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Moral Distress Experienced by Behavioral Health Clinicians Who Have Worked with Maternal, Opioid-Using Clients

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Abstract

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Jill Lee-Hubble

MA, Concordia University, 2009

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

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Abstract

Moral distress (MD) is a concept that has been well studied in nursing and other medical fields as a precursor to provider burnout. Understanding how MD impacts behavioral health (BH) clinicians provides insights for counselor educators and supervisors to identify clinical situations that often lead to MD. This qualitative phenomenological study explored how MD was experienced by five BH clinicians who have worked in residential and hospital settings providing counseling to maternal, opioid-using clients. Substance use during pregnancy is highly stigmatized in society; thus, a feminist conceptualization was integrated as the theoretical framework. Interpretive phenomenological analysis (IPA) informed the research methodology and was followed for data analysis, including reading & re-reading transcripts, creating exploratory notes and experiential statements, sorting those statements into clusters, and identifying experiential themes. These were shared with the participants for synthesized member-checking. Finally, a cross-case analysis was completed to identify themes. Results included seven primary themes and nine sub-themes. Themes centered on specific systems that cause MD when working with the population, ways to mitigate MD, and how the experience impacted the perception of MD situations as providers and organization leaders. Recommendations include integrating information about MD in formal and continuing counselor education and further exploring how those in leadership positions identify and approach MD. Like other health care professions, the counseling profession is experiencing post-pandemic stresses and workforce shortages. Understanding MD is pivotal to training and retaining healthy counseling practitioners.

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Dedication

This dissertation is dedicated to my family. To my children, Tori, Gabe, and Izzy: everything I do, I do for you. I hope you see my work and dedication and know it is all because I want to be part of making the world a kinder, better place for you. Thank you for always being there to give me a hug, to tell me you are proud of me, and for being so understanding when Mommy had to work on my dissertation. You all put in so much effort with me, and I could not have completed this journey without your love and support. I am so excited for what the future holds for all of us. I love you more than you know or can imagine, my darlings.

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Chapter 1: Introduction to the Study

According to the National Institute on Drug Abuse (NIDA, 2021), the most recent surge in opioid overdose-related deaths began in the 1990s when pharmaceutical companies assured physicians that the new opioid formularies were shown to be non-habit forming. The surge in illicit opioid use in the United States has led to more women seeking treatment for an opioid use disorder (OUD) during pregnancy, increasing the demand for behavioral health (BH) clinicians to provide services to this highly complex population (Martin et al., 2015). The existing workforce shortage of BH clinicians, combined with high turnover rates, has led to a gap in services for maternal, opioid-using clients (Knudsen, 2006; Martin, 2015; Powell, 2015; Young, 2015).

One explanation for the high turnover rate in substance use treatment is burnout by BH clinicians (Knudsen et al., 2006). A concept studied in nursing for over two decades, moral distress (MD) is reportedly a precursor to provider burnout (Dalmolin et al., 2014). However, as noted by Nuttgens and Chang (2013), the field of counseling has not explored MD as it relates to clinicians despite the similarities between nursing and BH clinicians as frontline workers. They argued that more research in this area would help supervisors understand how to mitigate the impact of MD experienced by BH clinicians. It follows that reducing the impact of MD may slow turnover in the field, thus allowing for more stable staffing in programs.

Through my research, I sought to understand BH clinicians' lived experiences when working with a small but complex group of clients facing considerable barriers to care while pregnant (Smith et al., 2012). These barriers exist on three distinct levels: the

individual level related to substance use; at the societal level, where pregnant women experience stigma and bias not only from their community but also in medical settings (Shaw, 2016; Syvertsen et al., 2021); and on a broader level, where they are often seen by society as a failure to womanhood and motherhood (Campbell, 2015). Chapter 1 includes an explanation of the background and history related to MD and counseling for maternal, opioid-using clients, my research problem statement, the purpose of the study, research question, theoretical framework, nature of the study, definitions, assumptions, scope, and delimitations, limitations, and significance.

Background

Andrew Jameton introduced the term MD in 1984 to describe a phenomenon where the nurses had the experience of knowing the right thing to do, but institutional and professional constraints prohibited the right course of action. (Jameton, 1984, p. 6). These events are often caused by caring for specific populations and settings where resources can be limited (Jameton, 2017). After the term was coined for the profession of nursing, other healthcare fields began to research the impact of MD on other healthcare providers, including psychologists (Austin et al., 2005) and social workers (Kuip, 2020; Lynch & Forde, 2016; Oliver; 2013).

MD has been identified as a factor in turnover in human service professions and appears to be a precursor to burnout (Dalmolin et al., 2014). According to Lamiani et al. (2017), MD differs from other job-related constructs (e.g., emotional distress or burnout) and is the “perceived violation of one’s professional integrity and obligations and the concurrent feeling of being constrained from taking the ethically appropriate action” (p.

51). Jameton (2017) and Epstein and Delgado (2010) stated that MD is not a problem unique to nursing, reporting that MD appears to be gaining attention in other fields such as psychology. They further argued that other professions could benefit from exploring this phenomenon (Jameton, 2017, p. 628). BH clinicians face many of the same systemic stressors as nurses but in different ways. Rather than caring for patients for a brief period as nurses do, BH clinicians working in a hospital or residential setting treating clients over a longer period of time and with a higher degree of intensity.

Problem Statement

Powell (2006) stated that the shortage of BH clinicians trained to treat substance use disorders was as significant as the nursing shortage in medicine. Despite Powell's concern (in 2006), workforce shortages have persisted. According to the U.S. Department of Health and Human Services Health Resources and Services Administration, Bureau of Health Workforce (2016), there are six provider types with estimated shortages equating to more than 10,000 full-time positions. These professions include psychiatrists, clinical counselors (BH clinicians), school psychologists, substance abuse counselors, social workers, and school counselors (p. 3). Adding to the workforce shortage is a high turnover related to burnout among BH clinicians working in the field of substance use disorders. Young (2015) noted that turnover rates in the field of substance use disorders are significantly higher (18.5% to 25%) when compared to other "high-stress fields" such as teaching (13.2%) and nursing (12%; p. 676).

Although a significant amount of literature exists in the field of nursing and other medical professions, it cannot be assumed that those studies are generalizable to BH

clinicians, as the role of a BH clinician differs from other medical professions in intensity and scope of practice. Nuttgens and Chang (2013) noted a substantial lack of research in counseling related to MD and recommended that future research explore how the phenomena impact BH clinicians. Turnage-Butterbaugh (2015) explained that the significant lack of attention to MD in the field of counseling is problematic as the experiences of MD can serve as an "ethical canary" that could signal to educators and supervisors that a new clinician is being negatively impacted (p. 433). Recently other health care fields, such as social workers (He et al., 2021) and marriage and family therapists (Patterson et al., 2021), have begun to explore MD related to their fields.

Specifically, my research focuses on understanding how working with maternal, opioid-using clients impacts MD for BH clinicians. My study was designed to identify themes specific to counselors working within this subspecialty to inform counselor educators and supervisors of the stress points for BH clinicians. Understanding the MD clinicians face can lead to new education, training, and supervision insights that may help increase retention and mitigate turnover, thereby addressing some of the current workforce shortage.

Purpose of the Study

Qualitative studies allow researchers to explore human interactions and behavior and understand human phenomena (Kagan et al., 2017; Lichtman, 2011). The purpose of my qualitative, phenomenological study was to explore the impact on BH counselors who had provided residential and hospital-based treatment to maternal, opioid using clients. Like medical providers, BH clinicians are frontline workers who support women through

various modalities during pregnancy. However, behavioral healthcare providers are not medical providers and have significantly different training and scope of practice.

The basis for my research lies in the difference of scope of practice, training, frequency, duration, and intensity of the therapeutic interventions BH clinicians provide that are distinct from other medical providers. These differences proved to be enough to demonstrate different outcomes in qualitative studies, making the studies with nursing and other medical staff less generalizable to BH clinicians. To understand how BH clinicians working with this population experience MD as part of their work with the population, I asked open-ended questions that explored how BH clinicians experienced MD during their work with the population under study.

Research Question

How do BH clinicians who have worked in residential or hospital settings experience moral distress as part of their work with maternal, opioid-using clients?

Framework

Patton (2015) suggested that phenomenological approaches to qualitative research emphasize uncovering the participants' lived experiences while setting aside the researchers' perceptions of the phenomena. Pregnancy, as a physical experience as well as a societal status, is a lived experience unique to females; these experiences include the use of pregnancy status by a variety of institutions to oppress and control women through legal and medical measures (Campbell, 2015). As such, I chose to integrate feminist thought and theory as a conceptual framework. Together, these theoretical and conceptual frameworks increased trustworthiness.

Phenomenology

Givens (2008) noted that phenomenology as a research approach was born from phenomenology as a philosophy in the humanities. Husserl (1931), one of the founders of modern phenomenological philosophy, explained that phenomenology allows the person to make their meaning based on personal interpretation of lived experiences. In 1962, Heidegger (2010) described phenomenological research as an approach to a qualitative inquiry in which the study participants discover meaningfulness based on lived experiences used to describe a phenomenon.

Hermeneutics

The concept of hermeneutics, or the interpretation of texts, has been a cornerstone of philosophy since Plato and his contemporaries (Given, 2008). Within hermeneutics, examining texts is not a linear progression; instead, it is described as a circular process. From this position, Heidegger (1962; 2010) postulated that to interpret a text, we must have a preunderstanding of the surrounding context (pp. 191-192). When uncovering a phenomenon, the researcher moves between their preunderstanding and the new insights that emerge through the hermeneutic process. Gadamer (1989) argued that Heidegger expressed concerns regarding hermeneutics to demonstrate that fore-structure is an important aspect of ontology (p. 268). He further clarified that the role of the hermeneutic circle allows researchers to examine the parts of the "whole" (Gadamer, 1989, p. 291). Central to Gadamers' argument is that interpretation of the data is not the same as understanding the data, and this difference is a key feature of hermeneutic approaches (p. 257).

Interpretive Phenomenological Analysis (IPA). Smith et al. (2012) developed Interpretive Phenomenological Analysis (IPA) by building on Heidegger and Gadamer (p. 34). Smith and Nizza (2022) updated some of the language used to interpret data, but all other aspects are the same. According to Smith et al. (2012), IPA brings hermeneutics to a level applicable to the social sciences (pp. 21-22). According to Smith et al., the IPA approach is "double hermeneutic" in that the "whole is the researcher's ongoing biography, and the part is the encounter with a new participant… in that the researcher is making sense of the participant, who is making sense of x" (p. 35). Based on this understanding, Smith et al. postulated that the researcher is also a participant in the research process, as their role is to bring together human experiences to understand the phenomenon based on what the participants' experiences illuminate. Using the double hermeneutic circle, IPA uncovers the superficial meanings and dives deeper to understand levels of meaning, including how the experience is constructed by the researcher (Smith et al., 2012, p. 36).

Conceptual

Feminist principles are inherent to the conceptual framework because pregnancy is unique to the female experience. Campbell (2015) explained that feminist epistemology is a relevant and important framework for understanding women with substance use disorders as a marginalized group. She emphasized that acknowledging women's substance use, as shaped by intersecting factors, is essential to research questions that include this population. Some of these include income, education level, race, cultural identity, social class, and maternal status (factors such as these are referred

to as “location” in feminist approaches, according to Campbell). While my study does not examine the experiences of the pregnant women receiving treatment, the clinicians who were part of my study worked within the context of these women’s lives.

Feminist Epistemologies

Brisolara et al. (2014) asserted that feminist epistemologies could be viewed as oppositional to male-centered standards that have been represented in research. She postulated that constructing knowledge through the feminist lens provides balance to research by challenging the androcentrism represented in research. As I conceptualized how feminist theory is integrated into my research, I discovered that social constructionism fits my study’s purpose and viewpoints better than other feminist lenses.

Social Constructionism

Lafrance and Wigginton (2019) noted several terms used to conceptualize epistemologies in feminist research, including social constructionism, constructivism, postmodernism, and poststructuralism. They explored these approaches as one under the term “social constructionist,” explaining that this approach focuses on how knowledge and meaning are made to construct reality. Freeman (2019) suggested that from the social constructionist perspective, the researcher looks at how meaning is made rather than the meaning.

