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The Role of Stigma in the Nursing Care of Families Impacted by Neonatal Abstinence Syndrome

Pamela Recto, PhD, RN; Kelly McGlothen-Bell, PhD, RN, IBCLC;
 Jacqueline McGrath, PhD, RN, FNAP, FAAN; Elizabeth Brownell, PhD, MA;
 Lisa M. Cleveland, PhD, APRN, CPNP, IBCLC, FAAN

ABSTRACT

Background: The current US opioid crisis has resulted in a significant increase in opioid use disorder among pregnant and parenting women. Substance use disorders, in general, are highly stigmatized conditions. Stigma serves as a well-documented global barrier to health-seeking behaviors and engagement in healthcare. While extensive research exists on the stigma of mental illness, few studies have explored the stigma experienced by families impacted by neonatal abstinence syndrome (NAS).

Purpose: Therefore, the purpose of this article is to explore the role of stigma in the care of families impacted by NAS.

Methods: In this article, we present a discussion about the effects of stigma on this patient population and provide exemplars of stigma experiences from our previous research and the existing literature.

Findings/Results: Mothers of infants with NAS faced the challenges of overcoming stigma as they were often ostracized, excluded, and shamed. Nurses who provide care for these women and their infants have reported experiencing ethical distress, moral distress, and compassion fatigue.

Implications for Practice: Greater awareness of the impact of opioid use on the maternal-child population has resulted in numerous educational offerings for healthcare providers; however, this alone is not adequate to end stigma. Fortunately, promising tools and methods have been developed for assisting nurses with addressing stigma in a manner that can be both nonconfrontational and highly effective.

Implications for Research: Future research is needed to explore and evaluate the efficacy of various existing strategies for counteracting harmful stigma in this patient population.

Key Words: family, mothers, neonatal abstinence syndrome, neonatal intensive care unit, newborn opioid withdrawal syndrome, nurses, opioid use disorder, pregnant/parenting women, stigma, substance use disorder

Every 15 minutes an infant is born experiencing the withdrawal symptoms associated with neonatal abstinence syndrome (NAS).¹ This is equivalent to 32,000 infants born annually with NAS and represents a 5-fold increase since 2004.¹ These statistics reflect a rise in opioid use during pregnancy that has also dramatically increased,² coinciding with the current US opioid crisis. Between 2008 and 2012, approximately 1 in 3 women of childbearing age filled a prescription for opioids every year.³ During this same time period, approximately 21,000 pregnant women reported misusing opioids in the previous month.⁴ This increase in

opioid use has resulted in a parallel rise in the development of opioid use disorders (OUDs) among pregnant and parenting women.⁵

Substance use disorders (SUDs), including OUDs, are one of many highly stigmatized conditions.⁶ According to Corrigan's⁷ model, stigma can result in the labeling of individuals or groups as inherently *different*, thus enabling discriminatory behaviors against them.⁸ These behaviors can ultimately deny stigmatized individuals of full social acceptance, thereby reducing their opportunities⁸ and fueling other social inequalities.⁹ Stigma serves as a well-documented global barrier to health-seeking behaviors¹⁰ and engagement in healthcare.⁷ For the family experiencing NAS, stigma has the potential to negatively impact outcomes.⁶ Therefore, in this article, we use Corrigan's model to explore the role of stigma in the care of families impacted by NAS (Table 1). We also share exemplars of stigma experiences and provide practice recommendations to improve the care of this often-stigmatized patient population.

STIGMA

Stigma is defined as "an attribute that is deeply discrediting," reducing someone "from a whole and

Author Affiliations: School of Nursing (Drs Recto, McGlothen-Bell, McGrath, Brownell, and Cleveland) and Center for Research to Advance Community Health (Dr Recto), The University of Texas Health Science Center at San Antonio.

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Correspondence: Lisa Cleveland, PhD, APRN, CPNP, IBCLC, FAAN, School of Nursing, The University of Texas Health Science Center at San Antonio, 7700 Floyd Curl Dr, San Antonio TX 78229 (clevelandl@uthscsa.edu).

