time, except that one incident, they were very supportive…It made me feel more involved with my baby and they never took him without asking me too, when I was there, like, staying there to visit him. They always told me what they were doing with him and what they were giving him, like medication, too. They always told me the levels, the scores, what the scores were like on a baby like with doing morphine weaning. (Madison)

Yolanda had a similar positive experience with the nurses. When I asked her what she felt contributed to the positive experience with staff, she attributed the positive interaction to her own qualities and felt that it is important to have a positive attitude. This stayed with me, and I noted who among the group appeared to have the most positive interactions. The two women who reported positive interactions were in a stable place with their addictions and in general had
optimistic attitudes. Both Madison and Yolanda described that they had embraced the nursing staff and wanted to learn from them. It is unclear if this was the case because they did not feel judged and therefore felt more involved, or if they were naturally more involved with the baby and therefore were apparently not judged by the staff. Nevertheless, positive interactions with staff led to positive interactions with the baby. Yolanda discussed her insight into the relationship with the hospital staff during her baby’s admission:

   My attitude, I think it is. It’s all how you handle it, I think. Like, I could have went in there and had already a chip on my shoulder and then I would have…It’s the way you treat people. That’s what I think it is. And plus my baby was cute. Like, everybody liked her and I was easy to talk to and get along with. You know, I always wanted to know what was going on with her. Plus, I was there the whole time. I was always, always there. So, like, the nurses in the NICU, they all got used to me. Like, I felt like they didn’t judge me. They didn’t…like, “Oh, you’re a bad mother. How can you…” You know? I didn’t feel that at all. I felt like they were there, like “Pretty soon, you’ll get to go home.” Like, helping us, you know? (Yolanda)

At a time of vulnerability for women, interactions with health care professionals appeared to have a significant impact on a new mother and her ability to embrace her new role and be a part of the baby’s care plan.

   External providers: experiences with child welfare. Child welfare was perceived as a constant presence in the lives of these mothers. This influenced feelings of ambiguous motherhood. Child welfare had been involved in some of their lives in childhood, for others, the knowledge of their impending motherhood brought forth thoughts of the child welfare system. All of the women reported fears of intervention from the system until the point of the infant’s
discharge from the hospital. Their desire to be mothers and to protect and provide for their children was threatened on a routine basis by their own thoughts of their children possibly being apprehended as a result of their substance use or methadone treatment. The women were able to identify that the lifestyle they led, which included substances, would not be seen favourably by child welfare, and the participants often thought they would be powerless to prevent their children from being taken into care. For some women, this threat became a motivator to ensure they maintained their commitment to methadone maintenance. However, despite being on a methadone treatment program, there was little faith that child welfare workers would recognize the treatment orientation of methadone, and the participants feared unfair judgement with negative consequences to their ability to parent.

Despite attempts to avoid involvement with the system, the majority of women reported the presence of child welfare in their lives in some capacity once their children were born. This led to feelings of constant scrutiny and a continuous need to fulfill ongoing requirements to ensure they were able to meet the needs of their children. Women reported feeling unsupported by child welfare workers, and frustration with the ongoing demands and perceived lack of clarity of their service plans. Shelley described her ongoing frustrations with child welfare:

I don’t know. I didn’t know [name of child welfare agency] was even going to be involved. Because apparently I was supposed to do a safe baby program. I didn’t do it when I was pregnant. It’s like, you know what? I’m depressed! I don’t want to do it, okay? I got enough shit on my plate. I gotta go to methadone every day. I got appointments up my ying yang and they wanted me to go to this baby program. If they told me “If you don’t do this we’re going to take your baby,” I would have done it! But they didn’t tell me that. They said it was my choice…But then I found out it wasn’t my
choice so they had to take my baby and now I’m on probation. I’m doing the program now. But I can’t have my… I can’t be alone with my child… I heard like, ten different excuses why they took my baby away this time. First it was the baby was going through withdrawals and they couldn’t prove it was only from methadone – which it was. After they found out, they said, “Oh, it’s your mental health. Oh no it’s because you didn’t go to the parenting seven years ago.” Like, which one is it, you know? Pick one. Because I don’t know where you guys are going with this.” (Shelley)

Shelley clearly defines the difficulties she experienced in attempting to understand the areas that she needed to work on in order to satisfy child welfare and be considered well enough to care for her newborn. Many women expressed confusion in their understanding of their responsibilities regarding the safety requirements mandated by the system. This lack of clarity led to frustration and discontentment.

For others, there appeared to be a sense of defeat when discussing child welfare. It seemed that the ongoing struggle to keep their children and satisfy the child welfare system left the women with a sense of powerlessness. The following outlines a conversation with Mary as she described the presence of child welfare in her life. What stood out for me most about Mary is that although she loved her children very much, she exuded a sense of hopelessness or defeat when talking about her children. Mary did not have any of her children in her care, and although I interviewed her in a hospital room only one day after having another newborn, Mary seemed to have a powerless acceptance that the possibilities of her children staying in her care were very slim. She described the role of child welfare with her previous pregnancy:

What happened at that time was my kids had missed some school and that really sucked because I guess they… one of my kids caught lice and then the other ones got it and then I
was having such a hard time with my methadone, being sick and all, it was really hard for me to get rid of it and I tried so hard. Instead of trying to help me, she just took them.

(Mary)

When asked where her children were at the time of the interview, Mary responded, “They’re in care.” . . . The two oldest ones are together in a home [foster care] and my daughter . . . She is alone in another foster home. Right now my mother’s trying to get her. She wants to have her in her care. . . . My sister has a daughter of mine and there was a boy that I had and he lives with his dad.”

Mary did not see any of her children.

During the interview, Mary gently cared for her one-day-old infant. She stroked her hair and held her in her arms. Although we hardly spoke of it, we both knew that her newborn would not go home with her. Mary appeared sad throughout the interview. She did not appear to have the ability to fight for custody of her newborn, and seemed to accept her fate and that she would not be parenting any of her children.

Unlike Mary, Madison’s involvement with the child welfare system pushed her to fight and advocate to persevere her role as the mother of her baby. Madison spoke of her conviction when dealing with child welfare:

I was just determined to stay on the program [methadone] and so I told them about it, what I was going through. And I told them [parents] I asked child welfare for help. I almost lost my kids that time. Child welfare went and turned around on me and made me sound like I was a bad mom and I had bad parenting because I was using and they made it seem like being on the methadone program was even . . . because I was on it, it was like a treatment and I wasn’t allowed to keep my kids. Like, I wasn’t capable of keeping my
kids. That’s how they made it seem…They were threatening me for at least a few months, saying if I don’t sign the papers and agree with them to check on me that I’m on methadone and check that I’m doing my pees and seeing the…they wanted to see the results of the urines [urine tests] and stuff like that. I said, “It’s OK for you guys to know I’m on the methadone. I’ll sign the agreement that you guys can know I’m on the program, but I’m not going to sign the agreement that you guys can check my urine to see if I’m still using because I don’t believe you should. You don’t have to know that because I don’t want you to know anything.” (Madison)

In light of the fact that the babies born to women in this study have experienced withdrawal from substance exposure in utero or methadone exposure as a treatment for substance exposure, it is not surprising that risks have been identified by the child welfare system. However, the participants reported feeling powerless and having many demands placed on them in order to parent their children. Like the others, Shelley continued to fulfill the requirements set out by the child welfare agency. She expressed insight into how child welfare negatively affects a woman’s ability to carry out all of the steps necessary to regain custody of her children:

That’s why I notice why so many Native women who I meet who don’t have families, who don’t have parents, who don’t have guidance from grandparents, sisters, brothers, and there’s so many out there like me who were abused growing up, that gave up like I did. But they don’t have a reason to keep going. They took their kids and they went “Do all this” what I have to do and they just went, “Arghh! Take my fuckin’ kid,” kill themselves, or go shoot up. ’Cause I could see why they would do that. I know so many girls I’ve been talking to and their like, “Oh, I haven’t seen my kids in two years.” “Well,
why not?” “Well, they wanted me to do this.” And I’m like, “I’m doing it. Why can’t you?” And they’re like, “You know what? I’d rather kill myself!” (Shelley)

Although Shelley had clear insight into the impact on others of not having their children in their care, she continued to meet the requirements set out to her by the child welfare system. She offered this explanation of how she keeps going:

I don’t know. Just my son. ’Cause I love him so much and I know what it’s like to lose that kid, to lose my other son, and I don’t want that to happen to me or to him. You know, the pain is just too much. And, honestly, if it happened again I probably wouldn’t want to live. I probably would go back to doing drugs and trying to kill myself again because that little boy is going to make my life better. I’m going to make his life better and he’s going to make my life better. We’re going to thrive off each other as like, a team of mother and son. You know? We’ll be, like, unstoppable you know? No one’s going to take that away from my son. No one’s going to take my love away from him. No one’s going to take his love away from me. He’s going to have what I didn’t have. For sure. (Shelley)

Despite the hardships that the system can present in a mother’s life, the fact that mothers expressed the hardships confirms the commitment to their children. Shelley’s words are a reminder that despite a harsh lifestyle and the many struggles in her life, the love between a mother and newborn is deep.

**Against the Odds: Resilience and Overcoming Obstacles**

The lives of participants in this study were marked by trauma, loss and sadness combined with a lifestyle that included a lack of support, poverty and limited access to resources. These adversities women experienced over the course of their lives may have influenced the use of
drugs and alcohol and many of the women expressed a connection. However, despite all of the obstacles they faced, most of the participants were able to move forward in their lives, confronting the hurdles and forging ahead to create a better life for themselves and their babies. It was noteworthy that throughout the interviews, there was an undertone of resilience across participants. This resilience allowed them to approach their lives with hope for their future.