My research question is grounded on how BH clinicians make sense of their work with maternal, opioid-using clients. The diversity of language and meaning that the participants express allows for reflexivity to identify how aspects of the phenomena may improve counselor education and supervision. Social constructionism is well suited as a

conceptual framework. In an IPA study, Smith and Nizza (2022) recommended that the methods used align with the phenomena and the researcher's theoretical framework. A feminist approach frames my study with a lens sensitive to the complexity of the population participants serve as BH clinicians. These counselors serve women who have been oppressed and marginalized due to their substance use, gender, pregnancy status, social class, and race. This approach held me accountable for factors that could influence my interpretation of the data.

Nature of the Study

My qualitative phenomenological study used IPA, as outlined by Smith et al. (2012) and Smith and Nizza (2022). The study explored the lived experiences of counselors who have worked in residential and hospital settings with maternal, opioid-using clients. According to Smith and Nizza (2022), IPA is a participant-oriented approach to qualitative research. It allows for an in-depth exploration of the data acquired through interviewing and is useful when examining phenomena from a perspective of depth rather than breadth. Smith et al.'s version of IPA is structured so that the research question may evolve throughout the data collection phase, which allows for an organic approach to discovering meaningful outcomes (Smith & Nizza, 2022).

Using the approach developed by Smith et al. (2012), I conducted semi-structured interviews with five participants from the United States who were recruited through convenience and snowball sampling. I utilized Smith and Nizza's (2022) approach to the hermeneutic circle and data analysis structure to interpret and revise the data. To increase trustworthiness, I integrated synthesized member checking to help ensure accurate coding

of themes based on the participants' intent. Throughout my journal, I tracked my process and used bracketing as described by Smith et al. (2012, p. 25), which added depth to the audit trail (Patton, 2015; Ravitch & Carl, 2016; Smith et al., 2012).

Definitions

Behavioral health: According to the Substance Abuse and Mental Health Services Administration (SAMHSA, n.d.), BH is defined as "the promotion of mental health, resilience, and wellbeing; the treatment of mental and substance use disorders; and the support of those who experience and/or are in recovery from these conditions, along with their families and communities" (p. 1).

Behavioral health (BH) clinician or clinician: The term behavioral healthcare clinician aligns with the SAMHSA definition, which defines BH clinicians as mental health professionals working with addictions (SAMHSA, 2021). The terms behavioral healthcare clinician or clinician describe individuals with a professional-level mental health license. These include mental health providers who have an educational background in providing counseling services, such as licensed marriage and family therapists (LMFT), professional clinical counselors (LPCC), and professional counselors (LPC).

Co-occurring Disorders (COD): According to the SAMHSA Treatment Improvement Protocol (TIP) number 42, COD in behavioral healthcare occurs when at least one disorder from a mental health category and at least one from a substance use disorder category have been established independently of the other (SAMHSA, 2020, p. ix). Mental health and substance use disorders can also co-occur when physical

conditions are present. Throughout this proposal, when the term co-occurring or COD is used, it refers to mental health and substance use disorders occurring concurrently.

Counseling: The term counseling is broad and refers to various evidence-based practices employed to help clients improve their wellbeing. The American Counseling Association's (ACA, 2021) definition is: "Counseling is a collaborative effort between the counselor and client. Professional counselors help clients identify goals and potential solutions to problems which cause emotional turmoil; seek to improve communication and coping skills; strengthen self-esteem, and promote behavior change and optimal mental health" (para. 3).

Medication-assisted treatment (MAT): According to SAMHSA, Medication-Assisted Treatment (MAT) refers to "the use of medications, in combination with counseling and behavioral therapies, to provide a whole-client approach to the treatment of substance use disorders" (SAMHSA, 2021, para. 1).

Opiate vs. Opioid: The term opiate refers to the naturally occurring chemical combination from the poppy plant known as the Papaver Somniferum poppy plant. The natural opiates thebaine, morphine, and codeine come from this plant species. They are derived from the opium latex extracted from the poppy flower bulb (Kara & Hasan, 2021). Opioid refers to naturally occurring, semisynthetic, and synthetic analgesics that operate on the same receptors as opiates (Shorter & Kosten, 2019).

Stigma: The American Psychiatric Association (APA, 2020) defined stigma as "the negative social attitude attached to a characteristic of an individual that may be regarded as a mental, physical, or social deficiency" (para. 1). Three types of stigma

people with mental health conditions face include (a) public stigma, which "involves the negative or discriminatory attitudes that others have about mental illness;" (b) self-stigma, which "refers to the negative attitudes, including internalized shame, that people with mental illness have about their condition;" and (c) institutional stigma, which is "more systemic, involving policies of the government and private organizations that intentionally or unintentionally limit opportunities for people with mental illness. Examples include lower funding for mental illness research or fewer mental health services relative to other health care" (para. 3).

Substance use disorders/Addiction: According to the American Society of Addiction Medicine (ASAM, 2019), the term addiction continues to be used in the medical model to describe the cluster of symptoms synonymous with substance use disorders, but it also includes behavioral patterns such as gambling (p. xxxi). ASAM defines the bio-psycho-social-spiritual aspect of addiction as follows:

> Addiction is a treatable, chronic medical disease involving many interactions among brain circuits, genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences. Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases. (p. xxxi)

Assumptions

Strong et al. (2008) stated that counselors make meaning as part of the work process during counseling sessions, and in the additional activities as part of client care.

They also noted that counselors often make sense of their work based on the elements of their daily tasks and experiences. Based on Strong et al., one assumption I operated on was that clinicians would respond to questions based on their observations and would tend to provide superficial or task-related answers to questions. Therefore, I relied on probes to ensure that the interview approach invited their lived experiences of counseling this population.

Counselors engage in work that is mentally and psychologically exhausting. Tiwari et al. (2020) noted that jobs high in emotional labor (e.g., counseling, teaching, nursing) require the professional to display emotions that are genuine and appropriate at the moment, which inferred they may feel as though they have to fake, suppress, or show emotions in a particular way as part of their job (p. 524). Given the complexity associated with working with maternal, opioid-using clients, I assumed that MD was experienced by clinicians working with the population. I also assumed that how BH clinicians make sense of their work would be influenced by the emotional labor counselors put forth, based on my experience as a BH clinician.

Scope and Delimitations

The scope of the study was to explore how BH clinicians make sense of their work when working with maternal, opioid-using clients by exploring the clinicians' experiences of MD. To code for how they make sense of these experiences, the scope of my study focused on the depth rather than breadth of data collected (Smith et al., 2012). My research criteria included BH clinicians who have worked with maternal, opioid-using clients for at least nine months throughout their career, and that these services were

provided in a residential or hospital setting. By setting a minimum of nine months of practice with the population, I assumed the participants had enough time in their role to experience a variety of situations from which to draw, and time in their role to engage with clients after a learning curve in a specific setting or job (Gallo, 2019).

Patton (2015) asserted that qualitative research from a holistic perspective requires the researcher to examine data from multiple angles. My research was delimited by targeting a subset of BH clinicians who have worked with maternal, opioid-using clients without limiting the region in the United States where they have engaged in this work. Another delimiting factor was the professional clinical licensure of the participants. There is a wide variety of professionals who work with maternal, opioid-using clients, with degree levels ranging from associates to doctoral degrees. By including masters-level prepared BH clinicians, I maintained a homogeneous sample because all participants trained to the same degree level in counseling.

Opioids, whether obtained through a medical provider and taken as prescribed or illicitly, are common during pregnancy for pain management, but are often misused for euphoric or other effects. A delimiting aspect of my research was that I did not limit the sample of participants to those who have worked with clients who have used opioids illicitly. Instead, the emphasis was on the counselor's setting (residential or hospital).

Transferability

Transferability is the qualitative term used to describe how generalizable the outcome data is to other situations (Patton, 2015). Ravitch and Carl (2016) stated that generalizability is not superficial; transferability results from rich descriptions

demonstrating how the data can be conceptualized across settings. The BH clinician's role has some similarities to medical providers, which may impact transferability to others in the behavioral healthcare field. Regardless of their specific role, healthcare workers can benefit from understanding more about the impact of working with a complex population like maternal, opioid-using clients.

Limitations

One limitation of phenomenological research is the difficulty of developing trustworthiness (Bloor and Wood, 2006). Ravitch and Carl (2016) maintained that trustworthiness is vital in qualitative research as it is akin to reliability and validity in quantitative studies. They also noted that ensuring saturation to enhance trustworthiness in phenomenological methods is challenging. According to Smith et al. (2012) and Smith and Nizza (2022), it is important to focus on the quality of the data interpretation rather than the number of participants. Qualitative researchers have relied on larger sample sizes to demonstrate validity; however, recent advances in the field have shown that large sample sizes do not provide higher trustworthiness (Smith et al., 2012, p. 49).

Bias

Ravitch and Carl (2016) explained that researcher bias is inherent to the research process regardless of the approach. They noted that bias is problematic because it has the potential to impact the outcomes of data interpretation. However, bias can also be useful when the researcher is aware of their biases and utilizes them to increase trustworthiness. Smith et al. (2012) explained that in their approach to IPA, bracketing is one method to

better understand the researcher's fore-structure, creating an opportunity to examine the data through that lens as part of the cyclical process of data interpretation.

Patton (2015) noted that bracketing, maintaining an audit trail and research diary, and member checking are methods to uncover and control bias in themes. Bracketing is used in to IPA to understand the common factors inherent to reality while remaining an observer (Smith et al., 2012, pp. 13-14). Rather than bracketing to avoid bias and fore-structure, IPA utilizes the researcher's fore-structure as part of the interpretation process. In doing so, I was able to identify my biases, bracket them, then use those biases transparently in the interpretation process, thereby increasing trustworthiness.

Significance

According to the CDC (2021), there was an additional surge in opioid overdoses during the COVID-19 pandemic. SAMHSA (2021) reported that between January 1, 2020, and January 1, 2021, opioid-related overdose deaths increased 31% with more than 94,000 fatal opioid overdoses recorded during this time frame. Given the current trend, the opioid epidemic will likely continue to impact the work of BH clinicians who treat SUDs, due in part to the lack of knowledge on how to support these clinicians to reduce burnout and turnover. Research examining how BH clinicians experience MD as part of their work can add to the existing literature in nursing, social work, and psychology and explore how this phenomenon impacts BH clinicians specifically.

Summary

There is currently limited research to provide counselor educators with insight into clinicians facing MD when working with maternal, opioid-using clients. The study

outcomes could support professionals and educators in developing training for those working with women who use opioids during pregnancy to help reduce clinician burnout and turnover. Training can be targeted for behavioral healthcare providers, administration and staff at medication-assisted treatment (MAT) centers, and other healthcare providers, including social workers, nurses, and physicians. These concepts are further explored throughout the literature review in chapter two.

Chapter 2: Literature Review

The surge in opioid use and opioid overdose-related deaths that began around 2010 (Bridges, 2020) and surged during the COVID-19 pandemic (SAMHSA, 2021) continues to be a public health and social problem in the United States (CDC, 2020). A primary difference between the current surge in opioid use and those of the 1970s is the increase in women experiencing opioid use disorders (OUD; Schieber et al., 2020). Rather than incarcerating pregnant women who use illicit opioids, policymakers and judges have begun to offer treatment as an alternative (Johnson, 2019). One impact of these changes is that in-patient hospitals and residential treatment centers have become overwhelmed with clients and pregnant patients with a co-occurring OUD (Martin et al., 2015).

Much like nurses, BH clinicians who work with maternal, opioid-using clients are front-line workers; however, unlike the nursing profession, there is limited research examining how BH clinicians are impacted by MD due to their work with the population. My qualitative phenomenological research aimed to explore the lived experiences of BH clinicians related to MD as a result of working with maternal, opioid-using clients. According to Johnson (2019), factors influencing clinician stress include systemic barriers, the stigma maternal, opioid-using clients face when seeking care, and the clinician's perceived inability to act ethically due to these factors.