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TABLE 1. Corrigan's Stigma Model: Multiple Dimensions of Stigma

| Social Cognitive Constructs | Public Stigma | Self-stigma |
|-----------------------------|--|---|
| Stereotypes | Pregnant women who use substances are criminals | Pregnant women who use substances are criminals |
| Prejudices | Societal agreement that pregnant women are criminals | I am an unfit mother (leads to lower self-esteem and self-efficacy) |
| Discrimination | Children should be taken away permanently; healthcare providers and case workers should not offer any help Loss of opportunity to facilitate recovery | Why even try perception: I am not worthy to receive help |

usual person to a tainted, discounted one,” leading to a “spoiled identity.”^{8(p3)} In general, stigma is a socially discrediting attribute, causing an individual to feel rejected and discriminated against.⁸ Stigma has been widely studied in the context of mental health¹¹; however, research specifically focused on the stigma surrounding SUDs is lacking, particularly among childbearing women.¹²

Stigma is a complex construct that can be difficult to explain in a single definition; therefore, it is sometimes divided into 2 distinct components^{7,13}: social cognitive processes (stereotypes, prejudice, and discrimination), and types of stigma (public stigma and self-stigma) (Table 1). Social cognitive processes of stigma are the general experiences common among stigmatized and often disrespected groups.¹³ For example, stereotypes are harmful, negative perceptions about a group that are typically learned from one's culture.¹⁴ Prejudice occurs when individuals agree with stereotypes.¹⁴ The combined impact of *stereotypes and prejudice* becomes apparent through negative discriminatory behaviors enacted against groups (Table 1).

Public stigma is the endorsement of stereotypes by the general population through discrimination. It may be embedded within communities, including private and governmental organizations, that intentionally or unintentionally proliferate stigma, which can serve to restrict opportunities for stigmatized individuals.¹³ Furthermore, stigma can seep into the community as well as broader institutions where it can undermine the delivery of lifesaving programs and interventions.¹⁵

Self-stigma occurs when individuals internalize the corresponding stereotypes and prejudice assigned to them by society.¹⁶ Self-stigma consists of 4 stages¹³: (a) becoming aware of stigmatization (ie, “society thinks I'm a bad person”); (b) agreeing with the stereotypes and prejudice (ie, “they're right, I am a bad person”); (c) self-application (ie, “I have this condition; therefore, I am a bad person”); and (d) decrease in self-esteem and self-efficacy (ie, “why should I even try?”). Empirical research suggests that the overall impact of stigma may indirectly sabotage treatment outcomes by perpetuating negative emotions such as low

self-esteem and self-efficacy.¹⁶ Furthermore, the extent to which individuals identify with the stereotype may determine the degree to which their self-esteem is impacted (ie, increased identification with a stereotype is related to lower self-esteem).¹⁷

STIGMA, PERINATAL SUDS, AND NAS

Attitudes toward pregnant and parenting women with SUDs have evolved over time. Records from the early 20th century largely reflected beliefs in the United States that SUDs were psychological conditions and not the result of moral failure.¹⁸ Childbearing women were perceived as being more prone to addiction due to biological vulnerabilities rather than poor character.¹⁹ In the 1920s, emerging knowledge about the addictive properties of opioids and the growing public fear of individuals who used them led to mounting concerns that they were a threat to the nation.²⁰ State laws were established to control drug use, resulting in individuals with SUDs being labeled as “disreputable.”^{20(p619)} In the decades that followed, the perception of SUDs as social and criminal problems rather than biological conditions persisted and contributed to the refusal of healthcare for many pregnant and parenting women with SUDs.²¹ In addition, there was less interest in substance use research, which potentially hindered the evolving science of addiction. This lack of knowledge and understanding perpetuated public fear and indignation toward individuals with SUDs.²⁰

Gendered perceptions of women who use substances are pervasive in the mainstream society.²² Women experience greater stigmatization than men who use substances, as this behavior is contrary to the public's beliefs about expected behavior in pregnant and parenting women.²² The stigma surrounding SUDs is particularly intensified during the perinatal period. Women express the challenges of overcoming stigma as they are often ostracized, excluded, and shamed.²³⁻²⁵ More specifically, pregnant and parenting women with OUDs are seen as “bad mothers” because, in the eyes of society, they violated the socially defined role of nurturing

caregivers.²⁵ Cleveland and Bonugli²⁶ found that mothers of infants with NAS felt judged by the nursery nurses because of their history of substance use. These findings were corroborated (L.M. Cleveland, PhD, unpublished data) by one mother who described her experiences when visiting her infant son in the hospital:

I went to go visit [my son] in the hospital. I felt like [the nurses] were judging me. I just thought they think of me as a bad mom—that I probably shouldn't even have my baby. That's how I felt.²⁶

Pregnant and parenting women with OUDs frequently encounter stigma in the form of punitive and exclusionary healthcare practices.¹⁵ As a result, they commonly described feeling excluded from the care of their infants, receiving judgmental verbal and nonverbal reactions from healthcare providers, as well as subjective scoring of NAS symptoms.²⁶⁻²⁸ In a study by Cleveland and Bonugli,²⁶ these feelings were further supported when one mother explained her feelings of being left out of decisions about her infant's care, "It felt like because I'm the drug addict and I'm the reason he's here, I have no say. I'm not welcome to have any opinions about my son's care." (L.M. Cleveland PhD unpublished data.)

