



Nurses' Descriptions of Interactions When Caring for Women With Perinatal Substance Use Disorders and Their Infants

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ABSTRACT: The purpose of this review is to describe health care interactions between nurses and women with perinatal substance use disorders, including interactions with their infants from the perspective of the nurses. Findings from 11 qualitative inclusion articles were synthesized using a metasummary approach. The majority of articles showed that nurses experience problematic interactions when providing care to women with perinatal substance use disorders and their infants, although some results indicated that some nurses engage in interactions that are assuring. Six types of conflictual interactions were identified: inadequate care, distressing, condemning, deficient knowledge, rejecting, and dissatisfying. Two types of therapeutic interactions were identified: compassionate and supportive. The findings underscore the importance of managing stigma, enhancing knowledge of the science of addiction processes, and promoting best practices when caring for this population.

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As the United States and Canada face the current opioid use epidemic, substance use disorders (SUD) during the perinatal period is a notable concern for maternal-child well-being in North America. The *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition,

defines SUD as substance use from a variety of types of substances (e.g., alcohol, opioids) that results in patterns of symptoms that include impaired control, social impairment, and health risks (American Psychiatric Association, 2013). Rates of maternal opioid-related diagnoses increased

CLINICAL IMPLICATIONS

- Seeking resources to reduce stigma can help nurses self-reflect, evaluate, and address negative perceptions and judgments they may hold against women with perinatal substance use disorders (SUD).
- Nurses can seek knowledge as it relates to the science of addiction to reduce stigma and improve quality of care.
- Nurses and other clinicians should be knowledgeable in clinical guidelines for best practices for women with perinatal SUD and their infants.
- With knowledge of the latest evidence, nurses can promote best practices to support women with perinatal SUD in their maternal role.

significantly from 3.5 to 8.2 per 1,000 childbirth hospitalizations among 47 states and the District of Columbia from 2010 to 2017 (Hirai et al., 2021). Women in the United States have also reported tobacco use (11.6%), alcohol use (9.9%), and illicit drug use (5.4%) during pregnancy (U.S. Department of Health and Human Services, 2019). Although recent national trends in maternal substance use for Canada are lacking, Ontario reported a significant increase in mother–infant dyads affected by opioid dependence, from 46 in 2002 to 800 in 2014 (Brogly et al., 2017). More recently, 1% of pregnant women reported opioid use and 3% of pregnant and breastfeeding women reported cannabis use in Canada (Statistics Canada, 2019).

Substance use during the perinatal period is a complex condition that can increase the risk for maternal morbidity and mortality, prenatal complications, and exposure to viral infections such as hepatitis C (Forray & Foster, 2015; Zibbell et al., 2015). Fetal, neonatal, and infant complications can include preterm birth, stillbirth, intrauterine growth restriction, and neonatal abstinence syndrome (NAS; Forray, 2016; Ko et al., 2016; Lander et al., 2015; Maeda et al., 2014; World Health Organization, 2014). Lifelong disabilities can occur in infants exposed to substances in utero, particularly disabilities linked to prenatal alcohol use (Chang, 2020).

NAS, a withdrawal syndrome, is commonly experienced by infants exposed prenatally to substances. This syndrome includes a variety of symptoms including irritability, tremors, high-pitched cry, loose stools, and poor feeding (Koehlerakota, 2014; Reddy et al., 2017). An increase in the incidence of NAS in North America has coincided with the opioid epidemic. NAS rates in Canada tripled between the

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years of 2003 and 2014, from 1.8 to 5.4 per 1,000 live births (Filteau et al., 2018). In the United States, rates of NAS increased from 2.8 per 1,000 births to 14.4 per 1,000 births between 2004 and 2014 (Winkelman et al., 2018).