When a female client with an OUD is pregnant, the BH clinician must also consider the client's medical status and possible legal involvement as part of the treatment process (Johnson, 2019). Through the therapeutic relationship, the clinician is

faced with providing care within the broader societal system, which often stigmatizes, shames, and punishes women for their substance use disorder, especially when pregnant (Bergly, 2015, Knopf, 2019). In this literature review, I focus on topics that shape the perspectives of BH clinicians who work with this highly complex population. Major sections of this chapter include the search strategy I used; moral distress; behavioral health clinician training; behavioral health clinician ethics; a brief overview of opioid pharmacology and how this relates to the etiology of OUDs, in-utero opioid exposure, and concerns of opioid withdrawal while pregnant; childhood outcomes in the context of prenatal exposure to opioids; perspectives of opioid use; treatment interventions for maternal, opioid-using clients, including medication-assisted therapies (MAT); and cultural bias and systemic barriers to care.

Literature Search Strategy

Utilizing the Walden University online library, I searched the following databases: PROQUEST, PsychArticles, PsychINFO, Academic Search Premier, MEDLINE, Science Direct, PubMed, and SAGE Journals. I also utilized the American Society of Addiction Medicine (ASAM) placement criteria and the Diagnostic and Statistical Manual of Mental Disorders (DSM-5 TR). I limited the search range to the past five years to ensure the research was recent. After accumulating current literature, I also conducted an open search to discover how research outcomes have advanced.

I completed the literature search between June 2020 and June 2022 using various search terms to locate sources from a multidisciplinary perspective. Search terms to identify literature included the following: *moral distress, maternal opioid use, pregnancy*

or pregnant opioid use, opioid epidemic, opioid use disorders, feminism, counseling pregnant substance use or substance abuse, clinician perspectives substance use and pregnancy, and *social determinants of health*.

Conceptual Framework

Clinicians working with maternal, opioid-using clients engage with a highly vulnerable population. In general, women have faced barriers to education, employment, medical care, and basic human rights throughout history. Despite advances in women's rights, clinicians who work with maternal, opioid-using clients continue to face systemic barriers that often prevent them from providing their pregnant clients with access to resources and interventions due to the stigma associated with female substance use. These barriers include stigma from the medical community, judicial, and social service providers. Stigma is heightened when pregnancy is also a factor. This section focuses on the history of the feminist movement in the United States as a conceptual framework for my research.

Feminism: Origins

Brunell (2021) reported evidence of organized protests for women's rights dating back to the third century BCE. These protests were against a government mandate designed to limit women's participation in society. Osborne (2001) pointed out that women throughout history have stood against patriarchal systems. She noted the accomplishments of Joan of Arc (1412-1431), Queen Elizabeth I (1533-1603), and Catherine the Great of Russia (1729-1796) as evidence of women who were successful within and despite patriarchal systems. Historical writings about women's equality and

emancipation focused primarily on upper-class White women being educated with the same intent as men. In the mid-eighteenth century, women began a large movement to advance these ideals through their writings and societal groups (Brunell, 2021; Osborne, 2001). The feminist movements began organizing in the 1800s, stemming from a need to address how multiple systems oppressed women's human rights.

A common conceptualization of feminism is to view the movement as a series of waves or times where feminist activism led to specific changes in public policy (Chazen & Baldwin, 2016). While these waves correlate with periods in time, it has been suggested that conceptualizing the waves as a distinct movement in a region is necessary as different regions experienced waves at different times (Brunell, 2021; Chazen & Baldwin, 2016). Brunell (2021) also argued that these waves of feminist movements in the United States are often distinct from those in other areas of the world. This literature review focuses on waves that began in Europe and migrated to the United States.

First Wave (c. 1170 – c. 1930)

According to Eschle and Maiguashca (2010), modern Western feminism began after the French Revolution with Mary Wollstonecraft's Vindication of the Rights of Women (1792). In her writings, Wollstonecraft's argument exceeded the humanist arguments focused on equal rights by postulating that women had been oppressed and viewed as less than men. Women's education was in areas that pleased men but did not expand the mind (e.g., embroidery). She fought for mixed-gender schools to deliver equality in education, which would lead to equality in other areas (Wollstonecraft, 1792). The emancipation efforts of the latter half of the 1800s in the United States were

evidence of a movement towards disenfranchising women and others. Moynagh and Forestell (2012) explained that during the first wave of feminism, the movement was an international collaboration that included European, American, Turkish, Irish, Afghan, and later (c. 1848), North American Indigenous men and women.

American Feminism was grounded in the anti-slavery and abolitionist movements (Brunell, 2021; Osborn, 2001). On July 20, 1848, the women's suffrage movement started in Seneca Falls, New York. Elizabeth Cady Stanton wrote the Declaration of Sentiments, which outlined the Seneca Falls Convention, the first organized gathering of feminists in the United States (Brunell, 2021). The declaration noted 16 ways women were being oppressed by the patriarchal system in the United States. Among these were women's inability to own or have rights to property, inequality in education, lack of employment opportunities, and the inability to vote (Brunell, 2021). As abolitionist and suffrage movements experienced victories in the government, laws began to change. Additionally, the first and second world wars (c. 1914 to 1918 and 1939 to 1945, respectively) sent hundreds of thousands of men overseas, thus requiring opening the workforce to women (Osborn, 2001). The need for women in the workforce led to *Rosie the Riveter* as a national campaign in 1943 to create a visual of a strong woman who worked outside the home (Bellou & Cardia, 2016).

Second Wave (c. 1961 to c. 1985)

Freidan (1963) examined the lives of White middle-class women in the late 1950s and early 1960s. Her published work, *The Feminine Mystique*, is credited as the catalyst for the second wave of feminism in the United States (Brunell, 2021; Levine, 2015;

Osborn, 2001; Turner, 2013). Freidan discovered an undercurrent of female hostility resulting from the expectation that women leave the workforce and tend to the home after the men returned from the war. Whether this is a fact continues to be a debate in and out of feminist circles. Freidan's primary argument was that women could find happiness and fulfillment outside being a wife and mother, yet society actively kept women from finding their individuality. Citing popular media directed at female readers, Freidan noted that women were told they should find their fulfillment and joy as mothers. Freidan extrapolated the view of the modern woman in the United States by citing a June 1960 edition of Redbook:

> For the mother, breastfeeding becomes a complement to the act of creation. It gives her a heightened sense of fulfillment and allows her to participate in a relationship as close to perfection as any woman can hope to achieve… The simple fact of giving birth, however, does not of itself fulfill this need and longing… Motherliness is a way of life. It enables a woman to express her total self with the tender feelings, the protective attitudes, and the encompassing love of the motherly woman. (Freidan, 1963, p. 83)

From this statement, Freidan deduced that women were being oppressed due to a patriarchal system that has existed throughout human history and was an ever-present injustice in society.

Motherhood

Nowhere in *The Feminist Mystique* does Freidan (1963) state that motherhood is not fulfilling. Instead, she argued that women often seek more than motherhood as part of

their life's joy and fulfillment. In the same way, many men find meaning and joy in fatherhood. Freidan discussed that the perception of motherhood as the ultimate goal led to policies and practices that oppressed women who wanted more or were different. Freidan claimed that these patriarchal practices were designed to hold women to the unattainable ideas of purity, goodness, and complete dedication to their children. Women who did not meet these criteria were harshly judged by society for their perceived ineptitude as women and mothers. In current literature, this has been coined as the *myths of motherhood* (Ambrosini & Stanghellini, 2012).

Criticisms

According to Swinth (2018), women have entered the workforce at much higher rates since the 1970s, yet they remain the primary caretakers of children, thereby doubling women's social, emotional, and financial burdens, or what she terms "the myth of having it all" (p. 236). Swinth (2018) suggested that women's liberation from motherhood and the advancement of equal rights in the workforce produced by the second wave of feminism created the unintended consequence of failing to protect women from being overburdened by ultimately carrying more burdens than their male counterparts.

Diverse Representation

Blencowe (2011) explained that the second wave of feminism ignored eugenics, racism, and supremacism. The lack of diversity and inclusion of racially diverse voices in the second wave caused a divide between White middle and upper-class women who were advancing their agendas, and women from other groups whose agendas were not

part of the narrative (Osborne, 2001; Roth, 2004). Roth (2004) suggested that the women's liberties and rights movement coincided with the Civil Rights movement of the 1960s, which addressed some needs of the Black community but was still focused mostly on increasing Black men's ability to secure employment. With both parties pushing for radical changes to public policy and seeking legal protections, it was a period of immense change and growth (on paper) for women and the Black/African American and Latinx communities (Osborne, 2001). Brunell (2021) noted that while the feminist movement viewed all women as needing legal protections and expansion of rights, some Black women found, "White women were as much the oppressor as White men" (para. 2).

Intersectionality

The concept that has bridged the second and third waves of feminism was the Black Feminist movement of the 1970s, known today as intersectionality (Davis, 2020). The term refers to the praxis at which class, gender, sexual orientation, and race intersect and impact women differently (Aguayo-Romero, 2021; Mane, 2012; Mann, 2013). Kimberle Crenshaw, an American law professor, coined the term intersectionality in 1989, stating that intersectionality is "a prism for seeing how various forms of inequality often operate together and exacerbate each other" (Steinmetz, 2020, para. 2). As a basis for the feminist movement, intersectionality provides a more comprehensive and inclusive view of how and why women face continued discrimination by placing the cause in social justice and advocacy (Aguayo-Romero, 2021; Steinmetz, 2020).

Third Wave (c. 1990s to ?)

Evans (2016) explained that to fully understand the impact of a movement, a substantial amount of time must pass. By allowing for this, historians and others can evaluate how change happened through a more objective and holistic lens. Evans noted that not enough time has passed to apply academic rigor to evaluate the contemporary feminist movement and suggested the term contemporary feminism as more appropriate.

Schuster (2017) differentiated the second and third waves by comparing the different perspectives of the movement. Specifically, the personal perspective is the political rally cry of the third-wave feminists, which acknowledges that feminist activism is both personal and political due to the politicizing of women's liberties. The second-wave feminists rallied around the idea that a collective approach has more power than any individual approach. The loss of control over the movement led many "third-wave" feminists to view personal power and advocacy to retain rights and prevent capitalist as infringement on the movement, rather than as collective or group organizations advancing the cause (Evans, 2016, p. 650).

Current Wave?

If historians are too close to third-wave feminism, as Evans (2016) suggested, then the current and possible fourth wave are even more difficult to appreciate and explain. Brunell (2021) and Evans (2016) noted a debate as to whether we are currently experiencing the fourth wave of feminism, or if the actions of the third wave are continuing in a more targeted manner. Current feminist approaches recognize that previous feminist movements primarily focused on White women and their attainment of

equality, ultimately shifting towards a more globalized view (Brunell, 2021). The current perspective seeks to engage all women with a special focus on raising the voices of Black and Brown women in the fight against racism. Additionally, this wave is focused more on the patriarchal sexualization and exploitation of women in the media and internet (e.g., the #MeToo movement). How the loss of federally protected rights to abortion, which stemmed from the second-wave feminist movement, will impact the current wave (or possibly start a new wave) remains to be seen (Dobbs v. Jackson Women's Health Organization, 2022),

Literature Review Related to Key Variables and Concepts

Pregnant women who engage in substance use treatment programming to address their opioid use disorder are surrounded by various healthcare and social services providers. These include BH clinicians (mental health clinicians and addiction counselors), medical providers (medical doctors and nurses), social service providers (social workers), and often criminal justice agents (such as judges, attorneys, and probation officers; Roy & Miller, 2012). The complexity of treating maternal, opioid-using clients requires clinicians to provide services to these clients within and around various systems, including healthcare organizations, insurance companies, governmental funding, and judicial and social services. In addition to their interaction with these systems, clinicians also address the various stigma and other barriers clients face accessing care when pregnant and facing a co-occurring OUD, while maintaining their ethical practices. The following literature review is focused on the broad and unique aspects of the clinical role of BH clinicians as they assist their clients during their

pregnancy journey, as well as the potential of experiencing MD, which has been demonstrated to be a precursor to clinician burnout (Dalmolin et al., 2014).