Chris was one of the participants who faced many obstacles in her life. Although she faced many challenges, including lack of support, severe addiction and abuse, Chris appeared to have an inner drive to survive and to help others. For example, she described a time when she confronted the obstacles in front of her in an effort to make a difference for other women:

I lost my kids, so I had a home, but I didn’t have no hydro or gas or anything. It was winter…so we were on the streets…I was the lowest I’ve ever been. I went on CBC Radio. They asked me to go on there. They asked me how it was living on the streets as a woman. So, I went on the show and we went around [name of street] asking…She had a microphone in my mouth and I was walking past my dealers and everybody and they wouldn’t even acknowledge me. They thought I was ratting them out or something but I was just speaking out for women and how it is for us living on the streets. (Chris)

The same inner drive that Chris appeared to have also seemed present in Emily. Emily had a very difficult life that included sexual abuse, poverty, abuse from partners and drug addiction. She spoke nonchalantly about her time in the hospital when she sat with her sick baby. She described feeling extremely judged and was accompanied by security guards when she spent time with her newborn. I asked how she could stay in the NICU under such adversity. She replied, “It was hard. Especially knowing the door is there and I could just leave to go get high” (Emily).
However, Emily continued to visit with her baby and I believe her behaviour reflects an inner conviction to forge ahead.

Madison spoke of the determination she had to be better for her family. At the time of the interview, she had been in the methadone maintenance program for a number of years. She spoke with pride of starting methadone in an effort to leave her past and addiction behind her. Madison’s determination and resilience was exemplified in her statements about the methadone program:

When I went there on my own I was really happy. Like proud of myself that I made it there alone. I didn’t need to…Like, most of my buddies that I had living in [name of community], most of my friends that I had were put on there because of CAS or got told to put on there by court or whatever to keep their kids or whatever. Me, I didn’t have that situation, so I was really happy that I actually did it on my own….Just determined. Determined to get help. ’Cause I’m like that. Once I set my mind to something, I go for it. (Madison)

Yolanda’s determination was evident in the way she spoke of her baby. Yolanda had firsthand experience of being in the child welfare system herself as a child. She knew when she found out she was pregnant that she wanted more for her child than she had herself. As an addict, Yolanda faced harsh judgement from those around her, and while on methadone she continued to feel judged as a junkie. Yolanda described her commitment to her baby and her resilience shone through when she spoke of the hospital staff:

I knew they were there to help and, as much shame I had, I had to put that aside. Because I had to deal with the kid too. So, I was like, “Okay, I’ll put my tail between my legs and,
you know, I don’t care what people think and I just need to stay healthy and make sure
the baby’s healthy.” So, I didn’t really care what people thought. (Yolanda)

Carol shared the same strength and determination as she spoke of her interactions with
health care professionals: “I’m feeling like, ‘Yeah, They’re probably judging me. Probably think
I’m this junkie. I’m waiting till they see I’m not’” (Carol). Carol’s statement about her
reflections on her life that clearly demonstrate her ability to overcome obstacles and find an inner
strength to strive for a better life for herself and her baby:

Years ago I looked at people with pills – I never knew about pills before and I looked at
them and thought, “I’ll never be like that.” Then all of a sudden, there’s me…And I am
still ashamed of it. Like, I don’t look at myself like how I used to be, you know what I
mean? But I’m learning to overcome that and just deal with it and just say, “You know
what? I’ve got to look ahead. I can’t keep thinking about the past.” And that was hard for
me. I never thought I’d even say that. (Carol)

Through coping with lives filled with pain and addiction all of the women exhibited
resilience. Shelley’s early life was significantly affected by abuse, loneliness and addiction.
When she spoke of her early life and I questioned how was she able to meet life’s challenges?
Shelley described the pattern in her life, and embedded in her dialogue I sensed an undertone of
resilience:

I had one tubal [pregnancy] from a rape. I had one abortion and like, three miscarriages.
So, that was really hard. It was really hard. The abortion was really hard on me too. But I
was really scared back then. I was only 19 and didn’t know. I didn’t have anybody. I
didn’t have anywhere to live. So that was the hardest part…I didn’t know that if I went to
welfare they would help me. I didn’t know that. I didn’t know anything about life. I
didn’t know there was help out there. I thought if you’re born the way I was born and raised, well, that’s the way you were going to die. You know? Sleeping on people’s couches for the rest of your life and bumming. I thought that’s honestly the way my life was going to be. And now that I know that there’s help out there from the government to start your life off, and I’m taking advantage of that. But nobody told me that, you know, when I was 20. “Hey, did you know that you can go to school? Did you know that you can do this?” ’Cause I would have done it. I would have been a good mom, even at that young age, at 19. But that’s what I mean. Like if I knew I could have taken care of that baby, I would have kept him. But too little, too late. You know? I found out too late and that’s what really messed me up. Then having my other son, I was totally straight, totally cleaned up, not doing drugs. I quit working as an escort and I just had my son. (Shelley) Shelley spoke of her life now that she is on methadone and not abusing drugs. She talked about wanting more for herself and her baby. Like the other women, Shelley expressed dreams for her future that included stability, a home, a job, a profession and the ability to have a normal life. After reviewing the transcripts, it was clear these women possessed something inside of them that had served them well throughout their lives. They had determination, an inability to accept life as it was, and hope for a life free of drugs and alcohol. I believe they will reach greater goals because of the determination and resilience that has already been a close companion to them through life’s challenges.

The Meaning of Motherhood

Perhaps the most powerful theme that emerged from the data was motherhood. The women who participated in this study had difficult lives. In many cases they did not have
positive role models as mothers, yet all of them spoke with a fierce sense of commitment to their babies as mothers. In many ways, the statements reflected a paradox regarding societal views of pregnant women who use substances. Contrary to the judgements the participants faced in their lives and the difficult lifestyles they lived, being a mother was extremely important to them. While the participants acknowledged that their substance use and other factors in their lives such as abuse, poverty, depression and isolation may not have been in the best interest of their children, they were very clear that regardless of life’s circumstances, what was best for their children was having a mother who loved them, cared for them and sometimes made difficult decisions to keep them safe and well. Women expressed wanting their children to have a better life than they did, and a better life included a mother who was stable. This is reflected in their commitment to methadone maintenance despite the many hardships it caused for them. Most chose methadone or traditional counselling treatment as a means of attaining better outcomes for their children. Although NAS was an outcome for all of the babies of mothers in this study, it was apparent that the participants in this research predominantly stayed with their babies despite the difficult experience of watching them withdraw combined with facing criticism and judgement from health care professionals. For the woman who didn’t stay, she was no less a mother to her newborn. Rather, motherhood for Chris was defined by loving and letting go. She was able to recognize her own limitations in caring for her baby and consequently chose a more stable life for her newborn through adoption. Chris spoke of the meaning of the difficult decision she made for her newborn that ultimately speaks to her role as a mother:

I knew he was going to be sick and I knew I couldn’t care for him. I knew he needed special medical attention. I couldn’t give it. I knew if I needed money for his medication or different kind of milks or whatever, I couldn’t give it. I couldn’t give him that
attention. I was too high on my drugs and there was no stopping it. So, I went to a private adoption and I told them the baby’s going to be sick when he’s born. (Chris)

While Chris chose to let go of her son in order to give him the kind of life she wanted for him, many of the other women held on as tightly as they could. They advocated remaining in the hospital during the baby’s hospitalization, and they got well for their baby and to ward off child welfare. Being a good mother was top priority for them. Yolanda spoke of the sacrifices and changes in her lifestyle she made to give her children a good life:

I wanted to be a mother that was there for her kids. I wanted to be there. I wanted to be interactive with them. I didn’t want to lose them. I wanted them to come home with me…I knew I wanted to be a good mom; a clean mom; like, stable. I didn’t want drinking. I definitely didn’t want drinking around my house and I wanted to do stuff with my kids and like, give them what they wanted; like, the kind of lifestyle I wanted – family. (Yolanda)

Like Yolanda, Carol also dramatically changed her life for her children. She established herself on the methadone program in an attempt to keep her children. Despite the absence of her own mother in her life, she spoke with such love for all of her children. Carol knew how her lifestyle had negatively impacted herself and she wanted to break the cycle for her own kids. She spoke of her dreams for the future:

I want to do better. I want my children to be proud. And I want them to be a better mother and father. I want them to be good – to treat their kids good and have a good opportunity. You know? I don’t want them to end up…I want them to grow up and have a job and education. So they can be good for their kids. (Carol)
The participants’ hopes for their children reflected their thoughts on motherhood. For Chris, although she made a decision to place her baby for adoption, her other children who also experienced NAS were in her care. Chris spoke of her kids and the meaning they gave her:

As long as I have my kids with me…They’re my everything. My kids are my everything. That’s my new empowerment. I feel powerful. I feel loved and I feel wanted and needed and accepted. Unconditional love. That’s what I get from my kids and that’s what I’ve always looked for. (Chris)

Although each woman’s life had many obstacles, including early trauma and loss that are more than anyone should experience, the resilience of these women was remarkable. None used their life circumstances as an excuse for their substance use, and all were at a place in their lives to know their current situation was not good for them or their children. However, the women only changed for the sake of the baby, not for themselves. This is evident in Shelley’s dialogue regarding the love she had for her son and how that love made her change her life and commit to treatment,

[if I didn’t have my son] I probably wouldn’t want to live. I probably would go back to doing drugs and trying to kill myself again because that little boy is going to make my life better. I’m going to make his life better and he’s going to make my life better. We’re going to thrive off each other as, like, a team of mother and son. You know? We’ll be, like, unstoppable, you know? No one’s going to take that away from my son. No one’s going to take my love away from him. No one’s going to take his love away from me. He’s going to have what I didn’t have.