Furthermore, pregnant and parenting women frequently shared how powerless they felt when facing discriminatory behaviors against them in the healthcare setting.²⁹ These behaviors were observed to be pervasive among some nurses. In a study by McGlothen et al,²⁵ one mother described the encounter that followed when she informed her infant's nurse that she intended to breastfeed:

At the hospital, one of the nurses was just like, "Oh, you're on methadone? Don't you think you shouldn't breastfeed?" Like, "the baby's going to be sick and you're going to be torturing it by giving it more methadone." I just said, "No, that's not right. That's not what I was told." So, I didn't listen to her. Then, she was also like, "You were using [drugs] while you were pregnant? Oh, my God ... they should put people in jail for that." I just thought, you're a nurse. You're not supposed to be saying that.^{25(p539)}

Consequently, psychological distress is common during the perinatal period because women with SUDs are simultaneously coping with issues related to child protective services interventions, family conflict, and the demands of treatment programs.³⁰ These difficult events and encounters may lead to or exacerbate existing or perinatal depression and anxiety disorders.³⁰ A woman's inability to cope with her emotions and the stress being experienced may perpetuate behaviors such as disengagement, decreased hospital visitations, and even defensiveness toward healthcare providers.³¹ In the study by Cleveland and

Bonugli,²⁶ one mother discussed how she used substances to cope with negative emotions:

We don't know how to cope with reality, and so we're scared of it. When we relapse ... just to go back to the comfort of numbing [those feelings]. I'm used to numbing it whether it's with Methadone [or other drugs]. [I pray for] the strength to cope with this reality.^{26(p323)}

Loss of custody, termination of parental rights, and fear of incarceration contribute to decreased retention rates in health and social services.^{29,32} Fear was a common sentiment among pregnant and parenting women with OUDs as they expressed worry and stress over child welfare involvement. They described this as being counterproductive to their recovery and a potential trigger for substance use relapse.^{31,33} Mothers in recovery also reported difficulty repairing their reputation within society as they tried to improve their lives by maintaining sobriety and becoming actively involved in treatment. However, even with these efforts, many continued to live in fear that child protective services would take their children. In a study conducted by Howard,²⁸ one mother discussed being cautious of her behaviors as they may be misinterpreted by social workers:

...being really sensitive to people in authority, you know, health care providers, or social workers, [people] like that. I tend to get a little bit more tight-lipped, because you don't want anything to get misinterpreted. Or get taken the wrong way. I remember being really anxious about that and not wanting something to happen to this baby.^{28(p76)}

The influences of public and self-stigma are a vicious cycle that erodes one's self-worth and dignity, potentially deterring individuals from engaging in treatment and maintaining recovery. Agreement with public perceptions of "unfit" or "bad" mothers and self-application of these labels may result in "why even try?"¹³ Internalization of stigma was a dominant theme that Knaak et al¹⁵ discovered through their research:

All the time I would tell myself I'm worthless. I don't deserve any of this. I should just go and off myself, or something like that. Lots of people around me eventually were telling me that I'm a piece of shit, that [I'm] doing really bad things, and we hope nothing good for you. And eventually I started to believe in it, because I heard it so much.^{15(p11)}

Feeling ostracized, diminished, and alienated, mothers become discouraged and may altogether cease to interact with or visit their infants and forgo efforts that facilitate their recovery, thus perpetuating

stereotypes about perinatal women with OUDs.^{25,31} In a study by Cleveland et al,³⁴ one mother recounted her strained interactions with the nursery staff:

You're not a very strong person when you're in the midst of your addiction. So [feeling unwelcome in the nursery] can be a trigger and it's easy to just be like, "You know what? Whatever! They don't want me to see my son? Then I'm not gonna see my son. I'm gonna keep using [drugs] and leave him there, and never go back."^{34(p124)}

These behaviors may dangerously backfire against mothers as they can be perceived as being apathetic and lacking interest in their infant, which can then lead to greater mistrust by healthcare providers and social workers.³¹

It is well documented, how perinatal women internalized the public's scrutiny of their OUD, especially when their infants experienced NAS.²³ For example, Cleveland and Gill²³ found that women expressed profound shame and guilt when observing their infants experience opioid withdrawal, as many blamed themselves for causing discomfort for their newborns. These findings are supported by one mother's statement (L.M. Cleveland, PhD, unpublished data):

I felt guilty because it was all my fault [he was] there. Even though I was doing what I was supposed to do. Clean and everything. My UAs [were] always clean. But I was feeling guilty because of what I was having to put my family through, and what I was having to put him through.