Moral Distress

The term moral distress was introduced in 1984 by Andrew Jameton to describe the phenomenon nurses experience when they "know the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" (Jameton, 1984, p. 6). These events are often caused by caring for specific populations and settings where resources can be limited (Jameton, 2017). Furthermore, Dalmolin et al. (2014) found that MD is a precursor to burnout in healthcare settings.

Since Jameton's initial definition of MD, others have expanded on the concept to refine the definition and further differentiate the concept from burnout. Barlem and Ramos (2015) expanded on Jameton's definition by stating:

> Moral distress could also be defined as a painful feeling or psychological imbalance resulting from recognizing an ethically correct action that cannot be performed because of hindrances such as lack of time, reluctant supervisors, or a power structure that may inhibit a moral, political, institutional or juridical action. (p. 608-609).

Epstein and Delgado (2010) noted that MD could indicate that ethical challenges in the setting are not being adequately addressed (para. 1). They explained that when a clinician experiences MD, it results from having identified actions needed based on their professional, ethical principles and integrity. They explained that distress results from internal or external barriers; and is often related to institutional policies and procedures.

Morley et al. (2019) reviewed 20 different explanations of MD and identified the primary concepts linking these definitions. Their explanation of MD encompasses how the individual experiences MD and the psychological distress caused by the institutional constraints, internal constraints, or epistemic injustices. They explained that it is the interaction of these two aspects that cause distress. Institutional constraints include policies and procedures that direct employees to take specific actions. Internal constraints were identified as "self-doubt, lack of assertiveness, socialization to follow orders, perceived powerlessness, and lack of understanding" (p. 658-659).

Epistemic injustice, in the context of Morley et al.'s explanation, refers to frontline staff being required to enforce decisions made by others (i.e., nurses following the physician's orders), the uncertainty of when they can act independently, and not having autonomy. They also found that research uncovered common feelings and emotions when MD is experienced. These feelings include anger, frustration, exhaustion, helplessness, distress, depression, and guilt. Morley et al. also noted that the physiological aspects are often experienced as difficulty sleeping, nausea, migraine headaches, a general sense of tearfulness, and physical exhaustion (p. 655).

What Moral Distress is Not

Ethical Dilemma

Epstein and Delagdo (2010) explained that when a clinician experiences MD, it results from identifying the ethical principle. Thus, the MD is not caused by a questioning of the right course of ethical action but rather the inability to act in accordance with one's professional ethics as a result of external or internal factors.

Burnout

Clinician burnout in opioid treatment settings has been the focus of recent research. According to Kirsch (2019), burnout syndrome is an official medical diagnosis recognized by the World Health Organization (WHO) that stems from chronic stress related to the workplace. Burnout, according to Kirsch, has three types: mental exhaustion, distancing to negative feelings about one's work, and reduced efficacy and value in the workplace. Kirsch also noted that in treatment settings contributing factors to burnout include low pay, high caseloads, long hours, reduced decision-making ability by front-line staff, and lack of social supports. Lamiani et al. (2017) and Morley et al. (2020) stressed that MD is focused on the individual's inability to act on an event in a way that aligns with their professional ethics and integrity. Their inability to act can result from internal or external factors related to their work. MD can contribute to negative feelings about one's work, disengagement from the workplace, and other factors associated with burnout. The experience of MD is differentiated from burnout in the literature.

Vicarious Trauma

Figley and Ludick (2017) explained that the term vicarious trauma (VT), also referred to as compassion fatigue or secondary traumatic stress, has evolved since the 1990s to refer to various reactions that result in a feeling of depleted ability to maintain well-being as a result of the psychotherapy services provided to clients (p. 579). The cause of vicarious trauma, as noted by Figley and Ludick, is not typically the result of a single exposure to a client's recounting of trauma but typically being exposed to these stories repeatedly over time when working with a client population that experiences

trauma. They also emphasized that not all psychotherapists who work with clients with a trauma history will develop reactions to this exposure.

MD and VT are distinctly different phenomena. MD results from the clinician's inability to act in accordance with their ethical principles (Epstein & Delagdo, 2010), whereas VT is about exposure to a client's experiences of trauma. Under some circumstances, the two could be linked. For example, if a clinician is experiencing decreased empathy for their clients, a sign of VT, according to Figley and Ludick (2017), and they do not have access to supervision, the clinician could experience MD. The 2014 American Counselor Association (ACA) *Code of Ethics* section C.2.d stated, "counselors continually monitor their effectiveness as professionals and take steps to improve when necessary. Counselors take reasonable steps to seek peer supervision to evaluate their efficacy as counselors" (p. 8).

Theoretical Model of Moral Distress

Barlem and Ramos (2015) developed a theoretical model of MD. In their model, they presented the idea of the "chain of moral distress," which refers to a "triad of cyclical, continuous or intermittent situations characterized by feelings of reduced resistance and mortification of interests and the individuals themselves while being subjects of moral action" (p. 611). They argued that when faced with these situations, providers cannot express their concerns from an ethical or advocacy perspective, or what they termed "advocational inexpressivity" (p. 611).

Once this experience had begun, they theorized that three possible outcomes could occur. First, the individual may return to the situation and deliberate the scenario

which leads them to experience discomfort. The second is “abandonment of the professions ideal’s” resulting from the experience of stagnation. They argued that stagnation happens when the professional feels a sense of “powerlessness” (p. 611). Finally, the professional may recognize the MD but, for whatever reason, does not actively engage in changing the situation.

Barlem and Ramos (2015) argued that the chain reactions result from feelings of powerlessness, reduced engagement in advocacy, and a change in interest caused by a sense of hopelessness that the system is inflexible. Their research demonstrated that the physical and emotional inexpressivity could compromise patient care due to reduced advocacy by the nurse. Additionally, they found that emotional and physical changes degrade the individual’s sense of agency and dissatisfaction with their role to the point that turnover intent increases (p. 612).

From the Field of Nursing

The field of nursing has been researching the impact of MD since the 1990s. According to Jansen et al. (2020), nurses working in psychiatric settings face particularly difficult situations caring for patients on these units. Among these is coercive administration of medications, insufficient resources such as lack of staffing, and inadequate treatments delivered because patients were often discharged sooner than the nurses felt they should be. They noted that the realities associated with lack of funding, the need to stabilize and discharge so other patients could use the bed, and a sense of failing their patients contributed to the negative feeling associated with MD.

Substance use during pregnancy adds an additional layer of stress and distress for nurses working with infants and their mothers. As Welborn (2019) illustrated, the MD experienced by nurses when providing health care to maternal, opioid-using patients, their work primarily centers on the care of the fetus and infant. Welborn stated that nurses often find themselves experiencing MD, including "overwhelming comfort needs of the infant, unrealistic care expectations by some families, strained and tense interactions with families, and potential role conflict" (p. 502).

Not all nurses working in high-intensity settings experience MD (Bralem & Ramos, 2015). Krautscheid et al. (2020) found that social support reduced MD and increased resiliency in new nurses. These social supports between peers and clinical faculty helped new nurses cope with ethical dilemmas. They recommended resiliency training be integrated into nursing programs to mitigate the detrimental effects of MD and possibly curb the turnover rate common among new nurses.

In the Field of Counseling

The literature relating to MD in counseling is practically non-existent as a whole concept. However, the aspects identified by Jameton (1984) and Barlem and Ramos (2015) have been researched independently. For example, Eby and Rothrauff-Laschober (2012) discovered that the organizational environment was more predictive of turnover than clinical supervisor leadership in substance use treatment settings. They noted that the elements associated with burnout (low pay, high caseloads) are mitigated when the environment is supportive, and counselors feel a sense of accomplishment, which are key factors in resiliency noted in the MD theory by Barlem and Ramos (2015).

Knudsen et al. (2006) did not use the term MD but did note the importance of understanding the predictors of burnout. They stated that emotional exhaustion is one of the key elements associated with burnout and that burnout is a precursor to leaving one's job (turnover). As a result, they argued that by understanding what causes emotional exhaustion, treatment organizations could identify ways to reduce counselor turnover (p. 173). Furthermore, they highlighted the lack of resources, the complexity of client presentation, and the pressure to "deliver more and higher quality services with fewer resources" (p. 174).

Nuttgens and Chang (2013) noted that MD is an under-researched topic in counseling. They demonstrated that as of 2013, there were only two studies relating to MD (one in psychiatry and the other in psychologists), whereas other behavioral healthcare fields had not conducted significant research in this area. They argued that MD is a common topic in supervision as clinicians often face situations where they feel they are being prevented from acting in accordance with their ethics because of some barrier (e.g., insurance companies limiting the number of sessions). They also stated that clinical trainees are at the highest risk of experiencing MD. According to Nuttgens and Chang, supervisors needed a better understanding of the phenomena related to BH clinicians.

Behavioral Health Clinician Training

BH clinician training requires a minimum of 48 master's or doctoral level credit hours in similar core courses in mental health diagnosis, skill training, multicultural counseling, and foundations in psychosocial theories relevant to the treatment of BH conditions (Council for the Accreditation of Counseling and Related Educational

Programs [CACREP], 2018, February 9). Licensed alcohol and drug counselors (LADCs) and licensed alcohol and other drugs of abuse counselors (L-ADOA) specialize in treating alcohol and drug addiction and are often prepared in bachelor's degree programs for their specialized work (CACREP, 2016). Many online and in-person universities and colleges offer dual-licensing or co-occurring counselor education programs, which combine the state's requirements for masters-level mental health programs and the alcohol and drug counseling requirements integrated into their master's level clinical mental health counseling program (CACREP, 2016). Additionally, some in-person and online universities offer a master's certificate in alcohol and drug counseling that can be obtained after attaining a master's or doctoral-level degree.

Co-Occurring Physiological, Mental Health & Opioid Use Disorders

Mackain and Noel (2020) contend that BH clinicians with training in mental health and SUDs are in high demand and in short supply. They argued that the interactions between SUD and other mental health conditions create a need to train BH clinicians to work in SUD treatment settings. Knopf (2012) discovered significant growth over the past two decades in programs that prepare clinicians to work with individuals who experience co-occurring disorders (COD). Lloyd-Hazlett et al. (2020) recognized that the increase in BH clinicians working in settings with other medical providers has also led to an increased need to provide counselors with an overview of medical systems in their education. They postulated that the co-occurrence of physical concerns, emotional disorders, and SUDs would continue to increase the demand for BH clinicians in settings with medical personnel as part of the care team.

Specialized Training for Opioid Use Disorders and Pregnancy

Clinicians working with maternal, opioid-using clients need to understand the research and theories associated with substance use disorders in a way that allows them to bridge theory to practice (Reddy et al., 2017). Currently, there are no specialized certificate programs for BH clinicians working with this population. Continuing education focused on opioid use and co-occurring pregnancy is not often available. In addition to counseling, psychology, and addiction conferences with special topics on OUD during pregnancy, BH clinicians can attend medical conferences that address the issue (Richard Moldenhauer, personal communication, April 22, 2021).

Ethics

The ACA ethics and professional standards are integrated throughout clinical training (CACREP, 2016). These ethics and standards address the clinicians' role as a professional grounded in autonomy, nonmaleficence, beneficence, justice, fidelity, and veracity (ACA, 2014, p. 3). Standards of practice require clinicians to promote trust by respecting confidentiality and privacy; establish professional boundaries; advocate and promote change that helps to improve quality of life and remove potential barriers to accessing care; develop working relationships with other professionals; considering the clients personal and cultural context; contribute to the education of new counselors, and contribute to research by participating and conducting research for publication.

Jacob et al. (2021) stated ethical dilemmas are a constant reality for clinicians. They expressed that understanding the written code does not provide direction; rather, it provides guidance. Therefore, training and supervision to help clinicians understand the

nuances of the ACA ethics is key to working through ethical dilemmas. They also noted several approaches and models that clinicians use to resolve ethical dilemmas but note that even then, "it depends" is usually the rule rather than the exception when integrating ethics into practice. Clinicians (new and more seasoned) turn to supervision to help resolve ethical dilemmas; however, as Nuttgens and Chang (2013) noted, supervisors are not always fully prepared to understand how to work with a clinician's MD.