Although the physical health implications for women with perinatal SUD and their infants are concerning, this population may also be at risk for a variety of negative psychosocial consequences. Substance use can result in challenges to parenting that can lead to poor maternal–infant attachment, which can interfere with healthy infant developmental outcomes (Forray & Foster, 2015; Hatzis et al., 2017; World Health Organization, 2014). Furthermore, women with perinatal SUD sometimes experience loss of infant custody as the result of substance use and often in combination with other factors such as mental health comorbidities, criminal justice involvement, and a lack of social support (Canfield et al., 2017).

Substance Use and Stigma in Health Care

Stigma associated with substance use can prevent individuals with SUD from seeking health care services (Ross et al., 2015). Erving Goffman (1963), a sociologist, defined *stigma* as “an attribute that is deeply discrediting” (p. 3). Goffman theorized that stigma leads to low self-esteem, depression, and isolation (Goffman, 1963). Stigma associated with substance use can hinder positive health outcomes and may occur at an individual level or may occur at a structural level through cultural norms, laws, and policies (Tsai et al., 2019; van Boekel et al., 2013; Wogen & Restrepo, 2020). Structural and individual stigma can detrimentally affect how health care is accessed (Tsai et al., 2019). Structural and individual stigma leave those with SUD more vulnerable to disruptions in their care through decreased participation, engagement, and successful management of their health (Paquette et al., 2018; Tsai et al., 2019; Wogen & Restrepo, 2020).

Owing to complications in the infant resulting from prenatal substance exposure, such as NAS, the perinatal period can be a particularly stigmatizing time period for women with SUD. Differing views of maternal substance use exist, with some health care providers viewing substance use as a moral failing rather than a medical condition; such judgment can interfere with appropriate maternal, fetal, and infant care (Terplan et al., 2015). Women with perinatal SUD can be the target of a punitive mentality and have reported a general evasion of health care as well as limited available care choices (Stone, 2015).

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outcomes (Harvey et al., 2015; Renbarger et al., 2020). However, nurses have reported that they hold judgmental and negative attitudes toward women and their infants affected by substance use (Raeside, 2003). Consequently, other studies have indicated that women with perinatal SUD often feel judged and stigmatized by their nurses. For example, women with perinatal SUD report that nurses view them as “bad mothers”; hear them make disparaging comments; question their ability to make decisions for themselves and their infant; and treat them differently than other women who do not use substances (Cleveland & Bonugli, 2014; Cleveland & Gill, 2013; Demirci et al., 2015). Negative relationships with nurses and other health care providers can have potentially damaging consequences on maternal–child health outcomes. For example, women with perinatal SUD tend to receive inadequate prenatal care by missing appointments, limiting disclosure of information related to substance use, and avoiding care altogether (Harvey et al., 2015; Phillips et al., 2007; Roberts & Pies, 2011). Conversely, nurses and other health care providers who approach women with perinatal SUD in a supportive, nonjudgmental manner may be able to increase women’s confidence in their ability to parent and, therefore, promote better maternal–child health outcomes (Harvey et al., 2015; Kramlich et al., 2018; Phillips et al., 2007).

Although a number of qualitative studies have described how nurses perceive health care interactions with women with perinatal SUD and their infants, the findings of these studies have not, to our knowledge, been well synthesized. A comprehensive description is needed to provide information that could be used to develop interventions to improve the health care experiences of women with perinatal SUD. Therefore, the purpose of this review is to synthesize the findings of published qualitative studies to gain an understanding of how nurses perceive health care interactions with women with perinatal SUD and their infants in prenatal care, labor and delivery, postpartum, and nursery/NICU settings.

Methods

Design

A qualitative metasummary, guided by Sandelowski and Barroso (2007), was conducted to synthesize the findings of studies focused on nurses’ descriptions of health care interactions with women with perinatal SUD and their infants. A metasummary is an approach used to systematically integrate findings from prior qualitative studies (Sandelowski and Barroso, 2007). Sandelowski and Barroso describe a *metasummary* as a “quantitatively oriented aggregation of qualitative research findings” that is topical or a thematic survey of data (Sandelowski & Barroso, 2007, p. 17). A metasummary approach was chosen because the findings of the inclusion studies were identified by the researchers as topical or thematic surveys. According to Sandelowski and Barroso, topical surveys are quantitatively informed, remain close to the data,

and can include lists and inventories of topics identified by the participants. Furthermore, thematic surveys move further from the data to describe themes or the patterned responses of participants (Sandelowski & Barroso, 2007). The research team for this study consisted of two nurse researchers with qualitative and maternal–child expertise, a master’s degree–prepared registered nurse certified in maternal–newborn nursing, and a graduate student in a counseling psychology program.