Like Shelley, participants disclosed the growing love they had for their babies once they were born, and this continued to grow throughout their baby’s withdrawal. They wanted to be
mothers. They wanted to be the kind of mothers who fulfilled their child’s dreams, and many wanted to provide a better life than they had had. The participants were resilient, and did not allow their past and present circumstances to dictate their future path. Despite the hardships Shelley faced without mother to guide her in her own role as a mother, Shelley was very insightful on what motherhood meant to her:

Oh, I don’t know. Just always, always being there for your kids. Loving them no matter what. Giving every ounce of strength for your children. Just living for them. Being healthy for them. Being able to be there when they became parents, you know? I think that’s a mother’s responsibility. I do think it is to be there to be a grandmother, maybe. You know, be there to help your kids realize what a good parent is. I don’t know how I am a good parent but apparently I am but I never had one, so, I don’t really know how to be a mother because I never had one. But my son’s love me. You know, my older son, he loves me to death. Even though I’m not there, he’s happy. He has what he needs. He just doesn’t have me. But he has me on the phone and he knows that I love him. I think being a mother, that also too is like you have to go through pain so your kids don’t go through pain. You know, like I had to give my son up to give him a better life with his father because I knew on welfare I couldn’t do that. But I have a chance right now to be a good mom and stay with the father, but we’re working on it you know? If we can stay together, we’ll stay together. But I mean, I told him, “You gotta get a house in town. Counselling.” Not just me, but he does too. Doing that for my son, I think, is being a mother too.

(Shelley)
The Essence

According to Giorgi (1997), the essence of an experience is an articulation based on intuition of a fundamental meaning without which a phenomenon could not present itself as is. Furthermore, Creswell (2007) indicates that a reduction to the “essence” of an experience must be shared by all who experience it. This reduction to a shared invariant structure or essence is supported by Osborne (1990). As such, the goal of the phenomenological researcher is to reduce the data that is presented by participants to a shared description of the underlying structure of the experience.

Participants involved in this research disclosed personal, emotional and deep-rooted accounts of their experiences under the condition of having a newborn with NAS. The open-ended nature of the questions, combined with the skills of active listening, paraphrasing and probing techniques used throughout the interviews, revealed a shared understanding of the essence for the eight participants in the study.

Although the intent of this research was to explore mothers’ experiences of NAS, what emerged from the data was an exploration of the transformative nature of motherhood. Had this research been designed from a quantitative lens, the research question may have been, “What impact does NAS have on mothers’ experiences?” However, by designing an inductive qualitative study, what emerged from the data is an account of mothers’ experiences in the context of having a newborn with NAS. This account brought forth what was relevant to the women themselves, and this would not have been uncovered through a quantitative lens. The findings suggest that motherhood was the emergent essence of the experience, and while NAS
may have been a component of the experience, the transformation to motherhood was of primary relevance to women.

As such, the essence uncovered through this research is that becoming a mother was a transformative process. Given the wealth of data shared through this research, I considered a number of potential essences. However, I landed on transformation as the essence of the experience for participants because it appeared to most closely align to the direct descriptions given by participants. Despite complex and troubled lifestyles that led to depression, drug use and often a lack of regard for themselves, the participants engaged in a transformative process that provided new meaning and purpose that extended beyond themselves to another human being. Although their substance use was linked to NAS in their newborns, the women’s experiences were not defined by NAS. On the contrary, the experiences leading to NAS created a shared structure across participants. Motherhood is and was transformative.

Summary

In this chapter I have presented thematic reflections as directly stated by the participants themselves. The themes derived from the data, provided by participants, uncovered issues of relevance for the women involved. NAS is a significant event in the lives of mothers who have infants with the syndrome. However, NAS does not define them. Mothers brought forth a series of moments in their lives, from early trauma, abandonment, drug use and addiction to pregnancy and the birth of their children. To inquire into any one of these moments would have been insufficient to describe mothers’ experiences with NAS. Mothers were clear that their histories framed their experiences, and at the root of these experiences is that mothers are transformed by their children. Without knowledge of the histories, contextual issues and struggles in the lives of
mothers before they had children, the essence of transformation would not have revealed itself.
The thematic descriptions are accounts of the experiences of a courageous group of women who participated in a new discourse on what it is like to have an infant with NAS.
CHAPTER 6: DISCUSSION

The purpose of this research was to describe the lived experiences of mothers of newborns with NAS. Through phenomenological inquiry consisting of face-to-face interviews with eight mothers, the rich description of the experiences of mothers was explored directly from their vantage point. Firsthand accounts of their personal stories challenge the predominant stereotypical discourse which reflects mothers as responsible and not worthy of parenting (Boyd, 2004; Klee et al., 2002); essentially, participants revealed a desire to be good mothers, not “bad” addicts. The thematic descriptions of participants’ stories provide support for the essential nature of being a mother of an infant with NAS.

This descriptive phenomenological study used the seven steps of data analysis as outlined by Colaizzi (1978) and revealed nine themes that were salient for the participants themselves. Although this research initially centred on the issue of NAS, participants expressed a pathway of experiences that began early in their lives and led to becoming pregnant with their child with NAS. This pathway added context that was important to their stories, and participants expressed how their early experiences could not be discounted when outlining their experiences as mothers. As such, the thematic analysis revealed the following themes that weaved across all participants in the research 1) trauma, abandonment and loss 2) the cyclical nature of depression 3) the trajectory of drug use 4) becoming a mother: pregnancy 5) self-sacrifice: the paradox of methadone maintenance treatment 6) being a mother: the experiences with the newborn 7) ambiguous motherhood 8) against the odds: resilience and overcoming obstacles and 9) the meaning of motherhood. These themes supported the finding that the essence of the experience for participants was the notion that motherhood is a transformative process.


Background Context

Trauma, abandonment and loss. Mothers of infants with NAS have endured harsh scrutiny in the public eye. Not only are these women looked upon negatively because they use substances, but the judgement from the general public and mass media has also scrutinized and stigmatized them even more harshly because they are pregnant and responsible for another human being (Harrison, 1991, Klee et. al., 2002). In a publication entitled Mothers and Illicit Drugs: Transcending the Myths, Boyd (1999) criticized the media and health care providers for demonizing substance-using women by portraying them as unfit parents who scar their unborn children through their choice to continue using drugs. Furthermore, in recent media portrayals of the growing problem of NAS in Canada as presented by the Toronto Star (Brennan, 2012), while the article itself presents a fairly balanced view of the problem for both infants and mothers, the public commentary following the online article draws attention to the continued stigma towards women who use substances and the public’s lack of knowledge of the realities these women face. The public discourse makes frank statements regarding women as unworthy of parenting, ‘junkies’ who should be subject to forced sterilization, the need for immediate removal of children from mothers, among many other derogatory and blaming comments.

This research draws attention to the contextual realities for mothers of infants with NAS that serve to challenge the predominant stereotypical discourse. Whereas public interpretations of mothers who use substances is based on a perception of maternal failure to protect (Rhodes et al., 2010), mothers in this study reported their experience with trauma, abandonment and loss that caused severe emotional pain that impacted their lives and their drug use trajectory. This finding is consistent with other research that has identified a strong link between the experience of trauma and substance use (Cross & Ashley, 2007; Enoch et al., 2010; Haight, Carter-Black, &
Sharidan, 2009) and lack of parental role modelling (Jansson & Velez, 1999). Mothers’ reports of emotionally painful early experiences highlight the environmental, relational and historical experiences for women that shape their view of the world and their pathway toward addiction. These experiences shed light on early experiences as a critical time in development that could influence positive or negative decisions regarding issues such as drug use. Therefore, while many depict addiction as a choice (Russell, Davies, & Hunter, 2011), these mothers introduce an opposing contextual framework.

Despite knowledge of the link between trauma and addiction, there continues to be a dichotomous presentation of the issues faced by pregnant women who use substances and their affected infants. The literature typically reports on either the mother or the infant. In the field of NAS, which is focused on the infant’s complex care needs that are the result of the mother’s drug use, it is common for infant-centred thinking to prevail, leading to beliefs about mothers that are judgemental, oppressive and based on a limited understanding of the mothers’ realities. Marcellus (2003) stated, “It is easy in the midst of swirling rhetoric to dichotomize positions and take the side of the mother or the infant; what is not as easy is the ability to respect the alternate position and reach out for shared meaning.”

The early experiences faced by the mothers in this study may not be new to the field of addiction, but understanding mothers’ trauma histories and abandonment or loss of trusted relationships is an understudied and important finding in the field of NAS. The contextual factors, as presented by mothers, may help enlighten those who are primarily focused on the newborn. Knowledge of the realities and hardships faced by mothers may serve as a means of generating a new discourse that is more consistent with the realities of mothers affected by substance use. In accessing the accounts of women, the previously held notions of mothers who
choose to harm their newborn is at least challenged by stories that reveal a path that is clearly not one of choice but rather often of circumstances beyond their control. These circumstances affected their life course, feelings of depression, levels of support from which they could draw upon, recurrent emotional pain and vulnerability toward addiction.

In a study on postpartum depressive symptomatology, Tatano-Beck et al. (2011) found that two variables significantly related to postpartum depression (PPD) symptomatology. These variables were post-traumatic stress symptom scores and health promoting behaviours (healthy diet, managing stress, rest and exercise). Although it is unknown if early trauma for study participants was associated with diagnosed post-traumatic stress (PTS), the identification of traumatic experiences and participants’ perception of the link with depression and drug use may suggest that further assessments for PTS are needed among this population. The experience of trauma and the potential link to PTS and PPD may prompt early interventions to support mothers as they confront previous traumatic experiences. These interventions may provide benefit to both mother and newborn as poor maternal mental health has been linked to poor neonatal outcomes (Austin & Priest, 2005).