Clinician Workplace and Roles

There has been a substantial increase in pregnant women giving birth to infants who are physically dependent on opioids (CDC, 2021), leading to more need for specific treatment programs to address the population's needs. A BH clinician's work providing therapeutic services to maternal, opioid-using clients is multifaceted and spans several settings (Roy & Miller, 2012). This section explores the clinician's role as it pertains to treating maternal, opioid-using clients, the settings they often work in, and the tasks associated with their daily work in the role.

Levels of Care

According to CACREP (2021), clinicians work in various settings ranging from organizations and agencies to private practice (para. 4). The American Society of Addiction Medicine (ASAM) has developed screening and assessment techniques to help those working in healthcare systems and providers determine the level of care most appropriate for an individual based on six dimensions that factor in the bio-psycho-social-spiritual impact of SUDs (Mee-Lee & Shulman, 2019). Based on the assessment

outcome, clients can be recommended for care levels from 0.5 (early intervention) through 4.0 (medically managed intensive in-patient).

Medical/Hospital. In hospital settings, clinicians work on units that treat mental health and substance use disorders. In these settings, they deliver psychotherapy and work with other medical team members to monitor and stabilize patients. Berger-Greenstein (2018) noted that the understanding of psychological processes and their impact on physical health (and vice versa) had created an opportunity to expand multidisciplinary teams to include BH clinicians (para. 6). Patients seen in medical and hospital settings have highly complex treatment needs that require ongoing medical monitoring. Having a co-occurring OUD during pregnancy is one medical factor that may require an enhanced level of care for some women (Mee-Lee & Shulman, 2019).

Mee-Lee and Shulman (2019) explained there are two levels within this setting. The medically monitored setting (ASAM level 3.7) provides 24 –hour care staffed with nurses and physicians, and of that 24 hours, and 16 hours include integrated care with BH clinician staffing. Medically managed (ASAM level 4.0) has 24-hour nursing and physician staffing with BH clinicians available to provide treatment. The primary difference is that at the medically managed level, patients have higher acuity and may not be able to participate in counseling activities as they would be able to in a medically monitored level of care.

Residential. Residential treatment for substance use disorder (SUD) can range from low-intensity (ASAM level 3.1) to high-intensity in-patient treatment (ASAM level 3.5). These settings have 24-hour care staffed by BH clinicians and substance use

counselors trained to stabilize acute clients and prepare them for an out-patient level of care (Mee-Lee & Shulman, 2019). Treatment at residential and residential in-patient substance use and co-occurring disorders settings is appropriate for pregnant women who are medically stable (Grella, 2010). According to Zhou et al. (2021), a residential level of care benefits individuals with co-occurring disorders as the setting provides stability of housing and access to care. (p. 39).

Residential treatment settings typically provide a minimum of 5 hours per day of programming led by BH clinicians (Barthwell et al., 2019). Clients live at the treatment center, sometimes with their children, if the facility is licensed as a family treatment center (Chou et al., 2020). As noted by Zhou et al. (2021), the approaches to care in these centers range from 12-Step facilitation (based on the Alcoholics Anonymous [AA] principles) that typically lasts three to six weeks to treatment communities (TC) that have a length of stay that is typically 12 or more months (Barthwell et al., 2019). These programs frequently integrate case management as part of the treatment modality, helping clients navigate medical, judicial, and educational systems in addition to vocational assistance (Barthwell et al., 2019; Zhou et al., 2021).

Outpatient. According to Mee-Lee and Shulman (2019), out-patient care is much broader and typically lasts longer than higher levels of care and is primarily staffed by BH clinicians. The highest level of out-patient care, partial hospitalization programming (PHP) (ASAM level 2.5), has a minimum of 20 hours a week of programming, including education, psychotherapy, group, and individual counseling. Intensive out-patient (IOP) requires a minimum of 9 hours a week of programming (ASAM level 2.1) and is intended

to increase the client's stability while they engage in life activities such as work or school. Clients in the lowest level of care, which many consider "typical" out-patient settings, engage in group or individual therapy for 1 to 8 hours per week. At this level of care, Mee-Lee and Shulman noted that focusing on motivation enhancement therapies helps the client function and remain stable in their recovery. Any level of out-patient setting can include medication-assisted treatments (MAT) such as methadone or suboxone (Mee-Lee & Shulman, 2019).

Therapeutic Interventions

Counseling interventions are the most common approach to treating clients who are pregnant and have SUDs. While person-centered approaches have been demonstrated to address the shame and stigma associated with SUDs, no evidence suggests a specific counseling practice that works best for pregnant women with SUDs (Andraka-Christou et al., 2021). Given the stressors related to their medical condition (pregnancy), fear of losing their parental rights (active trauma), and OUD, a variety of evidence-based practices (EBPs) are generally used in treatment settings with this population (Elms et al., 2018). These practices most often draw from therapeutic modalities that focus on stress reduction, personal safety and boundaries, insight development, and emotional regulation (Coupland et al., 2021; Short et al., 2018; Wilson & Donachie, 2018).

Evidence-Based Practices. There is a lack of research focused on treating pregnant women who use substances (Staudt, 2018). Blehar (2013) explained that this gap exists because pregnant women, in general, are considered to be a vulnerable population and, therefore, difficult to obtain internal review board (IRB) approval for

research. BH clinicians rely on research to guide their practice, as they are tasked with designing treatment interventions that meet the client's immediate needs while also addressing the underlying psychological processes that have contributed to the development of the disorder. These interventions with pregnant women who have a SUD often focus on lowering stress and improving well-being to help clients feel supported and learn positive coping strategies (Thomas et al., 2014).

EBPs with the strongest support for treating women when pregnant and treating women with a SUD are Dialectical Behavior Therapy (DBT) and Acceptance and Commitment Therapy (ACT). Both approaches focus on mindfulness and coping strategies to mitigate stress. Chiesa and Serretti (2014) identified that mindfulness methods, which are part of both DBT and ACT treatment interventions, decreased participants' experiences of cravings, leading to less substance use over time (p. 494). DBT is a highly structured approach that teaches skills in mindfulness, interpersonal effectiveness, distress tolerance, and emotion regulation (Linehan, 2014). ACT is a therapeutic method that encourages the client to tolerate distressful feelings to change avoidance behavior patterns (Chiesa & Serretti, 2014). Chiesa and Serretti noted that ACT has also been demonstrated to reduce craving through the acquisition of the skills. Villarreal et al. (2020) presented a case study that adapted Motivational Interviewing (MI) and ACT for women who had a child in the neonatal intensive care unit (NICU) and had prenatal exposure to illicit substances. Their case study demonstrated an improvement in the mother's readiness to change by committing to receiving support and treatment for SUD.

Trauma-Informed Care. Women who use opioids during pregnancy often have a significant trauma history (Travis, 2019; Coupland et al., 2021). Trauma can also be part of the daily lives of maternal, opioid-using clients, as they frequently face significant uncertainty about what will happen to their parental rights because of their substance use. Many women using substances during pregnancy are engaged with social service agencies, determining the mother's ability to parent. The threat of having their child removed from their care creates a constant state of fear for many women, leading to a prolonged traumatic experience for many pregnant opioid-using clients (Earle, 2019).

Trauma-informed care is considered a best practice vital to the pregnant substance-using client's support (Delker et al., 2020; Travis, 2019). Clinicians working with maternal, opioid-using clients also have significant exposure to a client's past and present trauma events, which may be considered in discussions of burnout. Cosden et al. (2016) found a significant correlation between a clinician's exposure to vicarious trauma and the clinician's positive personal and professional growth in the areas of resiliency and psychological strength (also known as post-traumatic growth). Their research supports the idea that clinical work is challenging for clinicians, and there is a potential for growth associated with their work when there is adequate support, such as supervision.

Feminist Approaches. In addition to using evidence-based practices, some programs apply a feminist lens to their approach to care. Travis (2019) contended that historical approaches to treating SUDs had been grounded in male perspectives, which neglect the unique status and needs of women and mothers. Neale et al. (2018) reported

that women who participated in women-only treatment described the environment as allowing them to feel a high degree of safety and support and noted that the environment allowed them to relax and develop relationships with other women. Asta et al. (2021) identified that maternal, opioid-using client who participated in treatment with other women experienced increased feelings of support.

Many women experience trauma before engaging in treatment. Travis (2019) recommended that feminist approaches include trauma-informed care using boundary-setting as the primary method of creating a therapeutic community of safety and stability. Ma (2017) quoted women participants who were engaged in a feminist-based SUD treatment program as having stated that feminist approaches to their care allowed them to explore their morals and values in a safe space, with boundaries that allowed them to process the shame and guilt associated with their history of SUD.

Collaborative Care. International and national standards of care strongly support an integrated multi-disciplinary approach to care for maternal, opioid-using clients. SAMHSA (2016) integrated recommendations from the WHO, ASAM, and the American Association of Pediatrics (AAP). They stated that the best approach to treating maternal opioid use includes MAT and psychosocial counseling regarding the decision to utilize MAT during pregnancy. SAMHSA's guidance for providers recognizes each team member's background and roles in the care process for the highly complex cases when maternal opioid use is a factor. Coupland et al. (2021) found that providers across disciplines agreed that integrated care was preferable to treating pregnant women who also have a SUD.

Case Management. Vanderplasschen et al. (2019) stated case management has been designed to enhance coordination and continuity of care for people who have "complex needs" (para. 4). Case management is a critical aspect of addressing recovery from substance use disorders and mental health conditions (Fink-Samnick, 2021). While case management is part of the standard curriculum for clinical social workers and alcohol and drug counselors, it is not required in the clinical mental health counseling curriculum by national accrediting agencies such as CACREP (CACREP, 2016). Vanderplasschen et al. (2019) stated that case management is a key to retaining participants in treatment programming. They reported that the key features of case management (monitoring needs and assisting with access and coordination of services) as part of the "clinical model" of case management (para. 5), which is different from a community case management model.

Clinician Engagement Across Systems

BH clinicians who work with maternal, opioid-using clients interact with multiple systems as part of their daily work. As providers of therapy, clinicians are part of the larger healthcare system, including billing insurance and government funding programs (such as grants and Medicaid). As many maternal, opioid-using clients are involved with the criminal justice system, clinicians are often tasked with providing updates about the woman's care and treatment to agents of the court, even when the clinician feels that this violates the client's confidentiality (Baxter et al., 2019). Additionally, social service agencies, such as child protection (also known as family social services), may be involved to determine if the woman will bring her newborn home or if the infant should

be placed with another caregiver (Blakey, 2014). Organizational, institutional, and judicial policies and practices often dictate how BH clinicians work with clients and provide care, often in ways that lead to MD in clinicians. This section explores those systems and policies and outlines the aspects that may cause dilemmas leading to clinician MD.

Healthcare

Before the COVID-19 pandemic, the healthcare system in the United States was described as having been "broken" for decades (Austin et al., 2017; Brill, 2015). Although the Affordable Care Act (ACA) provided more structure and ensured that more Americans were covered by healthcare policies, there continued to be systemic issues leaving many unable to afford care or access care (Kominski et al., 2016). Davidson (2016) reported that the United States is "hamstrung by an ideological aversion to government-facilitated solutions to social programs by a political system whose decisions makers were often beholden to powerful economic interests that preferred the status quo to any number of possible reforms" (p. 302-303). They argued that even with improvements from the ACA, other countries far surpass access to healthcare.

Since the pandemic, the problems of the United States healthcare system have become more measurable and discussed more widely. Citing barriers to access, poor quality of care, and unregulated prices, Geyman (2021) discussed the primary issue of disparities and problems leading to the "broken system" are grounded not only in the for-profit insurance industry but in governmental funding and policies that are based on political pressures rather than research and science-driven evidence. Brill (2015) argued

that the politics and poor quality of healthcare delivery systems would eventually lead to a breakdown in healthcare systems across the United States that will require government and social services to reexamine how money is dispersed and care is evaluated. Jones et al. (2020) noted that the primary reason hospital settings for OUD treatment are at capacity is because the reimbursement rates for patients needing this level of care do not cover basic operating costs. Meanwhile, residential treatment settings most often accessed by women who lack stable housing are also closing due to a lack of funding (Barthwell et al., 2019).