The metasummary was conducted using the following steps as described by Sandelowski and Barroso (2007): (1) retrieving and appraising research articles, (2) extracting the findings, (3) editing the findings, (4) grouping the findings and forming abstracted statements, (5) calculating manifest frequency effect sizes of the abstracted statements, and (6) developing a taxonomy of health care interactions between nurses and women with perinatal SUD and their infants.

The first step involved retrieving the bodies of research for inclusion in this review. Research studies were eligible for inclusion if they (a) were original qualitative research; (b) were published in English; (c) were peer reviewed; (d) were from the perspective of the provider; (e) described nurses’ experiences working with women with perinatal SUD and their infants during prenatal care, labor and delivery, postpartum, and nursery/NICU periods; (f) conducted in the United States or Canada; and (g) published no earlier than January 1, 2000.

The term *nurse* has been defined broadly to describe individuals who provide perinatal care to women and their infants and includes registered nurses, nurse practitioners, nursing students, and midwives. Studies were limited to those conducted in the United States and Canada because of differences in cultural and political views regarding maternal substance use among various countries worldwide. Studies had to be published no earlier than January 1, 2000, to accommodate the rise in opioid use in the United States and Canada (Belzak & Halverson, 2018; Hirai et al., 2021). English is the primary language of the research team; therefore, studies eligible for inclusion were published in English.

The research articles were retrieved through the databases of CINAHL, American Psychological Association PsycINFO, and PubMed using the following search terms: “health care provider,” “nurse,” “doctor,” “practitioner,” “physician,” “midwife,” “midwives,” “views,” “perceptions,” “narratives,” “beliefs,” “experiences,” “attitudes,” “knowledge,” “pregnant,” “pregnancy,” “postpartum,” “perinatal,” “maternal,” “antepartum,” “prenatal,” “substance use,” “opioid,” “methadone,” “drug use,” “buprenorphine,” “methamphetamine,” “alcohol,” “cocaine,” “neonatal abstinence,” and “smoking.” A hand search of Google Scholar was also conducted using various combinations of the search terms. Studies were eliminated if the title did not contain a term for maternal substance use and for a health care provider. Next, the remaining studies were reviewed by their abstract and eliminated if they did not meet inclusion criteria. Finally, full article reviews were conducted, and studies that met all



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inclusion criteria were included in the study. The retrieved articles for inclusion were stored in a shared electronic system. The fourth author then created a cross-study display table (see [Supplementary Table S1](#)). The inclusion articles were appraised by all team members to verify that all articles met the inclusion criteria and that the findings of each report were best described as topical or thematic surveys.

The second step of the metasummary consisted of extracting the findings in each of the inclusion articles. Statements were extracted if they described health care interactions between nurses and women with perinatal SUD and their infants. Next, the third step involved editing the extracted statements into complete, declarative sentences that stayed close to the words of the authors while clarifying them for readers who may not have read the report ([Sandelowski & Barroso, 2007](#)). Each edited statement recognized the population and setting (e.g., “NICU nurses in the United States . . .”) followed by a belief or action of the identified group (e.g., “. . . worry about the infants when they are discharged home”). Fourth, the edited findings were then grouped together by combining similar statements, and redundant statements were eliminated. All edited statements in each group were then summarized into abstracted statements that captured the essence of the groupings. The fifth step involved calculating the manifest frequency effect sizes for each of the abstracted statements by dividing the number of articles containing an abstracted statement by the total number of articles included in the metasummary ($N = 11$). This effect size is a quantitative index of the prevalence of each abstracted statement in the reports ([Sandelowski and Barroso, 2007](#)).