**Cyclical Nature of Depression**

Self-defined or clinically diagnosed depression was experienced across participants and there was a clear pattern of depression as a cycle between feelings of sadness to happiness or increased energy and back to sadness again. Participants reported that their drug use clearly began following traumatic and difficult times in their life that lead them down a path of loneliness and depression. These feelings proved too difficult to cope with and the opportunistic nature of substances and the subsequent positive feelings of energy, ‘normalcy’ and happiness
replaced their depressive feelings. Drug use eventually led to addiction, which then led to further depression for these women.

It has been well established that women with addictions often have co-occurring mental health disorders such as depression. These mental health issues may present or be exacerbated during pregnancy (Jansson & Velez, 1999; Powis et al., 2000; Winklbaur et al., 2008). Despite knowledge of these co-morbidities with addiction, the SOGC (Wong et al., 2011) addressed substance use in pregnancy by focusing primarily on harm reduction to mitigate the harmful effects of drug use on the developing fetus, with a secondary focus on addressing the psychiatric co-morbidities of pregnant women who use substances. One cannot discredit the need to reduce harm to the fetus, but the experience of depression among this cohort of women suggests a need for a simultaneous focus. An integrated approach to assisting mothers and infants affected by substances that prioritize the needs of mothers as well as infants is needed.

Knowledge gained regarding feelings of depression draws attention to the need for comprehensive services that meet the psychological needs of mothers while also addressing the needs of the developing fetus. An analogy can be drawn from airline safety demonstrations that urge passengers to don their own breathing mask before assisting others. In a sense, health care providers caring for affected newborns are focused on the health and safety of the newborn while mothers must contend with issues impacting their mental health on their own. However, research has demonstrated the link between maternal and infant mental health. An analysis of the behaviour and temperament of four year old children has been associated with high levels of maternal stress in the prenatal period (Austin & Priest, 2005). Furthermore, a mother’s ability to respond and interact with her infant is impaired when depression is prolonged or untreated (McQueen, Montgomery, Lappan-Gracon, Evans & Hunter, 2008). Knowledge of depression,
trauma, loneliness and abandonment is suggestive that the women’s psychological needs require attention first so that they can be more responsive to the baby. Furthermore, women with a history of depression are at a greater risk of postpartum depression (Marcus, 2009) which indicates that further care is required in the prenatal period for substance using women who may be experiencing depression. Knowledge of depressive symptoms and treatment for maternal mental health may have long-lasting benefits for postpartum maternal-infant mental health and interaction.

**Drug Use**

The findings from this research highlight the power of addiction, and the unexpected and unplanned patterns of ongoing and increasing substance use in women’s lives. This is consistent with other researchers who have found that women progress more rapidly toward addiction than men (Finnegan, 2010; Tuchman, 2010). The power of addiction has been well established (www.camh.ca; Hyman, 2007) and is based on psychological and physical dependence (American Psychiatric Association, 2000). All of the women spoke candidly about a significant history of drug use combined with a loss of control that culminated in addiction. However, although the experience of addiction in their lives was profound, the experience of becoming a mother was strong enough for most of the women in the study to seek help through methadone maintenance, traditional treatment, community support or prenatal care. This is consistent with Haight et al. (2009) in their exploration of mothers’ experiences with methamphetamine use. They reported a rapid loss of control among methamphetamine-using mothers that was indicative of addiction. Mothers became “obsessed” with the drug and indicated that nothing was more important to them, not even the children they loved. Like the methamphetamine users, mothers
of infants with NAS in this study, shared an “obsession” with drugs. However, the ability to rise above addiction because of impending motherhood distinguished these mothers from other substance-using women who were unable to overcome addiction. Each woman spoke of multiple unsuccessful attempts at ending their drug use prior to pregnancy. These attempts were linked to external factors such as finances or withdrawal rather than an intrinsic drive to discontinue use. Cessation of substance use occurred during pregnancy or the immediate postpartum period, suggesting that the commitment to the unborn baby acted as a strong motivator to change the trajectory of addiction. In a recent study by Massey et al. (2012) of 693 women who made postnatal adoption placements following their pregnancies, 37% of participants discontinued substance use during pregnancy. These findings report that seeing oneself as an adequate provider to others while pregnant was independently related to the cessation of substance use during pregnancy. How participants viewed themselves in regards to providing for others distinguished between pregnancy abstainers and pregnancy substance users. The commitment to the infant is consistent with the reports of mothers in this research and is an important issue for consideration in developing prevention programs and strategies for engagement in treatment services. Maternal commitment to neonatal wellness directs further efforts toward strengthening the prenatal attachment to the developing fetus to assist in engaging women in treatment.

In addition to the finding of the participants’ commitment to their newborn children, the firsthand accounts of the realities of drug use among this sample of women also challenges predominant stereotypes that impose a harsh judgement on substance use and, in particular, women who use substances. If the public could be enlightened about the extreme disadvantage and psychological turmoil faced by addicted women who become mothers, perhaps the discourse would become more sensitive and empathic with an increased focus on the systematic and
interpersonal factors that are present in women’s lives. Interventions that allow women to either refrain from the use of substances or become more aware of their substance use and its effects (which would help them make healthy choices regarding the use of contraception or the reduced use of substances prior to pregnancy) are needed. Contrary to public opinion, drug use is not a choice, but rather a medical problem with physiologic components and a social problem related to the consequence of trauma and abandonment. In fact, a common issue among pregnant women who use substances is the daily decisions to try to stop their use only to be unsuccessful because of the severe pain of withdrawal. Research that explores the issue from the perspectives of those experiencing the problem serves to increase understanding from a different lens and break down misperceptions that exist due to ignorance of the realities of this vulnerable population.

**Pregnancy: Becoming a Mother**

It is well established that discourse regarding pregnant women who use substances is largely negative and stereotypical with an undertone of mother-blaming (Boyd, 1999; Fraser et al., 2007; Murphy-Oikonen et al., 2010). For those in the field of NAS who care for affected infants, misperceptions regarding mothers are frequent and embedded in the narrow infant-centric view of the issue. One such misrepresentation is the view that pregnant women are choosing a life of substance use in lieu of choosing a healthy lifestyle for their baby (Murphy-Oikonen et al., 2010). The findings from this research challenge the predominantly negative discourse about pregnant women who use substances through detailed accounts of the experience of pregnancy while using substances. Participants reported feelings of extreme guilt, shame and fear, combined with a loss of control of their substance use, and a strong desire to discontinue their drug use and engage with treatment services. Emily’s comment of, “I pretty much killed my
kid, if you thought about it. I made him have a bad life”, exemplifies the inner struggle that many women live with when they are unable to discontinue their substance use thereby impacting their baby. For Emily, the guilt served as one motivator to pursue treatment for addiction. This is consistent with the findings of Radcliffe (2011) who found that pregnancy among women who use substances represented a turning point and re-evaluation of their substance use. The emotions reported by participants are pivotal in understanding the compassion that mothers feel for their infants and their goals for the future.

However, while the feelings reported by participants are an important element to the effort to refute commonly held myths, women’s accounts of the immediate connection they felt with the developing fetus are also an important source of knowledge for clinicians working with both mothers and infants. Through this maternal-fetal connection, the merging of infant and maternal bodies of knowledge emphasizes opportunities for interventions to improve the maternal-fetal relationship, and potentially both maternal and infant outcomes. This growing connection is critical to the development of a positive and supportive maternal-child relationship. By capitalizing on the emotion and empathy that women feel in pregnancy, mothers can be supported to recognize this strength in themselves and this could be used to further develop their relationship with their baby. Literature on integrated programs for substance-using mothers and infants have demonstrated positive gains in the reduction of maternal substance use and the development of the maternal-infant relationship (Bowie, 2005; Milligan et al., 2010). This is consistent with the goals of the roots of empathy programs (ROE). ROE programs are intended to foster empathy in children and act as an antidote to breaking the intergenerational transference of poor parenting and violence (Gordon, 2003). In the same regard, the empathy women feel for their baby in pregnancy may serve to positively develop a long-term relationship with the child.
and strengthen the opportunity for maternal custody of children in a more stable environment in lieu of foster care through the child welfare system.

Not only is the maternal-fetal relationship and the development of this connection a potential factor in influencing the long-term attachment of mother and infant (DiPietro, 2010), but it is also an experience that provides opportunity for change. Despite many women who use opiates failing to seek prenatal care due to fears of revealing their substance use (Eyler et al., 2005), the women in this study are open about their connection to their babies and their desire to ensure positive health outcomes for them. As such, consistent with the findings of other researchers (Macrory & Boyd, 2007; Radcliffe, 2011; Terplan et al., 2009), pregnancy offers an opportunity to engage women who use substances into routine prenatal care and treatment services. Through regular and consistent interactions with health care providers, prenatal care offers an opportunity to promote health, foster and strengthen maternal-fetal attachment, and provide important linkages to community support and treatment services (Public Health Agency of Canada. Canadian Perinatal Health Report, 2008).

Terplan et al. (2009) reported pregnancy as a “window of opportunity” for drug treatment intervention due to the connection between improved participation in prenatal care and the reduction of maternal and fetal comorbidities associated with substance use. In a study to determine whether prenatal care would lead to a reduction in adverse infant outcomes for newborns of mothers who take illicit substances, mothers with no prenatal care had the highest incidence of illicit drug use during pregnancy. When comparing mothers with adequate prenatal care to those with inadequate prenatal care (N=6673), women receiving adequate prenatal care had a significantly less likelihood of taking illicit drugs. Perinatal outcomes such as prematurity and low birth weight were highest among mothers with inadequate prenatal care and continued
illicit substance use (El-Mohandes et al., 2003). However, given that it is common for pregnant women who use substances to avoid prenatal care (Schempf & Strobino, 2009) there is a need to capitalize on the connection felt by pregnant women as an opportunity for pregnant women who use substances to engage with services in the antenatal period. Social workers play a critical role in seizing the moment of impending motherhood as a motivator to engage women with services that promote and strengthen the growing bond between mother and fetus.