As part of the healthcare system, behavioral healthcare has faced the same concerns regarding funding and access to care. The National Council for Mental Wellbeing (2021) stated that financial viability for behavioral healthcare organizations, including those who provide mental health and SUD services, has been underfunded and understaffed for decades. While there have been improvements in funding, there continues to be a lack of access to programming due to financial constraints (Bogusz, 2020). SUD treatment is often considered a high-cost, low-return intervention by healthcare insurers. Like all chronic illnesses, addiction is expensive to treat, and often re-occurrences are the norm rather than the exception (Office of the Surgeon General, 2016).

Criminal Justice

Historically, the criminal justice system in the United States has been the primary method of exerting social control to dissuade problematic substance use. The Drug Policy Alliance (2015) reported that more than 80 percent of the 1.5 million drug arrests

in 2013 were for possession only. Sawyer and Wagner (2020) estimates show that up to 450,000 of the 2.3 million people in prison and jail in the United States are there on drug offenses or were under the influence of alcohol or other drugs when committing the crime(s) for which they have been incarcerated. The U.S. Department of Justice Bureau of Justice Statistics (2018) noted that most people convicted of drug offenses are on probation or parole (as of 2016), which has led to a decrease in the prison and jail populations across the country.

Prison overcrowding, the amount of funds associated with prison staffing and upkeep, and research demonstrating that the mere experience of being incarcerated increases recidivism have led to increased use of drug courts (Ekstrand, 2005). These special judicial approaches to addressing criminal activities related to alcohol and other drug offenses started in New York in 1974 and became more popular during the 1980s (Lurigio, 2008). Since then, this approach has expanded throughout the country. Rather than sending "drug offenders" to jail or prison, drug courts and their agents (primarily probation officers) monitor the individual's progress and adherence to court-ordered treatment and restitution activities (Roman et al., 2020). According to Mei et al. (2019), the collaborative approaches to problem-solving and monitoring the offender's progress appear to be the primary reason for the significant reduction in substance use and recidivism amongst participants. More recently, drug court has also been expanded to Family Treatment court. Seiger and Haswell (2020) reported that this approach to treating the family system has begun to show great promise, but more research is needed to fully understand the impact.

Thomas and Bull (2018) argued that although policies around substance use have been moved to the forefront of policy discussions, women's voices in policymaking have been largely absent. They identified that the unique treatment needs and barriers to accessing treatments for women had been demonstrated over several decades in the literature, yet policy guiding gender-specific treatment has lagged. Johnson (2019) argued that the potential for legal involvement outlined in the Comprehensive Addiction and Recovery Act (CARA) has further contributed to the stigma and fear women experience at the national level when faced with addiction and the medical situation of pregnancy, as states were required to outline how infants would be protected when parental substance use was an issue, including treatment needs of the parents. Ghertner et al. (2018) noted that although legal involvement remains high in this population, more judges are diverting pregnant women to treatment programs through drug courts rather than ordering incarceration.

Women. Chou et al. (2020) expressed that "historically, shame and punishment have not been effective deterrents for reducing maternal substance use," yet the criminal justice system continues to use these strategies for social control (para. 5). According to the National Advocates for Pregnant Women (2021), on October 5, 2021, a 20-year-old woman from Oklahoma was sentenced to four years of prison after being convicted of manslaughter in the first degree after experiencing a miscarriage she experienced three years prior. They explained that while miscarriage prior to 20 weeks gestation is not considered a crime (the medical examiner put the fetal development at 17 weeks

gestation), prosecutors argued that the cause of the miscarriage was related to the woman's illicit substance use.

According to the Guttmacher Institute (2021), 23 states and the District of Columbia consider substance use during pregnancy to be a criminal offense; 25 states and the District of Columbia have laws requiring medical providers to report suspected prenatal drug use. They found that 19 states have substance use disorder treatment programs dedicated to women who are pregnant. Their data also shows ten states that prohibit publicly funded substance use disorder treatment programs from discriminating against pregnant women and using substances. The data provided by the Guttmacher Institute also showed that three states (Minnesota, South Dakota, and Wisconsin) have laws that state substance use during pregnancy is considered child abuse and is grounds for civil commitment. They also showed that 25 states and the District of Columbia have laws stipulating medical providers are required to report their suspicions to state agencies and perform a drug test when drug use is suspected.

Social Services

Seiger and Haswell (2020) noted that the current surge of opioid use and opioid-related deaths has forced child welfare systems, including child protection and family social services, to find new ways to cope with parental substance use. The stressed foster care system was a prime example of the need to develop different systems, leaving these children with nowhere to go if they were removed from their parent's care. Falletta et al. (2018) noted that since 2013 there was a total of 415,129 children in foster care placement; in 2015, that number increased to 428,000. Falletta et al. identified the rise in

children being removed from parental care resulting from parent opioid use as the primary reason for the increase. They further attributed this increase to the rise in children being removed from parental care after testing positive for opioids at birth. Adding to an over-stressed system, Syvertsen et al. (2021) noted that reporting inconsistencies between medical providers and organizations led to increased fear as providers and mothers never knew when or if child protection would become involved in the case.

Stigma Faced by Maternal, Opioid-Using Clients

Stigma about substance use has been part of the history of the founding of the United States (Chamberlain, 2018). Chamberlain (2018) noted the highly stigmatizing language rooted in moral failings as a reason for the stigma associated with substance use in America. Chamberlain argued that the temperance movement was so profound that we still feel the effects today. One way that stigma is perpetuated is with language used to describe a person or situation. Counselors understand that the pejorative terminology used by society, families, and clients themselves contributes to the shame experienced by clients trying to move from substance use towards recovery and wellness. As Syvertsen et al. (2021) asserted, women face added layers of stigma associated with substance use.

Societal

Societal perspectives of substance use during pregnancy provide insight into women's stigma while pregnant (Chou et al., 2020; Stone, 2015). Women who have SUDs and parent children face economic, transportation, and childcare barriers (Frazer et al., 2019). These barriers are higher if a woman has a felony charge related to her

substance use history, as this criminal history often prevents her from obtaining employment that offers an income high enough to pay for daycare and healthcare services (Council on Foreign Relations, 2018). Howard (2015) identified societal stigma toward mothers who use substances as an indicator of increased feelings of guilt and shame during and after pregnancy. Stigma against pregnant women has continued to be a societal-induced barrier to receiving care (Chang et al., 2020; McCarthy et al., 2017).

Stone (2015) reported that societal sigma served as a formidable barrier to seeking medical care for most women who used illicit substances and alcohol during pregnancy. Stone also asserted that pregnant women and using substances take excessive measures to avoid detection out of fear they would be subjected to the criminal court system. Ettorre (1989) highlighted that substance use during pregnancy is presented as a failure to motherhood and mothering, while men are not held to the same standards and do not face the same degree of societal disapproval for their substance use, even when they are fathers. Syvertsen et al. (2021) explained that societal expectations of women to stop using substances place additional pressure on them to hide their pregnancy status and avoid shame. They noted that overt and covert messages from society often lead to detrimental health effects, including increased stress and anxiety.

Parental

Feelings of guilt and fear have been shown to dominate the psychological mindset of pregnant women who use substances (Howard, 2015). Asta et al. (2021) surveyed 50 women who were pregnant and had an opioid use disorder and discovered that 94% of them cited their pregnancy as the primary reason they sought treatment for their OUD.

According to Howard (2015), “the normative rhetoric around abstinence during pregnancy and early parenthood are fundamentally moral with motherhood framed as a corruptible bastion of purity and selflessness” (p. 5). These feelings not only impacted the women during pregnancy but after giving birth. Their research extrapolated guilt and shame as significant in contributing to low feelings of self-worth as a new mother. Syvertsen et al. (2021) noted similar findings; their qualitative study quoted one woman’s experience of guilt and shame after receiving consultation and psychoeducation to receive MAT during pregnancy.

Medical Professionals

The systemic stigma of maternal, opioid-using clients is a significant barrier to seeking and obtaining prenatal care. Syvertsen et al. (2021) discovered that providers often “fire” their pregnant clients who misuse opioids as they are afraid of the added liability of opioid use. They found that addiction specialists did not feel it was within their scope of practice to treat pregnant women. Syvertsen et al. (2021) found that 25 of 28 women surveyed had prior pregnancies, 14 of whom reported negative experiences in prenatal and birthing settings. These experiences included being treated rudely, judged, viewed as a “criminal,” delayed MAT, refused adequate pain treatment or treated like the “scum of the frickin’ earth” and “pure shit” (p.4).

Doctors. Beyond the scope of practice and fear of liability, moral concerns also permeate some medical providers’ unwillingness to treat maternal, opioid-using clients. Johnson (2019) asserted the reason for poor maternal and fetal outcomes, when opioid use is a factor, results from provider stigmatization grounded in morality clauses,

referring to the provider's personal beliefs and moral judgment dictating the care they provide, rather than standards of medical practice. Benoit et al. (2014) identified that medical personnel viewed substance-using women who were pregnant as "fetal incubators" (p. 260). Benoit et al. discovered that providers relied on their morals to determine the basis of the mother's substance-using behaviors, despite knowing that developmental concerns resulting from in-utero opioid exposure were inconclusive. Themes from their study centered around providers' views of pregnant women with a SUD or OUD ability to care for themselves during pregnancy and the child after birth and demonstrated significant judgments based on personal morality positions.

Moldovan (2012) asserted that there are many reasons prescribers may be hesitant to engage clients in MAT. They referred to these concerns as "Opiophobia" (para. 2). Moldovan cited legal worries, lack of education, and concerns about perpetuating the opioid crisis as underlying issues that led prescribers to be hesitant about using MAT. Holbrook (2015) explained that treatment interventions are often gender-biased. Men receive MAT at significantly higher rates than women, presumably because of the women's potential to become pregnant and the prescriber's reluctance to risk prenatal opioid exposure.

Nurses. According to Recto et al. (2020) and Fonti et al. (2016), pregnant women who use opioids face the most stigma, overt and covert, along with bias from their care nurses before and after delivery. Recto et al. noted that working with mothers and infants where opioid exposure was a factor also caused significant moral and ethical distress, as well as compassion fatigue. Recto et al. demonstrated the complexity of interpersonal

issues and concerns the mothers and professionals face. Shaw et al. (2017) demonstrated that obstetric nurses had mixed perceptions of women who presented with current opioid misuse. Additional themes emerged from Shaw et al.'s study focused on the nurses' predominantly negative feelings towards the mother. In addition to the stigma associated with MAT, participants in a study by Syvertsen et al. (2021) also noted that the reality of neonatal assistance syndrome was traumatizing, stating:

> So, I got there, and I had seen how uncomfortable [the baby] looked, I got really upset. [The nurse] seen me when I was crying, and I said somethin' about withdrawal and asked if he was startin' to go through bad withdrawal and she kind of got smart with me and told me, "Yeah! They didn't tell you about this? It's gonna be horrible, he's gonna be sick for months." … You could just tell by the way she said it, she didn't like the whole idea of taking methadone when you're pregnant…but I've been on drugs for a long time. There probably hasn't been a day where there hasn't been an opiate in my system since I was about 17-years-old. So if I just go with nothing, I'm really sick. I would've lost the baby. (p. 4)

Behavioral Health Clinicians. Research focused on BH clinicians' perspectives on opioid use during pregnancy is largely absent from the literature. However, Syvertsen et al. (2021) examined medical providers' attitudes and included counselors in the sample. They found that even when women did "everything they were supposed to," they still felt they struggled with their biases and "moral outrage" (p. 4). They reported this stigma in several settings, from methadone clinics to hospitals and treatment centers.

Some research examines attitudes about substance use in general, but there is limited research exploring how BH clinicians contribute to or refute stigmatization when clients are pregnant with a co-occurring OUD. Cornfield and Hubley (2020) found that counselors had a "somewhat positive" attitude toward working with clients who have SUDs (p. 654). They compared attitudes about working with SUDs to attitudes about working with clients with depression and recognized that the counselors had higher positive attitudes about working with clients with depression than those who had SUDs. When they examined questions indicating negative attitudes towards working with SUD clients, there was minimal negativity. By looking at attitudes from both directions, Cornfield and Hubley concluded that, in general, counselors have a positive attitude towards working with clients who have a SUD, but less so than when working with other populations.