[Supplementary Table S2](#) displays the abstracted statements with the associated manifest frequency effect size.

Finally, a taxonomy of health care interactions from the nurses’ perspectives as described by [Sandelowski and Barroso \(2007\)](#) was constructed. Similar types of health care interactions were grouped and labeled, each with a term that described the participants’ experiences in the interactions. The taxonomy described the different types of health care interactions experienced by nurses when caring for women with perinatal SUD and their infants. The taxonomy of health care interactions is displayed in [Supplementary Table S3](#).

Results

The databases of CINAHL, American Psychological Association PsycINFO, and PubMed were searched, resulting in 1,462 articles for review. The hand search of Google Scholar resulted in an additional four articles. After duplicates were removed, 737 remained and were further reviewed. Next, articles were screened by their title and abstract, and thus 722 articles were removed. Fifteen articles were left for full review. Of the 15 articles, 4 were removed to narrow the focus of the provider role to nursing, leaving 11 articles for inclusion in this review ($N = 11$). Results of the systematic search are displayed in [Figure 1](#).

All study samples were unique and represented in the 11 inclusion articles. Nine articles were conducted in the United States, and two were conducted in Canada. All articles used a qualitative method ($N = 11$), which included three studies that used mixed methods ($n = 3$). Of the three mixed-methods articles, which contain quantitative and qualitative approaches, only the qualitative data were used in this synthesis. The majority of the qualitative inclusion articles were descriptive in nature, which produced low-interpretive findings ([Sandelowski, 2000](#)). However, one article used a focused ethnography approach ($n = 1$), one article phenomenology ($n = 1$), and another grounded theory ($n = 1$). Ethnography, phenomenology, and grounded theory are types of qualitative approaches that typically produce highly interpreted and in-depth descriptions of the phenomenon being studied. However, the findings of these articles were found to be at the topical or thematic level of abstraction and therefore are included in this review.

The metasummary approach resulted in a total of 306 findings that were extracted, edited, and consolidated into 13 abstracted statements. A manifest frequency effect size was calculated for the 13 abstracted statements and ranged from .27 to .82. [Supplementary Table S2](#) summarizes the effect sizes of the abstracted statements; as shown in the table, the findings with greatest relative prevalence were mostly conflictual interactions between nurses and women with perinatal SUD and their infants. The three findings with the greatest effect sizes showed that nurses struggle with negative judgements against women with perinatal SUD, have safety concerns for the infants, and have difficulties providing optimal care. Although most interactions were conflictual, it was shown that nurses do sometimes approach women with

FIGURE 1 ARTICLE SELECTION

perinatal SUD in a nonjudgmental manner and provide compassionate care (.64).

Taxonomy of Health Care Interactions

The 13 abstracted statements were synthesized into a taxonomy consisting of six types of conflictual interactions and two types of therapeutic interactions. The types of health care interactions, the contributing abstracted statements, and the number of articles that referred to each type of interaction are displayed in [Supplementary Table S3](#).

Conflictual Health Care Interactions

In all of the articles ($N = 11$), participants described health care interactions between nurses and women with perinatal SUD and their infants that they considered to be conflictual. The conflictual interactions resulted in

participants struggling with their negative perceptions of the women, feeling powerless, and experiencing challenges to providing adequate care to women with perinatal SUD and their infants. Six types of conflictual health care interactions were identified: inadequate care, distressing, condemning, deficient knowledge, rejecting, and dissatisfying.

Inadequate care interactions (statements 1, 2, and 8). Eleven articles described conflictual interactions that were addressed as inadequate care interactions. In these interactions, participants described difficulties in providing adequate care for women with perinatal SUD and their infants. Participants recognized that their negative perceptions of women with perinatal SUD interfered with their ability to provide optimal care. Participants described caring for women

with perinatal SUD and their infants as complex and time consuming. Participants struggled to maintain a balance in workload when caring for women with perinatal SUD and their infants while experiencing difficulty in attending to the needs of their other patients. Participants portrayed women with perinatal SUD as being more demanding of their time and their infants as “unruly.”