**Self-Sacrifice: The Paradox of Methadone Maintenance Therapy**

The growing connection of mothers to their fetus during pregnancy is important for the development of long-term attachment and opportunities for change (DiPietro, 2010). All of the mothers in this research spoke at length of their desire to discontinue their drug use for the sake of their baby. Despite long-term drug use trajectories, most women in the study were committed to an MMT program, for the first time in their lives, with the goal of improving neonatal outcomes. Maternal feelings of responsibility began in pregnancy and fostered a commitment both to the pregnancy through methadone therapy and to the long-term health of their infant. All of the women in this study spoke of wanting to be in a more stable place for the child they were carrying, and for them, methadone was the only means of achieving this goal. MMT has been called the gold standard treatment for opiate addiction in pregnancy (Wong et al., 2011), but while there is a wealth of current research on MMT, there is an emphasis on outcome and quantitative data (Goff & O’Connor, 2007; Schilling et al., 2006; Ward et al., 1999). An important component in the delivery of MMT is developing an understanding of the impact and experience of being on a methadone program. There is little available research that explores the
experiences of those on MMT, and the issue for participants in this research was one that they felt was a strong component of their experience relative to the overall experience with NAS.

A literature search of the topics methadone and NAS is replete with studies on the efficacy of the treatment, the effects of MMT on maternal and neonatal outcomes, and a comparison of the treatment to other treatment modalities such as buprenorphine using quantitative methodology (Binder & Vavrinkova, 2008; Lacroix et al., 2011 McCarthy et al., 2008). While this research has advanced the scientific exploration of the treatment, there is little published on the motivations to seek treatment and the experiences of those who are on it. As women spoke of their feelings regarding MMT, the experience of individuals receiving methadone treatment is introduced to the discourse. This research finds that MMT may not be readily sought by women with addiction, but that pregnancy is a strong motivator to seek and sustain treatment. This knowledge is useful in allowing health care providers, social workers and addictions counsellors to seize a moment of opportunity that will assist in engaging women in treatment.

The findings also reveal the hardships of MMT. Given that MMT’s benefits are well established (Cleary et al., 2011), assumptions may be made that individuals on a methadone program are content with the treatment. However, participants in this research were seeking to be free of methadone, and if they do discontinue treatment there is a concern for relapse (Wong et al., 2011), which could have an impact on the long-term stability of the mother and the maternal-child relationship. This is not to suggest that methadone cannot be discontinued, but knowledge of women’s strong unease with the methadone program and their feelings of being trapped, as expressed through phrases such as “liquid handcuffs” or “making a deal with the devil,” make education about MMT and support for client goals important elements in preventing relapse.
MMT is controversial in the discourse regarding its use to mitigate the cravings associated with addictions. Radcliffe (2011) draws attention to the need for stimulant users to demonstrate their commitment to motherhood through abstinence from drug use completely, while MMT physiologically removes the need for illicit opiate misuse, thereby providing an opportunity to demonstrate commitment to the baby. Although this statement is accurate, the perception is that MMT is easy for those on the treatment program. Participants discredit this notion through their detailed reports of the hardships of the methadone program and the difficulties it has caused in their lives. It is clear that methadone offers substantial benefits, but these benefits come at a cost that cannot be dismissed. It is only through speaking directly with those in a methadone program that the program can be altered to continue to achieve the same benefits while reducing the impact of the program’s negative aspects.

The issue of feeling trapped on methadone challenges the rhetoric that pregnant women begin methadone treatment because they want a free and easily accessible drug. Although methadone is the gold standard treatment for opiate addiction in pregnancy, the irony of MMT is that methadone clearly has a hold on women that could be compared to the hold of illicit substance use. In the cases of both street drugs and methadone, the physiological need for the substance is a reality, and there are benefits and shortfalls to both. While there is no question that MMT reduces harm to both mother and infant and facilitates a more “normal” life, the hardships of the treatment cannot be discredited. The irony of MMT is that in comparison with illicit substance use, the hold of illicit drugs is also consistent with physiological need. Although the benefits of illicit drug use are difficult for non-users to identify with, the power of illicit drugs to decrease emotional pain and turmoil and make individuals feel normal have the same positive impact to the woman using substances than the positive impact of MMT.
Despite the treatment’s hardships and the multiple losses along the way, the benefits of methadone coincide with a commitment to the infant. Women were more likely to commit to treatment when they were focused on the well-being of the developing fetus. Methadone maintenance therefore offers an opportunity for engagement and relationship building for mother and infant. Social workers and other health care providers must use the loyalty of women to MMT to improve maternal and neonatal outcomes to engage women in appreciating the positive steps they have made to improve the lives of their children. This can be a starting place for family healing. Methadone offers an opportunity for daily contact with a health care provider. Combined with the self-identified commitment to the unborn baby as a motivator, this contact can be used to encourage women to maintain treatment. This type of support must be offered with a strengths-based approach in which women are able to recognize the importance of their commitment to their infant and the developing attachment.

**Being a Mother: Experiences with the Newborn**

Mothers spoke openly of their lives that were marked by addiction. The experience of addiction is profound among pregnant women. In 2002-2003, one in four women reported substance use during pregnancy (Havens et al., 2009), and although the motivations to seek a substance-free lifestyle are varied, the mothers in this research were unanimous in their accounts of motherhood as being the motivator they needed to commit to reduced or a complete cessation of substance use. One of the challenges for opiate-addicted pregnant women is that the treatment for the particular type of addiction is a prescribed opiate (MMT) that, despite its benefits, also causes an infant to experience withdrawal. When I spoke with women about their experiences with their newborns, the accounts of mixed emotions consisting of fear, guilt, shame, love,
happiness and anxiety were evident for all participants and painted a picture of the complexity of emotions felt by women who have a baby with NAS. Given that many of the women lack sufficient support in their daily lives, the complexity of emotions is concerning and important for health care providers and social workers, who should be attentive in supporting women and helping them navigate the emotional experience of an infant’s birth. Managing these emotions is essential for women to maintain their commitment through pregnancy and to further strengthen the mother-infant relationship.

The findings further draw connections to the relational context of mother and newborn. Regardless of the complexity of emotions experienced by mothers, the strength of their relationship with their newborns ensures that most of the participants did not retreat from their babies, but rather rose to the occasion and committed themselves fully to the care of their newborn despite feelings of guilt, shame, and fear. Interventions aimed at capitalizing on the relationship of mother and baby must be delivered in an integrated approach whereby parenting, trauma counselling, medical treatment of baby, and addiction counselling for mother, are offered holistically in a one-stop model. This model may provide more substantial benefits in building the capacity of mothers to attend and attach to their babies. Integrated programs have demonstrated promising trends for both mother and newborn (Milligan et al., 2010; Pajulo et al., 2012). Supportive programs must be developed that utilize a strengths-based approach to reframe fear and guilt into opportunity for healthy maternal involvement.

The experience of mothering an infant while the infant is experiencing withdrawal has not been explored to date. This is concerning given that to understand an infant’s withdrawal and provide holistic care, one must also explore the experience for the mothers of affected infants. This research has demonstrated the growing connection between mothers and their infants and
the power of motherhood as a motivation to seek a healthier lifestyle for the sake of the newborn. Health care providers who compassionately care for sick infants have the ability to detach from the infant when providing care is their job. The NICU is a foreign environment for women, one that is highly technical and evokes fear and stress (Franck et al., 2005; Heerman et al., 2005; Wigert et al., 2006). It is even more so because the ability for women to detach from the experience is not possible. Shelley was most articulate about this when she stated, “No one thinks, ‘Oh, the poor mom has to watch her baby go through this.’ It’s always like ‘Oh, the nurses have to watch the baby go through this.’ It’s like, that’s my baby.” In essence, women experience a type of culture shock in the new health care environment and their fears for the baby are combined with their fears for the unfamiliar. Despite their role in the infant’s current plight, every woman in the study experienced guilt and wished they could change their baby’s circumstances. Knowledge and awareness of this emotional turmoil for women can guide interventions that are more sensitive and empathic through understanding that regardless of drug use, methadone treatment or life circumstances, women remain mothers who are connected to their infants. This is a call for action in the field of health care to make engagement a central component to care. Mothers of babies with NAS require the same support and teaching that is offered to mothers of premature or ill infants. Attention should be taken to provide respectful care regardless of the cause of the problem or potential need for social service intervention.

**Ambiguous Motherhood**

The experience of becoming a mother and the realization of the maternal role upon birth of a newborn is an evolutionary experience for women that are fraught with uncertainty. Despite the uncertainty, the women embraced their new role and made positive changes in their lives to
reflect their place as a provider for their newborn. Mothers were well aware that their history of drug use and the accompanying lifestyle would not be looked upon favourably by child welfare workers. As such, fears of child welfare were a constant presence in their minds. These fears were not unfounded as evidence suggests that children born to women with substance abuse issues who are not stabilized through treatment or reduced use are more likely to enter the child welfare system, and maternal custody is more likely to be maintained among mothers who are more stabilized in their lives (Gilchrist & Taylor, 2009; Grant et al., 2011).