Although it may seem counterintuitive, perinatal women participating in research often explained that using substances was a way of achieving normalcy in their lives and a means through which they coped with public stigma and their perceived personal inadequacies.²² In addition, women used substances to cope with the pressure of fitting into society's standards of being a "good" mother or a "successful" woman. The cyclical pattern between public stigma and self-stigma is evident such that self-integrity deteriorates as perinatal women internalize the public's negative perceptions and attitudes about them. Women then find themselves using more substances in an effort to feel "normal," regain public acceptance, and restore their self-esteem. In a study by Cleveland et al,³⁴ it was found that this behavior was ultimately detrimental to perinatal women as many spiraled further and further into substance use.

NURSES' EXPERIENCES CARING FOR FAMILIES IMPACTED BY NAS

At the same time, healthcare providers reported the personal stereotypes and prejudices they assign to perinatal women with OUDs.³¹ Some have described

feeling stressed when working with this population due to difficulties with treatment engagement, maternal defensiveness, and concerns for the infant's health and safety.^{26,35} Some nurses also struggled to set aside personal biases and provide adequate care. In one study, a nurse participant explained, "Some nurses tend to forget that these are people just like anybody else, and they let their judgments get in the way of sometimes providing really good care."^{35(p39)} Negative attitudes can impact how healthcare providers interact with mothers who have OUDs, causing them to be less engaged in patient care, take a task-oriented approach, and have less empathy for the mother.⁵ In addition, healthcare providers may refuse to offer certain services or may not administer adequate pharmacological intervention for patients experiencing pain.³⁶ For example, Cleveland and Bonugli²⁶ described how one woman who participated in their research was refused any pain medication while she was giving birth to her stillborn infant:

I had a stillbirth caused by my drug use. I wasn't on Methadone then—it was street drugs. I was delivering [the baby] naturally and [the nurses] were getting stuff ready. [The baby] was coming feet first because she was very early and dead already for two weeks. It was a horrible experience. I remember asking [the nurse] if I could have something for pain and she said, "No—you wanted to take your own medicine, so now deal with it!" So [the nurses and doctor] said—"Look what you did to your baby!" But, I should have expected that after what I did to an innocent human being. My son's dad was there with me, but they kicked him out because of the way everyone was treating me. He said, "You don't have to treat her like an animal!" He was cursing at the doctor, so they kicked him out—and then, I was all alone in the delivery room in pain and delivering a dead baby.^{26(p122)}

Nurses reported experiencing *ethical distress*,³⁷ *moral distress*,³⁸ and *compassion fatigue*³⁹ when caring for infants with NAS. Often these feelings were intertwined with frustration and resentment toward the infant's mother for having used drugs during her pregnancy. In research conducted by Maguire et al,³⁷ one nurse described the high-pitched, inconsolable crying infants experience as a result of withdrawal and how she blamed the infants' mothers:

I want to take a recorder and just record their crying, and have the mom have to sit at the bedside and whenever they fall asleep just put it on and say, "Listen, we have to deal with this weaning process that you put them through. And you just get to come at the end of this and say, "Okay, I'm ready to get my baby."^{37(p283)}

In the same study, other nurses explained that caring for infants with NAS was not what they had

expected when becoming a neonatal intensive care unit (NICU) nurse. They envisioned their role as a critical care nurse with advanced skills and training providing care for medically fragile infants. This created an internal conflict for the nurses who perceived their role in the NICU as technically skilled rather than providing the “frequently mundane role of caring for infants with NAS.”⁴⁰ For example, one nurse participant explained:

I pictured myself caring for acutely ill babies and parents who were going through every emotion in the book. But I find myself caring for demanding babies who NEVER stop crying, walking around and around the nursing station with a baby in my arms or in a stroller, spending up to one hour trying to get a baby to eat a small amount of formula, but the poor thing is too disorganized to figure out how to suck. Dealing with parents can be just as time-consuming and frustrating. I did not intend on becoming a social worker.^{40(p309)}