However, the perception of clinician attitudes by clients differs from Cornfield and Hubley (2020). According to Barnett et al. (2021) described situations of judgment and discrimination by medical providers and staff. These participants explained that the lack of empathy, in addition to medical bias and stigmatization, created a sense of distrust toward providers. This distrust led women to avoid prenatal care. (p. 7-8).

Concern for Long-term Outcomes of Intrauterine Exposure

One possible reason stigma is so intense around maternal substance use is out of concern for the fetus, or what Stone (2015) referred to as "fetal protectionism" (para. 1). The Maternal Lifestyle Study (MLS), sponsored by the National Institute of Child Health and Human Development (NICHD), is one of the few longitudinal studies, which

provides researchers with data related to the long-term impact of cocaine and opioid use during pregnancy (Lester et al., 2016). The study began in 1993 and ran through 2003; however, its impact was substantial, and data was continuously updated on the website until 2016. With data from over 16,000 participants, the MLS data provides researchers with a substantial amount of information examining the impact of prenatal exposure to opioids or cocaine and childhood outcomes. Findings from the data demonstrate no long-term adverse effects on the child after the neonate phase (Azuine et al., 2019; Doyle et al., 2018). The ACOG (2017) stated, "for the most part, studies have not stated significant differences in cognitive development between children up to 5 years of age exposed to methadone in utero and control groups matched for age, race, and socioeconomic status" (para. 46).

Barriers to Care for Maternal, Opioid-Using Clients

Martin et al. (2021) stated that of adults diagnosed with a SUD in the past year, 63.4% were men, and 36.6% were women. Additionally, they noted that only 10.6% received SUD treatment, and a greater percentage of women needed treatment for an OUD (11.9% women vs. 9.9% men) (p. 1). Navigating barriers to care is often part of the role of the BH clinicians working in residential and hospital settings.

Social Determinants of Health (SDoH)

According to the Office of Disease Prevention and Health Promotion [ODPHP] (2020), social determinants of health (SDoH) "are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks" (para. 1). They also noted

five domains associated with SDoH: economic stability, education access, and quality, healthcare access and quality, neighborhood-built environment, and social and community contexts. Fordor and Zelena (2014) established that environment is a key factor in predicting a child's developmental trajectory when exposed to opioids and demonstrated that SDoH better-predicted childhood outcomes than intrauterine opioid exposure. Coupland et al. (2021) argued that SDoH is a primary consideration when developing and implementing care for pregnant women with a SUD (p. 4).

From the MLS data, Bada et al. (2008) discovered that the stability of early childhood living arrangements was a better predictor than prenatal exposure when determining the risk for behavior problems in children. The study also found that children who lived with their relatives had fewer behavioral disorders when compared to their prenatally exposed peers placed in the foster care system. These results were further validated through a meta-analysis by Arter et al. (2021), which identified childhood living environments were a better predictor of adolescents' long-term academic success outcomes. Environmental impact was also demonstrated by Šlamberova (2013), who found that some maternal rearing differences contribute to psychosocial and other developmental concerns.

Healthcare Access

Medication-assisted treatment (MAT) is considered the strongest evidence-based practice for treating maternal, opioid-using clients. The American College of Obstetricians and Gynecologists (ACOG) (2017) explained that discontinuing opioids during pregnancy could lead to intrauterine fetal withdrawal and that the stress (e.g.,

decreased heart rate, lowered oxygen levels) could lead to fetal death. Luty et al. (2003) discovered that the risk of spontaneous abortion resulting from withdrawal from opioids is approximately 6.87% during the first trimester of pregnancy. They reported that MAT is a safe and effective way to mitigate the risk of unplanned pregnancy loss. According to McCarthy et al. (2017), Medication interventions are used to decrease fetal stress that is associated with poor postnatal outcomes by decreasing the physical stress caused by opioid withdrawal (p. 226).

Zedler et al. (2016) suggested that the research examining the benefits and drawbacks of different MATs used during pregnancy has delivered clear outcomes showing both safety and efficacy. Both methadone and buprenorphine have been demonstrated to be highly effective at mitigating illicit opioid use during pregnancy, leading the ACOG, SAMHSA, and other oversight/regulatory organizations to recommend using either of these MATs during pregnancy (Holbrook, 2015). Despite the known efficacy of MAT during pregnancy, access to providers who are certified to provide MAT is limited. Even in large urban areas with more prescribers than rural areas, the number of medical providers certified to treat using MAT is limited, causing a shortage of providers.

Child-Rearing Responsibilities

Barnett et al. (2021) conducted a systemic review of the literature examining barriers to mothers with substance use disorders seeking care. Lack of childcare was a primary barrier to care for most women. Chou et al. (2020) noted that due to the most recent opioid surge, there had been an increase in family-centered substance use

treatment throughout the United States. Despite this increase, very few residential treatment settings allow mothers and children to reside in the treatment setting, despite research demonstrating that women who attend treatment with their infants have better outcomes (Elms et al., 2018; Staudt, 2018, p. 56).

Systemic Racism

A Public Health Emergency was declared on October 26, 2017, by the U.S. Department of Health and Human Services (HHS) regarding opioid-related deaths. A point of concern related to the emergency is data suggesting Black, Hispanic, and indigenous peoples were dying at high rates prior to the declaration by HHS, and it was not until there was a sharp increase in White people dying that the emergency was declared (Bridges, 2020). Bridges (2020) stated that "of the 47,600 people who died from opioid overdose in 2017, 37,113 (78%) were White" (p. 789). An example of how illicit substances (opioids in particular) have historically been used to marginalize the Black/African American population in the United States can be found in a Harper's Magazine article from 2016 by Dan Baum. He expanded on his research for his book *Smoke and Mirrors: The war on drugs and the politics of failure*. Quoting John Ehrlichman (former assistant to President Nixon overseeing Domestic Affairs for the administration), Baum (2016, April 1) reported:

> "You want to know what this was really all about?" Ehrlichman asked, referring to the war on drugs. "The Nixon campaign in 1968, and the Nixon White House after that, had two enemies: the antiwar left and Black people. You understand what I'm saying? We knew we couldn't make it illegal to be either against the

> war or Black, but by getting the public to associate the hippies with marijuana and Blacks with heroin and then criminalizing both heavily, we could disrupt those communities. We could arrest their leaders, raid their homes, break up their meetings, and vilify them night after night on the evening news. Did we know we were lying about the drugs? Of course we did." (para. 2)

Black/African American Women

Mennis et al. (2016) noted that Black/African Americans face the most systemic barriers to obtaining treatment for SUDs. They asserted that these barriers are high because most treatment services are provided in outpatient settings that require travel. They explained that income inequality experienced by the Black/African American community leaves many, especially women, to rely on public transportation to engage in substance use treatment. Public transportation is time-consuming and often unreliable, thus creating a barrier to accessing care.

Barlow and Johnson (2021) discussed the healthcare disparities Black/African American women face and noted that these disparities are part of the systemic racism in the United States. Syvertsen et al. (2021) reported that Black/African American or biracial women were less likely than their White counterparts to have a sustained recovery. Black/African American women are often viewed through a socio-cultural perspective, which leads to treatment interventions focused on poverty instead of the medical or psychiatric disease models often applied to men and White women with SUDs (Gray & Littlefield, 2002; Travis, 2019).

Bridges (2020) stated that Black women had experienced more criminal justice repercussions related to substance use during pregnancy than other groups. Bridges explained that the crack-cocaine endemic of the 1980s and 1990s primarily impacted the low-income Black/African American community. During this time, states relied on the criminal justice system to address substance use during pregnancy. Bridges noted that the result was that "Black women became the face of the criminalization of substance use during pregnancy" (p. 775).

Native American & Indigenous Women

Due to the historical trauma caused by colonization and the movement of Native American and Indigenous people onto reservations, research with Native American/Indigenous participants is limited. Reports resulting from data provided by tribal authorities provide some insight into the OUD concerns tribal communities are facing. By examining Minnesota Medicaid claims linked to birth records, Earle (2019) found that OUD during pregnancy has risen by 7.1% (from 7.7% to 14.8%) among Indigenous women in Minnesota since 2009. Citing state data from 2009-2012, Earle demonstrated that among Native American/ Indigenous births since 2009, the rate of infants born exposed to opioids was 110/1,000 (or 11%) of live births, with the next highest group being non-Hispanic White at a rate of 15/1,000 (or 1.5%) of live births, followed by non-Hispanic Black rates of 5/1,000 (or .5%) of live births.

Earle (2019) explained that tribal partners brought forward concerns related to the increase in infants born with opioid exposure, which, in 2014, led the National Center on Substance Abuse and Child Welfare (NCSACW) to begin collecting data from six states,

including Minnesota, as part of the Substance Exposed Infants (SEI) and In-Depth Technical Assistance (IDTA) programs. The data collection efforts intended to increase state and tribal authority's abilities to address the significant increase in infants born with opioid exposure. The data collected resulted in increased funding for measures to implement collaborative care models in Minnesota for Native American/Indigenous women, with the intent to reduce opioid use within this population.

According to Greenfield (2018), Native American and Alaskan Native women have the highest risk of dying from an opioid overdose. In response to the recent opioid surge, the Indian Health Services (IHS) and ACOG released a joint statement on recommendations to improve the care of Native American/Indigenous women with OUDs; the statement was based on the IHS and ACOG partnership document developed to address the rising rates of Native American/ Indigenous neonates born with NAS (IHS and ACOG, 2017). The recommendations included screening and increased monitoring for opioid use during pregnancy and recognized the importance of using trauma-informed approaches that align with the culture of each tribe.

Summary and Conclusion

The shortage of clinicians who work with maternal, opioid-using clients is in-part due to clinician burnout. Tiwari et al. (2020) compared BH clinicians to teachers (another high-stress helper profession). They reported that clinicians working in emotionally intensive settings (such as residential and hospitals) are at high risk of burnout because of stress related to their ability to do their job effectively. Working with maternal, opioid-using clients requires BH clinicians to provide services around systems that have been

known to oppress and marginalize women. Additionally, the focus of care differs from other settings in that mothers receiving treatment are often there under a court order or due to social service involvement. The fear of a compromised pregnancy, dilemmas over the impact MAT may have on their fetus, lack of access to resources, and the constant threat that they may lose parental rights require clinicians to address these realities when the mother is under their care.

From a feminist perspective, institutions such as healthcare, criminal justice, and social services can compromise the ability of BH clinicians to effectively and ethically provide care and help maternal, opioid-using clients. At the institutional level, healthcare systems are beholden to reimbursement rates that do not support the staffing required to provide quality care for this highly complex group of clients. Additionally, the history of the social service removing children from their mothers due to maternal substance use may not align with the opinion of the clinician and cause significant distress when that clinician is required by law to limit confidentiality in order to comply with judicial requirements (Baxter et al., 2019). On a social level, clinicians walking beside their clients during their pregnancy and treatment journey also collaborate with other professionals who may have significant bias and stigma toward their typical clients. While the term “moral distress” may not be common in the behavioral health, mental health, and addiction literature, the concept warrants further investigation in the field of counseling. In chapter three, I discuss the methodology used in my research related to the experiences of BH clinicians working with maternal, opioid-using clients.

Chapter 3: Research Method

The purpose of this qualitative IPA study is to understand how BH clinicians who have worked in residential or hospital settings experience MD as part of their work with maternal, opioid-using clients. IPA was chosen because of the systematic process of diving deep into the data based on the participants' own terms (Smith et al., 2012,; Smith & Nizza, 2022). According to Smith and Nizza (2022), IPA provides the researcher with an organic approach to data analysis that adapts to the emerging themes. As part of the interpretive process of the data, I applied a feminist lens as I followed the process outlined by Smith and Nizza (2022). To address potential issues of trustworthiness related to my outcome data, I implemented synthesized member checking to ensure the voice of the participant is heard through the researcher's interpretation while creating a collaborative effort as part of thematic development (Brit et al., 2016). I also created an audit trail that can be used as part of the peer-review process. In this chapter, I describe the specific research plan for the study, including a description of the research design and rationale, the researcher's role, methodology, and data analysis plan.