Participants also indicated that women with perinatal SUD did not have the knowledge they needed to actively participate in their health care and that of their infant. Participants described women as being surprised by their infants’ symptoms, not understanding the risks of substance use in pregnancy, and not understanding their infants’ treatment plan for withdrawal symptoms. In these health care interactions, participants were challenged by their own beliefs, the women’s lack of knowledge, and the complexity of care needed for the women and their infants.

Distressing interactions (statements 3 and 10). Ten articles described conflictual interactions that were indicated to be distressing. In these interactions, participants expressed concerns about the infants’ safety, the women’s ability to be a mother, and the long-term effects of maternal substance exposure. Participants were fearful about the infants’ safety in the home environment and worried the women with perinatal SUD would abuse or neglect their infants. Participants questioned the women’s ability to be “good” mothers and to provide basic care to their infants. Participants also were concerned about the long-term effects on the infants’ physical, behavioral, and cognitive development. Participants questioned whether the infants of women with perinatal SUD would be prone to addiction later in life. In these health care interactions, participants were distressed by their concerns and felt helpless, frustrated, and powerless in their ability to improve the situations of women with perinatal SUD and their infants.

Condemning interactions (statements 5 and 7). Eight articles described conflictual interactions that were identified as condemning interactions. In these interactions, participants openly blamed women with perinatal SUD for the infants’ withdrawal symptoms. Participants reported that the women did not participate in their infants’ care and believed they were not concerned with the health of their infants. Participants described women with perinatal SUD as “manipulative” and “selfish” and were convinced the women “just like to party.” Participants also described instances where they wanted the women to be penalized, such as by recording the infants when they cry and playing it whenever the women fell asleep or through the use mandatory birth control. In these health care interactions, participants were frustrated and resented the “poor choices” of the women to use substances during pregnancy.

Deficient knowledge interactions (statements 6 and 9). Seven articles described conflictual interactions that were labeled as deficient knowledge. In these interactions, participants described instances where they had limited knowledge and were unable to obtain necessary health information from the women to provide optimal care. Participants did not feel prepared in caring for women with perinatal SUD and their infants. Furthermore, participants had limited knowledge regarding breastfeeding and pain management in women suffering from perinatal SUD. Participants also indicated that women with perinatal SUD often withhold information, do not disclose their substance use, and do not always provide accurate information that would help nurses provide optimal care. Participants desired more training, education, and resources related to the treatment and management of women with perinatal SUD and their infants. As a result of deficient knowledge in these health care interactions, participants questioned their ability to improve care for the women with perinatal SUD and their infants.

Rejecting interactions (statement 11). Six articles described conflictual interactions that were labeled as rejecting. The majority of these interactions occurred in the NICU, and participants were mainly concerned with infants’ care and rejected the notion of providing care for the women with perinatal SUD. Participants believed that the women interfered with the infants’ care and even blamed them for the infants’ health concerns. Participants also described aggressive behaviors from the parents when trying to care for an infant in the NICU. Participants believed they had the ability help the infant but not the women with perinatal SUD. These health care interactions were stressful and frustrating; therefore, participants preferred to primarily care for the infants, involving the women with perinatal SUD only when necessary.

Dissatisfying interactions (statement 12). Two articles indicated conflictual interactions that were identified as dissatisfaction. In these interactions, participants expressed frustration and dissatisfaction at having to care for women with perinatal SUD and their infants who do not meet maternal cultural norms. Participants were frustrated over the demands associated with caring for women with perinatal SUD and their infants. Participants indicated they did not aim to work with this population or “intend to be social workers.” Participants described more challenging responsibilities that were not always congruent with the expected level of care typically provided in the health care setting. Participants were frustrated by the frequency with which they had to care for this population and preferred engaging in care interactions with women who do not have perinatal SUD. These health care interactions resulted in participants who were frustrated and dissatisfied with their nursing role when caring for women with perinatal SUD and their infants.