In general, *coping with the families*³⁸ was found to be a significant source of distress for nurses caring for infants with NAS. Perceived stereotypes fostered the categorization of these families as inherently different from the nurses or other families in the nurses’ care. As a result, nurses shared a sense of *us*—“the nurses” and *them*—“the families or mothers” during interactions. One nurse described her disdain for mothers with SUDs, “And so then if we have 30-50% population of drug-abusing moms, that’s who you get to visit with while they are here.”^{37(p283)} These same nurse participants also described their perceived stereotypes of the typical personality traits of mothers with SUDs:

The mothers all have that same personality, whether they are prescription drug addicted, or cocaine addicted, they all have exactly that same.... They walk in defensive. If you’re nice to them to try to break that defensiveness, then they try to use you.^{37(p283)}

Nurses also discussed how not being able to communicate their true feelings was a source of distress for them:

You just want to say, your baby is here because you wouldn’t stop using marijuana, you wouldn’t stop using cocaine, and you wouldn’t stop oxycontin. And you can’t say that to them. That’s an issue too, where you have to be nice to a person that’s blaming you for what they’ve done.^{37(p283)}

In some cases, this sense of distress led to what researchers labeled as *burnout*.⁴⁰ Nurse participants reported frustration that extended beyond their inability to console the crying of an infant with NAS. They described how difficult it was to care for these high-need infants while still managing other infants

who they viewed as more critically ill. For example, in one study a nurse participant explained:

It’s easy to spend the entire 12-hour shift with one baby, holding, walking, feeding, and trying to soothe. On days when there are a lot of acutely ill babies in the NICU, it’s not unusual to have to listen to a baby’s shrill cry for hours on end because nobody has time to comfort him, and the parents are nowhere to be found. This is upsetting and makes me as a nurse feel that I am not meeting the needs of my patient.^{40(p310)}

IMPLICATIONS FOR POLICY AND PRACTICE TO ELIMINATE STIGMA

In this article, we used the concepts from Corrigan’s⁷ stigma model to guide our exploration into the role stigma plays in the nursing care of families impacted by NAS. Public stigma, whether intended or unintended, can exacerbate existing problems for pregnant and parenting women. These women are exposed to multiple obstacles as they navigate through the complex and, often, stressful process of seeking health and social services. Healthcare providers who held negative beliefs and attitudes about the women perpetuated the stigma they were already experiencing. In general, rather than receiving support, education, and encouragement, pregnant and parenting women with OUDs often experienced unrelenting judgment, shame, and guilt.¹⁵

The American Nurses Association (ANA) provides a *Code of Ethics for Nurses With Interpretive Statements* as a guide for “carrying out nursing responsibilities in a manner consistent with quality in nursing care and the ethical obligations of the profession.”⁴¹ Interpretive statement 1.2, *Relationship to Patients* states:

Nurses establish relationships of trust and provide nursing services according to need, setting aside any bias or prejudice. Factors such as culture, values systems, religious or spiritual beliefs, lifestyle, social support system, sexual orientation or gender expression, and primary language are to be considered when planning individual, family and population-centered care. Such considerations must promote health and wellness, address problems, and respect patients’ or clients’ decisions. Respect for patient decisions does not require that the nurse agree with or support all patient choices. When patient choices are risky or self-destructive, nurses have an obligation to address the behavior and to offer opportunities and resources to modify the behavior or to eradicate the risk.^{41(p1)}

Furthermore, in their revised position statement on the nonpunitive care of pregnant and breastfeeding women with SUDs, the ANA calls for nurses to demonstrate “compassion, competence, and confidence” when educating mothers about effective techniques for soothing infants’ withdrawal

symptoms. They also recommend that *all* nurses participate in educational offerings to improve their knowledge about mental health, SUDs, interpersonal violence, and local and state treatment options for pregnant and parenting women with SUDs.⁴²

Approaches for Addressing Stigma

While it may be reasonable to believe that education could be beneficial in reducing stigma, it is unclear whether existing evidence supports this approach. In general, there are 3 commonly used strategies for addressing stigma: *protest*, *education*, and *contact*.⁴³ *Protest* is dependent upon a moral higher calling (“we should be ashamed of ourselves for disrespecting pregnant and parenting women with OUDs”) to suppress stigmatizing thoughts or the stigmatization of groups. The purpose of *education*, then, is to dispel stigma by replacing it with factual information. Finally, the role of *contact* is to erase stigma by encouraging interaction between the “us” and “them.” Of these 3 strategies, *education* and *contact* have been the most widely studied and implemented.¹³