Mothers reported a sense of ambiguity in their interactions with health care staff and child welfare workers. As women integrated the meaning of this new role into their lives and made efforts to make positive decisions for the sake of their babies, their interactions with professionals made the role of mothers uncertain. The participants reported a perception that child welfare workers and nurses took over the role of mothers to their children. When interactions with these professionals were negative, the mothers were uncertain of their place in their newborn’s life. Conversely, positive interactions strengthened their resolve, commitment and participation in the care of their newborn.

Interactions with child welfare are common for mothers of infants with NAS given that there is a high proportion of substance-exposed infants involved with child protection services (Friedman et al., 2009; Gilchrist & Taylor, 2009; Grant et al., 2011; O'Donnell et al., 2009). Although the goal of child welfare agencies in North America is to strive to maintain family unity, substance-use recovery for mothers does not always mesh with the child’s needs for safety or the timelines for the agency to make decisions, creating a tension between child welfare workers and new mothers (Marcellus, 2003). While balancing maternal and infant needs is a complex task, mothers’ fears and challenges when faced with child welfare must be
acknowledged and efforts must be made to engage mothers in the care of their newborns at a critical time in the development of the maternal-infant relationship. By virtue of their authority, child welfare workers have a complex role in ensuring the safety of newborns while also respectfully and sensitively ensuring that mothers have the space and ability to fulfill their new roles. Through a relationship that is supportive, mothers of newborns who experience NAS can be encouraged by child welfare workers to assume their important role in the life of their newborn. Given that mothers identify with wanting what is in their newborn’s best interest, this commitment must be embraced as a strength when child welfare develops safety plans for infants.

**Resilience**

At its most basic definition, resilience is defined as the ability to thrive and overcome adversity during overwhelming life circumstances. Resilience involves the interaction of risks and protective mechanisms that interact to enhance adaptation to adversity over time (Stajduhar, Funk, Shaw, Bottorff, & Johnson, 2009). Each of the women in this study faced multiple life stressors and adversities throughout their childhood and into their adult life. The concept of a “risk chain” (Sandau-Beckler, Devall, & de la Rosa, 2002) is particularly relevant to the women in this study. A risk chain is a set of sequential linkages of distinct risk factors leading to adversity, in this case substance abuse. These women shared a risk chain through trauma from physical and sexual abuse, abandonment or loss of their own mothers, loss of loved ones and trusted relationships, poverty, substance use in their own families, and lives filled with increasing responsibility for themselves and others at a young age due to a lack of parental role models. Many women who face such challenges in life may give up or develop negative means of coping
with stressors. Participants in this study shared early adversities and each of them coped with these adversities through substance misuse. However, while adversity contributed to the life path for women, they did not blame their hardships in life for their substance use. Rather, they took responsibility for their use and strove for an improved future that is free of substances and in which they could take on a positive maternal role. What was evident throughout the interviews was that despite the adversities and the negative coping mechanisms, these women rose above them and created opportunities for themselves to get well with very little support.

It is difficult to ascertain where the capacity to overcome originated. There was clearly an inner drive to forge ahead, but the external reinforcement and psychological process of becoming a mother combined with the goal of wanting better for their children gave these women the strength and perseverance to overcome adversity and substance misuse through a changed worldview. In this regard, the anticipation for these women of becoming a mother served as one protective factor to mitigate the risk chain in their lives. Protective factors promote resilience and are defined as forces that assist in ameliorating risk, whereas a protective process is a clustering of factors that protect against risk (Sandau-Beckler et al., 2002). Participants’ protective processes were initiated and enhanced when they learned of their pregnancy. Learning of pregnancy, combined with the internal process of desire to “become” a mother lead to seeking prenatal care and mobilization of supports. Similarly, setting goals for the baby, coupled with a determination to provide a better life to their baby than they had themselves, created a protective process that enhanced resilience.

Not all women who use substances have the same resiliencies that were observed in this group of women. Many substance-using women who become pregnant may choose to end their pregnancy (Reardon, Coleman, & Cougle, 2004) or are unable to discontinue or reduce their
substance use (Lund et al., 2012). However, this sample of women had the resilience to be able to anticipate a brighter future for their children. This is consistent with research that explored the perspectives of illicit injection drug users and found that the ability to set future goals combined with hope for the future were indicative of a transformed view of the world and the activation of resilience (Stajduhar et al., 2009). Furthermore, Stajduhar et al. (2009) found that the activation of resilience was evident in the decisions of participants to engage in harm reduction strategies to ensure their health and safety.

Motherhood

The essence of the experience of mothers of infants with NAS revealed that motherhood is a transformative process. It was necessary to explore early experiences and the trajectory of substance use as this was important to the participants, and their reflections on the overall experience of mothering an infant with NAS and their early life experiences provided a contextual framework for the salient finding of transformation.

Despite the adversities faced by these women, both in their own childhood and throughout the process of mothering an infant with NAS, for most of the women, the determination to ensure a better life for their children that is inclusive of their role as a mother, activated resilience. Becoming a mother meant commitment, caring for someone other than themselves, and having an overall sense of purpose that they did not have before they had their children.

NAS was emotionally difficult for mothers to observe, however, involvement with the newborn in a care provider role assisted mothers in coping through the withdrawal period. Understanding their commitment to their infant can aid in the treatment of newborns through a
facilitation of the maternal-infant relationship at the most critical time for the formation of infant attachment, which is immediately following the infant’s birth. Bowie (2005) found that maternal abstinence from substance use was the most important factor in improving maternal child interactions. As such, supporting mothers in their commitment to attain sobriety or take part in MMT for the sake of better infant outcomes may also serve to strengthen the maternal-child relationship and lead to long term-gains for the family. Pajulo et al. (2012) state that one of the most prominent concerns among mothers who use substances is their inability to stay emotionally connected to the baby, that is, to keep the baby a priority even above their own needs. The authors indicate that strengthening the maternal-fetal attachment may foster maternal motivation to attain and maintain abstinence from drug use and make changes to improve neonatal outcomes. Findings from this research provide support for the impact of this relationship on abstinence, as participants in this research were connected to their babies in utero, and this connection acted as motivation to abstain from drugs or engage with MMT. However, the long-term outcomes associated with the changed patterns of substance use and maternal-fetal attachment require further research to uncover the most effective interventions with this population.

In 2011, Radcliffe studied a combination of 24 pregnant or postpartum women with a history of drug use and found that substance-using women who are seeking help are motivated to act in the best interests of their children. These findings are consistent with the findings of the current research, which found mothers to be concerned for the well-being of their infants, and this extended to a commitment to treatment and recovery in an effort to create a better life for their child. Participants claimed their role as a mother early in pregnancy and moved along a path toward wellness by way of either harm reduction or cessation of illicit substance use. Radcliffe
examined this process through a sociological lens and described pregnancy as an opportunity for a woman who uses substances to attain an identity as “normal” by becoming “clean.” Although identity was not explored in depth, this formation of becoming a “normal” mother who is free of substances was consistent with the reports in this research. While Radcliffe found participants acted to persuade her of their worth as mothers, participants in the present research demonstrated genuineness in their claims of the maternal role through their commitment to treatment, advocacy for their newborns, and connection to resources that they otherwise would not have used. The identities of participants were changed upon learning of their impending motherhood, and the fact remains that motherhood for all participants, whether they continued to parent their children or not, was a transformative process that created a sense of purpose in their lives that was previously lacking.

Findings on the power of motherhood to transform are important to the field of NAS, which is generally focused on the newborn. Knowledge of mothers’ experiences can enhance the relational healing of newborns, and this will extend beyond the initial postpartum period to the natural home environments to which infants will return upon hospital discharge.

**Summary**

This chapter outlines the salient findings through the conversations with eight women regarding their experiences as mothers of infants with opiate withdrawal. There are many consistencies with the literature in the accounts of women’s early experiences and struggles with addiction. However, the experiences discussed here of MMT, pregnancy and being a mother through the withdrawal phase offer insights into an issue that has lacked sufficient exploration in the literature. These findings are important in informing practice and identifying gaps in policy
that serve to separate rather than strengthen the maternal-fetal and maternal-child relationship.

The final chapter of this dissertation will address some of the implications of the findings for policy, practice and future research.
CHAPTER 7: CONCLUSION

The ability for motherhood to transform women is at the essence of the experiences of the eight mothers who participated in this study. This research was designed to explore the rich descriptions of mothers’ experiences of having a newborn with NAS. The women who came forward to volunteer for the study were courageous in sharing their personal stories that are often viewed negatively. I appreciate their trust in me to represent their realities in a way that was pertinent to them. Upon reflection, qualitative research to explore this issue proved valuable in uncovering realities that I had no prior knowledge of despite years of experience in the field and an immersion in the literature on NAS. Women shared stories of hardship and resilience that I would not have been able to capture with a quantitative design. In my original research proposal, I anticipated focusing on the experience of the mother through pregnancy and following the birth of the infant. I was naïve in approaching the study with such a narrow view and have learned from the women that the experience of having a baby with NAS is embedded in a much larger experience of their lives, their hardships and their resiliencies.

This group of women is disenfranchised and often misunderstood. I have endeavoured to represent their stories through their words and in the themes that were identified by them as most important to them. It is my hope that these stories will influence the discourse as well as the care and management of the entire family of a newborn with NAS. I have always assumed that understanding the newborn cannot be complete in isolation of the mother. The stories in this research demonstrate the accuracy in this belief. Perhaps the quest for survival from mothers as they overcome addictions and strive for presence and unconditional mutual love with their children will influence a path of healing for the family.
Knowledge of NAS has centred on the needs of the infant. The biopsychosocial model urges an appreciation of NAS from a broader and more comprehensive perspective. The voices and experiences of mothers are important in providing context to the newborn’s experience given that mothers and newborns are deeply affected by one another. Therefore, the experience of NAS is more than an experience of the neonate. The voices of the eight mothers in this research aid in understanding NAS from a different vantage point, and although the sample size for this research was small, the voices were nevertheless formidable in influencing future considerations in the field of NAS and addictions. The insights of mothers, through candid and rich descriptions of their lives, provide insight into future policy, practice and research. These implications are inferred from the findings. However, although the implications modest, this study may contribute alongside other research.