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Therapeutic Health Care Interactions

Although participants in the majority of articles described interactions considered to be conflictual, some articles illustrated therapeutic interactions between participants and women with perinatal SUD and their infants. In the therapeutic interactions, participants attempted to approach the women in a compassionate manner and support the maternal ability of women with perinatal SUD. The two types of therapeutic health care interactions identified were compassionate and supportive interactions.

Compassionate interactions (statement 4). Six articles were associated with therapeutic interactions labeled as compassionate. Participants in these interactions tried to approach women with perinatal SUD and their infants in a compassionate manner. Participants listened, were sympathetic, and built positive relationships with women with perinatal SUD. Participants recognized the importance of maintaining a nonjudgmental attitude and establishing a relationship with the women. Participants recognized the complexity of factors contributing to perinatal SUD and the associated vulnerabilities, expressing a desire to gain a better understanding of the women's experiences. Participants in these health care interactions acknowledged the importance of compassionate care for women with perinatal SUD and their infants, approaching them with empathy, understanding, and hope for their future.

Supportive interactions (statement 13). Three articles described therapeutic interactions that were labeled as supportive. In these interactions, participants supported women with perinatal SUD in their maternal role. Some participants recognized the benefits of having the women with perinatal SUD be the primary caregiver for their infants. Participants considered the women with perinatal SUD to be better than nurses at soothing their infants and decreasing the infants' symptoms of withdrawal. Participants believed the women with perinatal SUD should not be separated from their infants and should assume full care when possible. Participants in these health care interactions made efforts to support women with perinatal SUD by embracing them in their maternal role development.

Discussion

This metasummary included 11 qualitative articles that described health care interactions between nurses and women with perinatal SUD, including their infants. All of the articles identified conflictual health care interactions that

were labeled as inadequate care, distressing, condemning, deficient knowledge, rejecting, and dissatisfying. Less common were health care interactions identified as therapeutic and labeled as compassionate and supportive.

A significant finding of this review is that nurses often lack an understanding of the science behind the disease of addiction during pregnancy and view women with perinatal SUD and their infants negatively when providing care (Jarlenski et al., 2019; Lewis and Jarvis, 2019; Loyal et al., 2019; Salameh and Polivka, 2020). Although some nurses recognized the need for a nonjudgmental approach, others viewed the women with perinatal SUD in an unfavorable manner.

This resonates with findings from other studies in which women with perinatal SUD believed nurses judged them harshly and engaged in behaviors that were overtly critical as a result of the women's substance use during health care encounters (Cleveland & Bonugli, 2014; Cleveland & Gill, 2013; McGlothen et al., 2018). The women described disparaging behaviors from nurses such as rolling their eyes, whispering, or calling them a derogatory name. As a result of the nurses' negative judgements, women with perinatal SUD felt ashamed, frustrated, angry, irritated, and dismissed during health care visits (Cleveland et al., 2016; Cleveland & Gill, 2013; Kramlich et al., 2018).

Another noteworthy finding is that some of the conflictual interactions resulted from nurses' concerns over the women's abilities to be mothers as the result of their substance use (Maguire et al., 2012; Romisher et al., 2018; Shuler and Horowitz, 2020). Other studies have also found that conflictual relationships exist between women with perinatal SUD and nurses because of concerns over a woman's abilities to care for her infant (Cleveland & Gill, 2013; Demirci et al., 2015; Fenwick et al., 2001). Another study found that health care providers, including nurses, held judgments about women's "good mothering" that were central to providers' beliefs and clinical decision-making (Nichols et al., 2020). Women with perinatal SUD have felt scrutinized by nurses when caring for their infants because of their substance use. The women with perinatal SUD believed that their nurses sometimes prevented them from caring for their infants, such as by not allowing them to hold or touch their infants. As a result of feeling scrutinized when caring for their infants, women with perinatal SUD believed nurses questioned their ability to be mothers. The women believed nurses did not see them as deserving their infants and therefore felt unwelcome and out of place when they visited their infants (Cleveland et al., 2016; Cleveland & Bonugli, 2014; Demirci et al., 2015; Fenwick et al., 2001).