The use of *education* to eradicate stigma has been studied in the field of mental health and is appealing to many.⁴⁴ Providing education about mental illness can increase utilization of resources by consumers because they have a better understanding of the underlying causes of mental illness.⁴⁵ However, education has little impact on the *prejudice* and *discrimination* experienced by individuals with stigmatizing conditions.⁴⁵ For example, in studies focused on education about schizophrenia, when knowledge increased, stigma actually worsened. Therefore, researchers concluded that educational programs framing mental illness as a brain disorder, similar to how one might frame addiction, may have unintended consequences.^{46,47} This approach did result in a decrease in *patient blaming* since it implies that individuals are somehow genetically “hardwired” to have these stigmatized conditions. However, it also led to greater stigmatization as affected individuals were characterized as having poor prognoses and little hope for recovery.⁴⁸

In contrast, *contact*, which is the interaction of the public with individuals who have stigmatizing conditions, has a greater impact on attitudes and behavioral intentions than *education*.⁴⁹ Furthermore, long-term impact was greater following *contact* interventions when compared with *education*. But, to be truly impactful, researchers have discovered that the *contact* must include actual face-to-face, in-person *contact* rather than using other mediums such as videos or documentaries.⁴⁹

It is important to note that both *contact* and, even more so, *education* can increase pitying of individuals with stigmatizing conditions,⁴⁹⁻⁵¹ which can be a double-edged sword. For example, reasonable reactions

to mental illness are sympathy and sadness. This, in turn, can contribute to affected individuals being viewed as *victims*⁵² while increasing the willingness for others to assist and provide a helping hand.⁵³ Pity has also been successfully used to influence legislative agendas and increase funding appropriations.⁵⁴ However, pity can also backfire by portraying individuals with stigmatizing conditions as incompetent and unable to make adult-level decisions.⁴⁸ This can further result in *benevolence stigma*, which implies that affected individuals require a benevolent authority figure who can make decisions for them.⁵⁵⁻⁵⁹

Addressing Stigma in Nursing Practice

Greater awareness of the US opioid crisis’ impact on the maternal–child population has resulted in numerous educational offerings for healthcare providers.⁶⁰⁻⁶² For example, the Mommies Toolkit⁶⁰ was developed to bring greater awareness to OUDs in pregnant women and infants with NAS and to describe the key components of a successful recovery program in Texas. At the core of this program are supportive “wraparound” services such as free transportation and childcare to address potential barriers to accessing and remaining engaged in recovery support services. The Moms Ohio⁶¹ program is another helpful resource containing educational modules for pregnant women with OUDs and the clinicians who serve them. Their Web site also contains links to important community agencies making referrals for women who need services much easier. Finally, the Mothering and Opioids: Addressing Stigma-Acting Collaboratively⁶² toolkit is a helpful resource created in Canada. Developed by the Center of Excellence for Women’s Health, this toolkit is divided into 4 easy-to-follow sections all of which contain helpful tools to assist healthcare and social services providers who work with women and infants impacted by SUDs. The 4 sections of this resource are divided by the following topics: (a) addressing stigma in practice; (b) improving programming and services; (c) cross-system collaboration and joint action; and (d) policy values.

While these resources may be helpful, it should not be assumed that they alone are adequate or effective in ending the stigma faced by families impacted by NAS as they encounter the healthcare environment. This is because stigma can be deeply engrained in one’s attitudes and beliefs (implicit biases) that are intertwined with personal and life experiences.¹³ Regardless, nurses have a moral and ethical obligation⁴⁰ to address stigmatizing behaviors in the healthcare environment. In doing so, they actively resist contributing to the culture of stigma and promoting a change in perception and behavior. The act of acknowledging their implicit biases and then setting them aside can assist nurses to provide excellent care to *all* patients regardless of their background, race, ethnicity, or disease processes. However,

this requires moral courage, which has been defined by the ANA as:

...the willingness to speak out and do what is right in the face of forces that would lead us to act in some other way. Nurses who possess moral courage and advocate in the best interest of the patient may at times find themselves experiencing adverse outcomes.⁶³

Fortunately, several quality tools and methods have been developed for assisting nurses with addressing stigma in the patient care environment in

a manner that can be both nonconfrontational and highly effective. One of these tools is the ACTS (Acknowledge-Create Circumstance for Reflection-Teach-Support)⁶⁴ script, which was developed specifically for addressing peer attitudes and stigma in relation to substance use in pregnant and parenting mothers. Scripts are structured communication frameworks that can be highly effective in health-care settings by supporting effective communication, facilitating teamwork and consistency when initiating difficult conversations. The ACTS script (Figure 1) was developed in a community hospital to

FIGURE 1

Definition

The acronym **ACTS** is a guide for responding respectfully and constructively to clinical situations where you see your coworkers stigmatizing or judging your patients.