Policy

Pregnant women who use substances face multiple sources of stigma and vulnerabilities in their lives. The participants in this research highlighted the injustices they faced as a result of their substance use and lack of accessible resources. The experiences of mothers draw attention to the need for alterations to public policy in order to provide accessible resources and support for the development of the maternal-infant relationship. Changes at the policy level that reflect the unique needs of women may be necessary to support the needs of women and to enable them to claim their roles as mothers in the lives of their children.

Participants spoke of the transformative nature of motherhood beginning when they learned of their pregnancy and the growing connection throughout the pregnancy between mother and baby. This emotional connection in the prenatal period must be capitalized on to
foster early attachment in an effort to reduce the harm to both mother and baby through reduced use of substances and healthier lifestyle choices for mother and infant. Furthermore, public education and health promotion in the preconception period that is designed to increase knowledge of drug use and its impact on an unborn child may serve to influence positive health behaviours and/or treatment seeking.

Knowledge gained from this research regarding the growing connection between mother and fetus is an area for future research that may influence government funding agencies as they make decisions regarding the allocation of federal funds for early child development services. Although the findings only provide preliminary data on early attachment and change, further research exploring interventions to promote prenatal attachment and outcomes reflective of decreased substance use among women who use substances may lead to implications for public policy regarding the accessibility of early intervention programs. I would argue that child development can begin in utero with interventions aimed at improving both the medical and psychosocial outcomes for the newborn prior to birth.

The findings presented in this research reflect the varying needs of women in different life circumstances. Current prenatal programming does not meet the needs of women who use substances as many women report refraining from attending prenatal care while using substances (Burns et al., 2007; Jansen & Velez, 1999; Powis, 2000). To decrease barriers and increase accessibility to prenatal care, funding for prenatal care can be enhanced with supportive resources beyond the traditional physician visit to be inclusive of access for women to social workers, prenatal educators and other interprofessional staff. These comprehensive services will be more adept at facilitating the developing bond between women and their unborn children while also providing support to women who may be lacking it in their daily lives. This is
consistent with such programs as the CenteringPregnancy Model, a community based prenatal care strategy that provides comprehensive group prenatal services to vulnerable women. That program has demonstrated effectiveness in decreasing high risk outcomes such as stress, anxiety and depression among women with social and financial disadvantage (Benediktsson et al., 2013). The development of interprofessional resources to meet the unique needs of women with addictions can be a catalyst to mobilize broader community support to enhance maternal and fetal well-being. Furthermore, these services could work to mitigate the injustices present in circumstances such as lack of housing, poverty, financial assistance and access to non-judgemental health care.

In addition, public policy needs to address the unique needs of mothers with addiction issues. Gender-specific interventions in treatment such as counselling for issues like trauma, violence, abandonment and depression would closely align with the needs of mothers who use substances as described by the participants in this research. Integrated addiction treatment programs that merge addiction counselling and support with the development of programs designed to enhance empathy, attachment, peer support and parenting may also serve to strengthen the growing relationship between mother and baby as well as potentially mitigate comorbidities for both mothers and infants through a decrease or cessation of substance use. This recommendation is consistent with the recommendations from a systematic review that found evidence to support improved outcomes among the integrated treatment group (Niccols et al., 2012); however, further research into the efficacy of integrated programs is required.

Integrated programs must also meet the unique needs of women through single-gendered treatment that will enable the unique needs of women to be safely addressed with comprehensive counselling (Greenfield & Grella, 2009). Although some programs have been funded and
designated to jointly address the complex needs of mothers and infants (Boyd & Marcellus, 2007), these specialized services are more of an exception than a norm and are often required to routinely justify the need for specialized program funding during a time of significant service reductions. Government funding agencies must recognize the benefits of these programs through research designed to measure neonatal and maternal outcomes through program delivery.

In an effort to raise awareness of the impact of substance use on a developing fetus, and to direct women to the appropriate community support programs, non-punitive public education campaigns are needed to address the effects of maternal substance use on the fetus and neonatal outcomes. Although there has been much public education on the effects of alcohol on the developing fetus, many women are unaware of the impact of their substance use on fetal development. Education aimed at identifying risks and providing accessible resource links for mothers, and empowering them to seek assistance for their addiction, may decrease the use of substances or reduce harm among pregnant women or encourage their use of supports to meet their own needs for a healthy pregnancy.

However, participants noted the difficulty in abstaining from drugs despite knowing they needed to quit for their own health and for the health of their infants. Women reported that unsuccessful daily efforts at quitting were a result of the painful experience of withdrawal. Given this, in my opinion, government support is needed to enhance medical detoxification programs that would enable individuals with addiction to safely detox with minimal amounts of pain. This could serve as a starting place, particularly for women who wish to become pregnant, to become clean from drugs prior to pregnancy.

The current findings suggest that for some women, the connection between mother and newborn was a powerful force for positive change for the family. This finding lends merit to
further research on interventions aimed at the development of the mother-infant relationship during the hospitalization period for NAS and may promote changes to both infrastructure and philosophy of care in healthcare settings. Infrastructure improvements that change the NICU environment to enable mothers and babies to room together during hospitalization would allow mothers to assume care of their newborns at a critical time for the development of the maternal-child bond (Health Canada, 2000). The Family-Centered Maternity and Newborn Care: National Guidelines state

During the immediate postpartum period, the mother and newborn, within the context of their family or personal support, should be viewed as a unit…The parent-infant bond – the first step in the infant’s subsequent attachments – is formative to a child’s sense of security and has long-lasting effects. Indeed, the benefits to the parents should not be underestimated: this early physical contact with the baby affirms their sense of accomplishment and promotes their self-confidence as parents. Keeping babies and parents together should clearly be of the highest priority. (6.6)

The philosophical changes required to support the dyad include a belief at the frontline staffing level in the care of mothers and newborns as a dyad as opposed to viewing them as independent patients. This shift in care would prompt nurses to be cognizant of the mutual care needs of mothers and newborns. To achieve these changes in the health care system, financial resources are required for mandatory training for health care providers in anti-oppressive, anti-stigmatic practice, and funding is needed to build hospital environments conducive of mother and baby.

Like health care, the child welfare system also requires transformation to support the needs of families struggling with addictions. The current child welfare system is focused on the
protection of children, which often necessitates either supervision or apprehension of children from the family home. Particularly in the instance of addictions, it is well documented that many infants are placed in alternative care homes while mothers undergo treatment or access additional services (Sundquist Beauman, 2005; Vucinovic et al., 2008). Although under-resourced, there is a need for child welfare agencies to shift their current focus on the protection of children to a focus on family well-being. Simply, there should be a shift from a child welfare system to a family welfare system. While risk protection for children is essential, developing simultaneous services within the agencies to support women with case management will assist them in accessing services to meet their own needs and those of their children. For example, case managers can act as brokers by linking women to counselling for trauma, violence, depression, addiction treatment or maintenance, and parenting support programs. These programs must not be subsequent to infant needs but simultaneous in order to meet the needs of both mother and newborn. Through my experience working with child welfare, the current observed practice involves the development of a service plan that outlines areas of strengths as well as risks that must be addressed, for example, addictions requiring treatment or parenting classes. However, women require more than a service plan to make gains in the reduction of risk, and case management can assist women in engaging with support. It is noteworthy that many agencies make attempts to assist families while also protecting children, but the needs of mothers and other care providers nonetheless appear secondary to the needs of the newborn.

**Clinical Practice**

NAS is typically managed at the infant level. The needs of infants are great and interventions aimed at improving care to affected newborns are essential to mitigate the impact
of the syndrome. However, the needs of mothers are also importance. Furthermore, concurrent management of maternal and neonatal needs is essential in addressing the syndrome from a holistic framework. The women in this research drew attention to the early-life issues that had an impact on their trajectory through addictions and parenting. Therefore, practice implications are not only warranted upon birth of the child, but must also address issues stemming from the women’s family of origin.

Alcohol and substance use existed in the lives of the participants in this research from a young age. Most reported exposure to substances before the age of ten, which contributed to a sense of normalcy in the use of substances. Whether this early exposure had a hand in causing substance use is not definitively known. However, it cannot be discredited that substance-related issues existed in the homes of participants when they were children themselves. Thus, in my opinion, prevention efforts must extend from women to children by addressing psychosocial and psychological issues present in children before they grow up to become mothers. It is evident that the early experiences of drug use have had an impact on the life experiences of these participants. The data leads me to consider some possible practice related implications. Indeed targeted interventions prior to pregnancy that aim to intervene on issues of trauma, depression or lack of positive parenting may have a positive impact on improving mental health, enhancing healthy coping skills and reducing the initiation of substances among young girls. However, given the small sample size of the current study, further research is required to distinguish the efficacy of a targeted intervention to address the identified risk categories and intended outcomes.

The intergenerational impact of addiction, trauma, poverty, violence and addiction must be addressed through research and prevention efforts. Regardless of the point of entry into the social
service system, whether it’s social assistance, child welfare or health care, there is a need for social workers to complete comprehensive psychosocial assessments to understand women’s histories and intervene to heal the effects of trauma and reduce the prevalence of emotional pain leading to addiction.