Consistent with other findings, we discovered that nurses experienced conflictual health care interactions, resulting in difficulty providing optimal care to women with perinatal SUD and their infants (Menard-Kocik and Caine, 2019; Murphy-Oikonen et al., 2010; Shaw et al., 2016; Nelson, 2016). Suboptimal care was sometimes the result of nurses' negative attitudes and lack of addiction knowledge. Additionally, the complexity of care

needed served as a barrier to women with perinatal SUD and their infants receiving optimal care. The nurses recognized that women with perinatal SUD often lacked the knowledge they needed to be able to manage their health care and that of their infants. This resonates with other researchers' findings that suggest women with perinatal SUD and their infants do not receive optimal care (Cleveland & Bonugli, 2014; Cleveland & Gill, 2013; Scott et al., 2017). Women with perinatal SUD have reported that they do not receive the health information they need and are not included in health decisions (Cleveland & Bonugli, 2014; Cleveland & Gill, 2013; Demirci et al., 2015; Scott et al., 2017). As a result of deficit-care health care encounters, women with perinatal SUD viewed nurses and other health care providers as unsupportive, uncaring, or untrustworthy and often discontinued care.

Limitations

This review has several limitations that should be considered. First, it considered the health care interactions only from the perspective of nurses. It is not known how women with perinatal SUD influenced the interactions with the participants. Next, the majority of the sample sizes of each report were small and lacked diversity. Therefore, it is not known how ethnic, racial, gender, and sociocultural factors influenced these interactions with women with perinatal SUD and their infants. Finally, differences between the types of nursing roles (registered nurses, student nurses, etc.) could not be determined. It is possible that the type of interaction varies depending on the nursing role. Future research should explore interactions among all roles of nurses and women with perinatal SUD and their infants in specific settings such as during prenatal care, labor and delivery, postpartum, and nursery/NICU. Studies with more diverse samples should be conducted to discover if differences exist between ethnic, racial, gender, and sociocultural groups.

Implications for Practice

Despite the limitations of this review, several clinical implications should be considered. First, nurses should consider relational aspects when providing care to women with perinatal SUD and their infants. Approaching women with perinatal SUD in a compassionate, respectful, and nonjudgmental manner rather than a punitive one can improve relationships between nurses and women with perinatal SUD and lead to positive maternal-child health outcomes (Kramlich & Kronk, 2015). Therefore, it is critical for nurses to self-reflect, identify, and address negative perceptions and judgments surrounding perinatal SUD (Renbarger et al., 2020). Nurses must recognize how their negative perceptions and attitudes toward women with perinatal SUD can have detrimental effects on the health outcomes of this population. The *March of Dimes* (2020) offers an assessment of health care providers' beliefs to determine if those beliefs are based on evidence and includes recommendations from trusted professional organizations. The *March of Dimes* (2020) also suggests avoiding

stigmatizing language when referring to women with perinatal SUD. The use of offensive terms such as "addict" or "substance abuser" can interfere with building important relationships between nurses and women with perinatal SUD (Ashford et al., 2018). Other resources and inventions exist to help nurses reduce and manage stigma against women with perinatal SUD. The *Substance Abuse and Mental Health Services Administration* (SAMHSA; 2020) offers a webcast series that aims to educate health care professionals in the use of nonjudgmental approaches when treating individuals with SUD. SAMHSA (n.d.) provides a list of stigma reduction resources found in its "Reducing Discriminatory Practices in Clinical Settings" guide. The *Government of Canada* (2020) provides resources for stigma reduction and prevention on its "Stigma Around Substance Use" website.