Rationale for Development

Frequently, health care providers share that they have a lack of knowledge about addiction. This lack of knowledge unintentionally may lead to stereotyped, stigmatizing, and judgmental attitudes, which can create an emotionally unsafe environment for patients. A key message to share with team members is that problematic substance use can be seen as a continuum, with addiction at one end of the continuum and recovery at the other end. Recovery is common, especially if people have caring, supportive people to help them.

Examples of comments that you may hear:

- How can she do that to her baby? She is a terrible mother.
- Some women can't have babies, and they would give anything to have this beautiful baby—she doesn't deserve it.
- If she really cared about her baby, she would . . . (stop using, leave the guy).
- I can't believe they are letting her go home with her baby—what kind of life will that child have?

ACKNOWLEDGE

Create safety by not directly criticizing. Rather, create an opportunity to open a dialogue:

- "I know, I used to feel the same way, then I got to know one of my moms and . . ."
- "I find it really difficult too, but I keep thinking about her circumstances and what has happened in her life."

CREATE CIRCUMSTANCE FOR REFLECTION

It is hard to challenge a coworker's values or judgments about a client. Instead of creating a confrontational situation, provide a circumstance that helps the other person to reflect on his or her practice:

- Ask questions or think out loud—"I wonder if she has experienced violence in her life? I wonder what may have happened to if this is the choice that she made?"
- "We probably need to think about some different ways of talking about this mom, since I am feeling uncomfortable with how this is being talked about."
- "It is difficult, I know. On the one hand, I feel frustrated and confused at her substance use/staying with her abuser, and, on the other hand, she is so gentle with her baby and trying to learn how to care for her baby . . . she asks all the same questions as any other mother."

TEACH

There are many opportunities for sharing this information with your team:

- Choose a high-quality, brief, and practical article about substance use and pregnancy that addresses attitudes and stigma. Leave it in multiple places around the unit.
- Ask permission—"Can I share something with you that I learned in a workshop?" (Share a little piece of information at a time).
- "I heard something that made me think about moms a little differently, about what I could do differently that would make mom feel better and me feel better."
- "I have learned that lots of women have experienced a lot of life before I have met them and learned to cope in ways that I don't necessarily approve of or agree with. I try to keep that in mind when I am working with them, and it helps me to take it slowly and try to build bridges rather than set up a wall between us."
- Use a recent clinical scenario to "unpack" what happened, what worked, and what didn't work. For example, you may discuss how a woman may have used substances as a way to cope with past or present abuse and violence . . . it may have been a rational decision for her to start with . . . and that by supporting the woman and the baby without judgment leads to improved outcomes for both.

SUPPORT

Provide immediate and continuing support to your coworkers as they try out some new approaches:

- Help them debrief: how did that work for you versus what you were doing before?
- Point out what you saw in the client—what the response of the client was to the new approach and also what you saw in your coworker: "I saw her smiling a lot when she was talking to you, that is new . . . she looked a lot more relaxed, and I saw her asking you questions about her baby . . . you looked more relaxed when you were with her."
- Share at staff meetings how you are seeing positive changes; ask how can we do this as a whole team instead of as just a few people.
- Identify and celebrate success. What worked? How can we do this more?

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address disrespectful and judgmental language some nurses had heard others using when discussing women who use substances. These occurrences created ethical conflict and moral distress for the individuals who overheard them. The ACTS script was designed specifically to help team members build the confidence and skills needed to address these behaviors effectively and respectfully with their peers.

The ACTS script⁶⁴ is unique because it helps nurses initiate conversations in the NICU about women who use substances from a place of curiosity rather than blame or anger. Based on the theoretical framework of Appreciative Inquiry (AI), the ACTS script allows for transformative change by assisting nurses to create opportunities for meaningful dialogue. AI is based on 4 phases of exploration: (a) what works, discovery; (b) what might be, dream; (c) what should be, design; and (d) what will be, deliver.