One of the surprising findings in this research was the broken connection between the participants and their own mothers in their early lives for most of the participants in this research. They spoke candidly about the lack of maternal role models in their lives, and for those who had contact with their mothers; the relationship was predominately negative and unsupportive. Knowledge of the lack of maternal role model in the lives of these mothers identifies a potential gap in the provision of social work intervention at an early age. The lack of a maternal role model may affect women’s confidence in taking on a role as mother. For many people, unresolved issues from their past affect present behaviour. Services that offer hands-on positive role modelling of infant care may assist mothers in engaging and participating fully in the care of their newborns. For women who lack a positive maternal role model in their own lives, it may be necessary to enhance natural and organizational supports in order to promote positive parenting and decision making.

In addition to interventions in the form of role modelling and community support, women reported that the hospital experience can greatly impact their experience as a mother of an infant with NAS. While not all health care providers are judgemental, women reported an overwhelmingly judgemental and negative experience with the professionals caring for their babies. Professionals working with infants and mothers must be sensitive to the complexity of experiences and the vulnerabilities that mothers face. They should also refrain from identifying with the infant in the absence of the needs and role of the mother. Insight into the hardships and
challenges faced by mothers not only creates an alternative discourse and increased understanding in the public and health care sectors, but it also highlights opportunities for family intervention.

The first point of contact for many of these women will strongly determine how their experience will play out. Frontline care providers such as physicians, social workers and nurses need to develop an appreciation of the complexity of women’s lives and the power of their approach in setting the framework for mothers’ involvement with their newborns. Anti-oppressive training, combined with sharing personal stories of addiction in health care, will serve to reduce the stigmatic responses of health care staff and create an atmosphere of empathy. Empathy has the capacity to minimize guilt experienced by women and maximize the caring and compassionate traits of women so that they can provide care to their babies. Hospitals can facilitate family healing by developing partnership programs for nurses to partner with mothers to shadow hands-on care, nurture attachment, and provide the support that is missing in women’s lives. Having a positive early experience will help women more easily assume their role as mothers with support and guidance and positive encouragement. As such, health care providers should embrace the biopsychosocial model when caring for infants with NAS. Caring from a framework that is comprehensive and inclusive of mother’s experiences and needs may bring upon positive change for the family. Knowledge of mothers’ experiences can serve as a catalyst for engagement and service provision.

Providers, particularly social workers and nurses, who provide frontline care to mothers and newborns must partner with women and directly address the guilt mothers experience and assist women with healthy coping strategies. Women must also be supported in understanding the vital role they play in the life of their baby. My findings lead me to conclude that by
engaging women as they transition into a mother role, there is a strong potential for a more positive long-term connection and commitment to the baby. Hospital intervention programs aimed at facilitating the maternal-infant relationship must be developed to enhance the opportunities for strong attachments at birth. In addition, health care can be complimented with peer support programs aimed at partnering women with others who have had similar experiences in an effort to strengthen natural supports in the lives of mothers.

Given that MMT is considered the gold standard treatment for pregnant women with addictions (Wong et al., 2011), and participants disclosed the difficulties they experience with the methadone program, methadone treatment programs must develop programming that is consistent with the needs of their patients in an effort to maintain the commitment of women to the program. Addressing the fears of women in taking methadone and counselling women through the changes to their social networks and daily activities may serve to better prepare and support women who experience loss from methadone treatment despite its health benefits.

Despite the hardships of methadone, the resilience of mothers was evident in their reports of overcoming hardships in their lives. Identifying the resiliencies of mothers despite adversities highlights the strengths as opposed to deficits of this vulnerable population. Kumpfer and Bluth (2004) suggest that substance use disorders run in families. A mother’s resilience can be utilized to strengthen her family and decrease the intergenerational impact of Familial vulnerabilities and addiction. This study and previous research has identified pregnancy as a window of opportunity for positive behaviour change (Terplan et al., 2009), and given this fact and the resilience identified among mothers, social workers must foster the strengths of women while taking advantage of a moment of potential change. Social workers and health care providers are called
to action to support, encourage and develop linkages with additional resources during a time of high motivation for change.

**Research**

In the absence of qualitative research on NAS, the dominant understanding of the syndrome is from a medical perspective as an issue affecting infants. Although NAS is a condition in newborns, the present dissertation draws attention to the impact of the syndrome on mothers. Mothers’ experiences in turn impact her newborn. Therefore, further research on the relationship between mother and fetus or mother and newborn is needed to uncover opportunities for strengths-based interventions with families affected by substance use. The development of an in-hospital intervention to enhance and sustain the maternal-child relationship at the time of the infant’s birth and through the withdrawal phase is required to capitalize on the positive disclosures made by mothers. Interventions must be evaluated through qualitative measures with mothers, and statistical measures such as prevalence of involvement with child welfare and length of hospital stay.

Research is necessary to explore the contextual factors of newborns to garner a more holistic understanding of what NAS is and how it impacts a newborn. Further research is required regarding mothers’ experiences with substance use, resilience and parenting in order to inform practice and influence government and policy. Research on the efficacy of integrated programs that include health and psychosocial outcomes for families is required to design programs that can meet the complex needs associated with drug use and motherhood.
Limitations of the Inquiry

Although every effort was made to ensure that all aspects of the research design, sampling and analysis were attended to with precision, this research has limitations. The voices of eight women comprise the findings in this research. Although they are few in number, the experiences they shared are no less powerful. However, despite an open sampling technique, the mothers in this research were similar in their drug treatment pattern in that all except for one individual sought treatment for their addiction. Because of the stigma and judgement of substance use, particularly among women, reaching a sample of women who will be forthcoming about their substance use is very difficult as many women are secretive surrounding their use (Eyler et al., 2005; Powis, 2000). As such, the resulting sample of participants has the shared feature of being further along a wellness trajectory than many other women who continue to use substances. This is a limitation of the current research in that the experiences of active drug users may yield variations in the findings and thus lead to potential differences in policy and service recommendations. It is unknown how much of an impact the quest for substance use stability influenced the experiences as mothers of infants with NAS that were recorded in this study. While some of the features of the experience may be shared with non-treatment substance users, the insights from this group of women may yield some variations.

This limitation is combined with the limitation of any qualitative research study, namely, an inability to generalize findings to a larger population. Generalizability was not the intent of this research, however, and the voices of mothers have achieved the goal of opening up the dialogue and offering a glimpse into an experience not previously explored in the literature.
Furthermore, the experiences of participants are bound by culture, time and space. It is unknown if these experiences would be shared among women in a different place and time as these participants were living in the same city and received services from the same hospital and community. The issue of culture is also a limitation in the inquiry. At the outset of the research, participation was unknown and it was not until the research progressed that it was evident that both Aboriginal and Non-Aboriginal women participated. As a social worker for the past 15 years, I am aware of the impact of colonization on Aboriginal people, and I wondered how the experience of mothering an infant with NAS might be different for Aboriginal and non-Aboriginal women. However, as the research progressed, I struggled with inquiring directly into the issue of Aboriginal identity as I was consciously intending to reserve preconceived notions, consistent with descriptive phenomenology. Furthermore, the issue of Aboriginal identity did not appear as a major theme in this dissertation. This is not to preclude it as a theme as it is no less important than other findings in this research. Indeed, given its potential importance to those with an infant with NAS, as well as to the literature, further research could usefully explore this issue more directly. While the present dissertation has not done so, it has certainly identified several major issues of note.

Further limitations exist regarding the role of the researcher and the design of the study. The research question and design of the study, combined with the interview questions, style of interviewing and data analysis, were all chosen and approached by the researcher. In this respect, despite multiple efforts to attend to these potential biases through bracketing and reflexivity throughout the research, there may be subconscious influences unbeknownst to the researcher. Nevertheless, every effort was made to ensure that bias was reduced and that the experiences that were important to participants came forth through the data.
Conclusion

Qualitative inquiry can take you on a journey of exploration and understanding from the vantage point of individuals whose experiences differ from those of the researcher. When I began this process of inquiry, I had worked for many years as a social worker in an NICU and witnessed NAS on a near daily basis from the perspective of a health care professional, which is a position of authority. The power differential was evidently in my favour, whereas families faced observation, in some cases scrutiny and rigorous assessment, and they often floundered in an unfamiliar and highly technical environment.

My experience in the NICU prompted me to attempt to better understand the plight of newborns in a more holistic way through conversations to gain understanding of the experiences of their mothers. In retrospect, I, unbeknownst to myself at the time, like many others, identified with the vulnerable infant while viewing the mother on the periphery, at best or as the cause of the infants harm, at worse. Although I had an appreciation for the hardships of the mother, it was only through the research process that I truly saw infant and maternal experiences as inseparable. What evolved from this process was a comprehensive understanding of the experiences of mothers from their early experiences to how their current roles as mothers, including how past circumstances have informed their present situation. By understanding mothers, we are also able to better understand infants. Thus, this research speaks to the overlap and mutual effect of mothers and newborns.

The voices of mothers who use substances or receive methadone treatment during their pregnancies are seldom heard. Given the stigma and legal consequences associated with substance use in general, and specifically during pregnancy, mothers who use substances often
are not forthcoming with information about their lives. This research has enabled the voices of eight courageous women to be presented to influence the understanding of NAS from a different perspective. Thematic analysis revealed similar trends across participants that require further exploration, but the voices represented here are indicative of some of the struggles faced by women who become mothers under stark circumstances. While the study was intended to focus on NAS, the final result produced research that was much more broad and inclusive of early life experiences. The fact that mothers spoke of their life path not as a separate issue from NAS but as a part of the experience was a surprise to me and it gave me a greater appreciation of how circumstances contribute to one’s life journey. I have been privileged to bear witness to and record mothers’ accounts of their lives and hope that the presentation of the issues impacting mothers of affected newborns will influence reduced stigma, improved practice and a broader appreciation for mothers and babies as an inseparable unit.
REFERENCES


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