Next, nurses should consider resources to improve their knowledge behind the science of addiction to help reduce stigma and improve quality of care. The findings of this review clearly indicate that nurses often lack the information they need to care for this population. Training courses on the science of addiction have been shown to improve health care providers' knowledge, skills, and attitudes when caring for individuals with SUD (Barron et al., 2012; Meltzer et al., 2013). For example, one study found that a 10-hr addiction medicine course was associated with a modest attitude improvement of internal medical residents toward individuals with SUD (Meltzer et al., 2013). Another study found that training to reduce bias increased health care providers' knowledge about gender differences and substance use among women who are pregnant (Seybold et al., 2014). The *International Society of Substance Use Professionals* (2020) provides an evidence-based substance use curriculum for health care providers to enhance their addiction knowledge. The *British Columbia Centre on Substance Use* (2020) in Canada offers a variety of training for health care providers that includes an online addiction medicine diploma program, an addiction care and treatment online certificate, and training for enhanced addiction skills.

Additionally, enhancing clinical competence surrounding clinical guidelines for best practices can help promote optimal care and health outcomes for women with perinatal SUD and their infants. Nurses must continue to develop skills to provide the complex care needed for this population. SAMHSA (2018) offers a clinical guide for treating pregnant and parenting women with opioid use disorder and their infants. The clinical guide offers interventions and guidelines for care in prenatal care, infant care, and maternal postnatal care. Nurses should also ensure that women with perinatal SUD are adequately educated about substance use during pregnancy. The *Centers for Disease Control and Prevention* (2020) offers information on substance use during pregnancy, NAS, treatment, and resources tailored to women and families with substance use concerns.

Finally, it is important for nurses to understand that SUD is a chronic condition and that incorporating best practice measures will support women with perinatal SUD in their maternal role. Research has shown that involving women with perinatal SUD in

the care of their infant diagnosed with NAS promotes more healthful outcomes for the infant. For example, breastfeeding has been shown to decrease an infant's need for pharmacologic treatment of NAS, decrease NAS symptoms, and decrease the length of infant hospitalization (Bagley et al., 2014; Welle-Strand et al., 2013). Moreover, the American College of Obstetricians and Gynecologists and American Society of Addiction Medicine (2017) suggest that breastfeeding should be encouraged for women who are stabilized on an opioid agonist, not using illicit substances, and have no other contraindications. Breastfeeding also facilitates the mother–newborn attachment process (American College of Obstetricians and Gynecologists & American Society of Addiction Medicine, 2017). In addition to breastfeeding, parental presence during newborns' care and rooming-in, a postpartum care model where a newborn remains in the hospital room with the mother, has shown to reduce the severity of NAS (Holmes et al., 2016; Howard et al., 2017; MacMillan et al., 2018). Avoiding the separation of women and newborns and offering rooming-in should be considered when possible to promote better health outcomes in the treatment of NAS. Nurses should consider evidence-based practices such as the eat, sleep, console (ESC) approach when caring for newborns with NAS. Eat, sleep, console was developed to focus on the comfort and care of newborns with NAS by using non-pharmacologic methods and has been shown to be effective in decreasing newborns' need for morphine (Grossman et al., 2018). Additionally, SAMHSA (2020) offers other supporting evidence and clinical guidance on the care of infants with NAS.

Conclusion

The findings of 11 qualitative articles that described health care interactions between nurses and women with perinatal SUD, including their infants, were synthesized using a metasummary method. Although participants described several positive interactions, the majority believed that the health care interactions were difficult and conflictual. The findings of this review underscore the importance of stigma awareness, knowledge of the science behind addiction, best practices with this population, and relational aspects to providing care. The findings of the review are based only on participants' perspectives and did not reflect a wide range of ethnic, racial, gender, and sociocultural groups. Future research should explore health care interactions between all levels of nursing and women with perinatal SUD and their infants and include more diverse populations. The findings from this metasummary indicate that nurses should have awareness and management of negative judgments and attitudes against women with perinatal SUD to develop therapeutic relationships and promote improved maternal–child health outcomes for these vulnerable populations.

Supplementary Materials

Note: To access the supplementary materials that accompany this article, visit the online version of *Nursing for Women's Health* at <http://nwhjournal.org> and at <https://doi.org/10.1016/j.nwh.2021.07.006>.

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