A practice-based example may be helpful in putting the ACTS script into action.⁶⁴ Consider that NICU nurse Karen is on shift one day and overhears her colleague, Jane, say the following about the mother of an infant with NAS: “How can she do that to her baby. She is a terrible mother.” Karen can employ the ACTS script by first *acknowledging* Jane’s statement and creating safety by not directly criticizing her. Instead, Karen uses this as an opportunity to open a dialogue with Jane by saying, “I know, I used to feel the same way, then I got to know one of my moms and I better understood the many challenges and sadness in her life.” Karen can then *create a circumstance* for Jane to *reflect* on what she had said. This is important because it can be difficult to challenge a coworker’s values or judgments. Therefore, rather than creating a confrontation, Karen provided a *circumstance* that helped Jane *reflect* on her practice. She might do this by asking a question or thinking out loud, “I wonder what must have

happened in her life to make her take this path?” To have even greater impact on her team, Karen might also look for opportunities to *teach* by opening a conversation with, “I heard something that made me think about moms a little differently, about what I could do differently that would make moms feel better and me feel better.” Providing *support* for her teammates as they institute alternate approaches is another important strategy Karen could employ. She might share at staff meetings the positive changes observed on the unit and invite the whole team to participate. Identifying the moral courage of her team members and celebrating every success, no matter how seemingly small, are also critical.

There are many ways the ACTS script can be integrated into nursing practice in the NICU environment (Table 2).⁶⁴ For example, opportunities to *learn* the ACTS script can be incorporated into nursing orientation through learning modules or simulations. Development of pocket guides that remind nurses how to use the script might also be helpful. *Peer feedback* is another important integration strategy and can be implemented by incorporating the ACTS script into general conversations rather than only using it for corrective purposes or performance management. It may also be integrated into professional and ethical competencies. Finally, the ACT script can be integrated as a *team development* tool by incorporating content about conflict resolution into team training activities.

CONCLUSION

Nurses have an ethical and moral responsibility to address the harmful effects of stigma experienced by mothers of infants born with NAS. Left unaddressed, this stigma may serve to drive women away from the very resources they need; therefore, jeopardizing

TABLE 2. How to Integrate the ACTS Tool Into Practice^a

| Element | Strategies |
|----------------------|---|
| Leaning | <ul style="list-style-type: none"> • Build into orientation modules • Integrate into simulation scenarios • Present at local meetings and workshops • Develop pocket tools |
| Peer feedback | <ul style="list-style-type: none"> • Discuss at team meetings so that the tool is familiar • Use for learning conversations, not just for behavior correction and performance management • Link to professional accountability and ethical competencies |
| Teamwork development | <ul style="list-style-type: none"> • Incorporate content related to conflict into team training • Align with other team training related to conflict such as the TeamSTEPPS CUS (Concerned-Uncomfortable-Safety issue) script or the two-challenge rule.⁶⁵ |

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Summary of Recommendations for Practice and Research

| | |
|----------------------------------|--|
| What we know: | <ul style="list-style-type: none"> • Stigma can prevent pregnant women with SUDs from seeking to services they need. • Failure to access prenatal care can jeopardize the health of the woman and her developing fetus. • Recovery from SUDs is possible. • Nurses play an instrumental role in dispelling the stigma that can accompany SUDs in pregnant and parenting women. |
| What needs to be studied: | <ul style="list-style-type: none"> • What types of interventions work best for dispelling stigma among nurses? • What impact does this have on nurses' career satisfaction? • How do interventions that address stigma affect the healthcare environment? • How do these interventions ultimately impact patient care and satisfaction? |
| What can you do today: | <ul style="list-style-type: none"> • Self-reflect on one's own personal stigma beliefs and acknowledge them. • Try implementing the ACTS script into your nursing practice. • Suggest that this script (or another stigma tool) be adopted as best practice in your patient care environment. • Recommend that the ACTS script be introduced in new employee orientation. |

their health and the health of their infant. Education and personal contact with stigmatized individuals are strategies that have been implemented to address stigma and have had varying rates of success and failure. However, these strategies are inadequate to mitigate the damage that stigma, in the form of *prejudice* and *discrimination*, can have on pregnant and parenting women with SUDs.

Nurses must implement more concrete and practical strategies for addressing stigma in the healthcare setting. Tools such as the ACTS script can be useful for practicing nurses who aim to combat stigma in the clinical setting and initiate difficult conversations with their peers in a manner that is both nonconfrontational and effective. The ACTS script can be included in orientation materials and clinical competencies. It can also be used to provide helpful peer feedback and conduct effective team development activities. As nurses, we are responsible for the ethics of our own practice and profession. Looking the other way or ignoring stigmatizing behaviors in ourselves or our peers is a direct violation of our *Nursing Code of Ethics* and must be challenged to protect the integrity of therapeutic nursing care and the rights and well-being of the patients we serve.

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