Research Design and Rationale

While there is research in medical healthcare exploring how providers (primarily nurses) experience MD as part of their work with maternal, opioid-using clients, studies investigating the impact of MD BH clinicians is lacking. My research was a qualitative study that explored the MD that arises when providing clinical counseling services to a stigmatized population because of their substance use and the societal bias their opioid use invites as women and as mothers. By exploring how this subset of clinicians

experience MD, my intent was to provide counselor educators and supervisors with research that could inform continuing education and supervision needs. In doing so, the broader aim was to support the field of counseling in its efforts to continually increase the quality of care provided and reduce turnover in an area of the field experiencing a severe workforce shortage. In doing so, more people can accesses counseling services.

Phenomenon of Study

The phenomenon I studied was MD in the context of BH clinicians who work with maternal, opioid-using clients. Nuttgens and Chang (2013) noted that features of MD might vary slightly between contexts; however, the broader constructs are similar across disciplines. They explained that BH clinicians, much like other healthcare providers, face situations causing MD due to the inherent healthcare systems in the United States. Jameton (2017) explained that clinicians face organizational problems created by the U.S. healthcare and social service systems. These systems can prevent clinicians from providing the care they deem most ethical and beneficial to their clients. As Jameton noted, when this happens, it can lead to a degree of MD that can compromise client care and clinician wellbeing.

Rationale

Nuttgens and Chang (2013) stressed the lack of attention to understanding how MD impacts clinicians' concerns as it is a concept that appears to plague the field. Turnage-Butterbaugh (2015) noted that further study to understand the phenomenon is warranted, especially since MD has been shown to be a precursor to clinician burnout. Beginning with understanding how this phenomenon presents in clinicians who work in

high levels of care (residential and hospital) with a highly complex population (maternal, opioid-using clients), the phenomena can be explored from multiple directions and generalized across the field of counseling. By exploring these lived experiences, the field of counselor education and supervision will have a better understanding of the stages before burnout, which is known to increase turnover in the field.

Clinicians working with maternal, opioid-using clients face a variety of external barriers to serving their clients. Women seeking treatment for opioid use, as well as women of color and women who have barriers to earning a living wage, face significant bias in healthcare settings (Barlow & Johnson, 2021; Syvertsen et al., 2021). Societal expectations of womanhood and motherhood are challenged in multiple ways when discussing women and substance use, especially in the context of pregnancy and substance use (Ambrosini & Stanghellini, 2012). The relationship between BH clinicians' training and practice is important when examining the phenomenon as it speaks to the foundational level of preparedness needed to work with the population (MacKain & Noel, 2020).

Research Tradition

Ravitch and Carl (2016) explained that qualitative research reports on the salient findings of topical inquiry. According to Saldana et al. (2011), qualitative questions provide researchers with an opportunity to explore the story behind the "social process" (p. 71). My research question seeks to understand how clinicians make sense of the experiences of MD when treating maternal, opioid-using clients. A phenomenological approach is best suited for this type of question (Ravitch & Carl, 2016). IPA places the

researcher in the position of using the data obtained from semi-structured interviews to make sense of the lived experiences reported by the participants (Smith & Nizza, 2022). Additionally, IPA acknowledges the researcher's experience in the context of the phenomenon and aligns well with feminist theory as applied in research (Smith et al., 2012).

There are many qualitative research traditions to choose from (Ravitch & Carl, 2016). While I was conceptualizing my study, I considered a case study approach, as it would allow me to examine data in great depth. Patton (2015) noted that case studies could be a person or "theoretical construct" (p. 259). The construct of the client-clinician dyad was my first inclination as it would allow me to explore how the clinician is impacted through their work with a specific client. However, I determined that the phenomena from a single case study would be more than a single theoretical construct. Therefore, a case study would not provide the breadth of data exploration.

Based on the phenomenon being studied (moral distress), I also considered transcendental phenomenology. According to Moustakas (1994), Husserl's work was a philosophical system that Moustaka developed into a qualitative study methodology (p. 22). Moustakas' transcendental methodology is focused on the "blending of the real and ideal" (p. 22), meaning that the philosophy of how something appears is not the truth; rather, the phenomenon is understood by examining the meaning of the data. While Moustaka's transcendental phenomenological approach is often utilized in studies about pregnancy (Bondas & Erickson, 2001), IPA held greater appeal for my study for its systematic approach to data analysis.

Role of the Researcher

Positionality refers to the researcher's role and the intersectionality of that role with social factors and identity (Patton, 2015). Patton (2015) argued the researcher is central to the study's design in qualitative research. According to Ravitch and Carl (2016), researchers must both consider their position on the subject being studied and be transparent in their research about their positionality. Brisolara et al. (2014) explained that when feminist theory is applied to research, the researcher must understand their role as knower and investigator. In the IPA qualitative model, Smith and Nizza (2022) stated the researcher plays a double role as observer and interpreter with their lived experiences and perspective, thus influencing the study's hermeneutic aspects.

Research Positionality

As a dually trained mental health and SUD clinician, I have worked with maternal, opioid-using clients since my graduate school field experience in 2011. As a clinical trainee, I began working in a hospital setting with maternal, opioid-using clients. As a new mother, I distinctly remember thinking, "how could these women harm their babies by doing drugs?" It was not until I began working alongside the medical providers that I realized I was judging and perpetuating the stigma women faced, not just about womanhood but about motherhood. Seeking help from medical providers and social services was a significant challenge, and the additional stressors of interacting with the criminal justice system while knowing what I said to these other professionals caused significant MD. Confidentiality is a cornerstone of the therapeutic relationship, yet I was

being asked by a variety of systems to disclose information that would contribute to a judge's decision whether to terminate the parental rights of the mother.

As a counselor educator and supervisor, I have also seen how students and clinicians are impacted by their work with maternal, opioid-using clients. As an educator, I have encountered hundreds of students who have a substantial bias toward women who use any drugs during pregnancy; this prompted me to develop a dedicated curriculum grounded in research from neurobiology psychology and addiction to dispel myths about the long-term impact of in-utero exposure and the realities of maternal overdose deaths postpartum. As a supervisor, I often see the toll taken on counselors by the lack of resources, the compromises of personal and professional values, and the systemic barriers faced by clinicians working with this population. My personal aim for this research was to better understand MD and develop training and support systems to help prevent burnout from this phenomenon, that in my experience, too often occurs in clinicians.

Managing Researcher Bias

Frost and Holt (2014) found that the researcher's identity significantly impacts more than the researcher's positionality. Their study discovered that being a mother influences one's research questions, the data collection, and analysis. Furthermore, they noted conflicting experiences as "mother, researcher, feminist, and woman" (p. 98). However, Frost and Holt found that researcher objectivity and "experiential legitimacy" (p. 99) were not compromised when the researcher identified as a mother. While IPA is the methodology I used to direct my study, the framework of feminist theory also drove coding and theming, as it affords the opportunity for deep understanding of the

relationship between the data and the experience of womanhood and motherhood (Anderson, 1995). As the primary researcher in this study, my background working with maternal, opioid-using clients, as a mother, and in current role as a clinician and leader in the integrated behavioral healthcare field influences my positionality around the phenomenon I am researching. My positionality awareness requires me to reflect on my inquiry methods, the structure of my questions, and personal biases and beliefs when coding the data (Ravitch & Carl, 2016).

According to Patton (2015), our lived experiences and constructs can be useful in qualitative research when the researcher is aware of their positionality and presents data transparently. Ravitch and Carl (2016) stated one way to increase rigor through reflexivity is to employ several strategies to minimize researcher bias. Due to my experiences working with maternal, opioid-using clients and my role as a supervisor, I plan to use three techniques to minimize researcher bias. These include member checking, bracketing (as outlined by Smith et al., 2012), and an audit trail.

Bracketing was used during my research process's data collection (semi-structured interviews) and data analysis phases (Smith et al., 2012). Bernard et al. (2017) noted narrative analysis in qualitative studies' phenomenological methods focuses on bracketing to account for bias and increases the study's credibility. I plan to bracket my experiences during the analysis phase by keeping a confidential journal to help me gain insight into how my experiences may influence my interpretation of the data, as described by Smith and Nizza (2022).

Methodology

As the care system continues to rely more on BH clinicians as team members, developing an understanding of clinical needs and approaches by those currently working in the field provides a knowledge base that is absent from the current literature. I used the IPA methodology, as outlined by Smith and Nizza (2022), to ground my study. By orienting my research in IPA and with a feminist framework to assist in the interpretation of the data, the outcomes provide insight into how counselor educators and supervisors can consider strategies to support BH clinicians in their work with women who are pregnant and have SUDs. This section outlines the instrumentation, participant selection, procedures for recruitment, participation, data collection, and trustworthiness issues related to my research.

Participant Selection

Smith and Nizza (2022) stated homogeneity is also an important factor in an IPA study but cautioned participants should not be identical in all respects (p. 50). Therefore, participant parameters were limited to BH clinicians who are licensed by their state board to practice as a professional clinical counselor (LPCC), professional counselor (LPC), or marriage and family therapist (LMFT). Participants must have had minimum of nine months of direct work with pregnant women who use opioids to participate in my study. Gallo (2019) found that it takes approximately six months to learn a new job. Based on this information, I added three months to the minimum requirement to ensure that the clinicians had time to engage with the population after the learning curve had plateaued.

Procedures for Recruitment, Participation, and Data Collection

Bernard et al. (2017) explained that network sampling methods, such as convenience and snowball sampling, are productive when participants are invested for reasons outside of research and care about social impact outcomes. Recruitment efforts included accessing my professional network at treatment centers with programming for pregnant women who have SUDs. I also posted the link to a brief screening survey through my contacts on Linked-In and CESNet, sent recruitment emails to my professional network of clinicians asking them to distribute the call for participants to those who may fit the criteria, and announced the study in a private counseling group on Facebook that had clinical social workers, substance use counselors, and professional counselors. Finally, I posted the link to the participant screening survey on the Walden University Center for Quality Research portal for participant recruitment.

Sample

Smith et al. (2012) argued that IPA does not require a large sample size to achieve trustworthiness due to the depth of the process. They stated experienced qualitative researchers could implement a sample size of one to three participants to achieve trustworthiness; however, those completing dissertations should consider four to six participants to ensure standards are met. My study included five participants who were interviewed once for approximately 60 minutes each. Smith et al. also recommended researchers using IPA methodology conduct a follow-up interview after interpreting data if gaps are identified. Participants were advised through the consent process of the time associated with participating in the research. I collected enough data through the initial

semi-structured interview to identify several themes and subthemes. Participants were notified that there would not be a follow-up interview needed.

Dual Relationships

Ravitch and Carl (2016) acknowledged that qualitative research often leads to the potential for a dual relationship between researcher and participant. They noted that to ethically manage this relationship and preserve the study's validity, the researcher should set boundaries for participants known to the researcher. I plan to use convenience and snowball sampling. As a counselor educator in Minnesota and Wisconsin, there was the possibility that a volunteer could be someone known to me. To mitigate for an enhanced power differential, I did not partner with the BH organization where I worked, or any of the universities where I was an instructor. Additionally, I did not accept volunteers who were current or former students, and I did not accept participants with a supervisory or oversight role in my work. Setting these boundaries provided distance between myself and participants who may know me (Ravitch & Carl, 2016).

Instrumentation

For my study, semi-structured interview questions focused on how counselors have experienced MD when working with maternal, opioid-using clients. Ravitch and Carl (2016) stated that semi-structured interviews provide organization to the interview process while allowing qualitative exploration to unfold through follow-up questions. Smith and Nizza (2022) asserted that semi-structured interviews are preferable in the IPA methodology for qualitative researchers as the structure guides the interview, yet allows for the organic process inherent to IPA. The authors explained that an IPA study

uncovers elements the researcher often had not considered, leading to questions relevant to the research question, rather than focusing solely on the researcher's constructed inquiries.

Smith et al. (2012) reported that for an adult participant interview that lasts from 60 to 90 minutes, the researcher would want to have between six and ten questions and probes prepared. If a follow-up interview is necessary, additional semi-structured questions would be developed based on identified gaps from the first interviews (Smith et al., 2012). As these questions arise directly from the coding process, it is expected that the content validity for follow-up questions will meet standards for trustworthiness. Appendix A provides the questions developed based on guidelines outlined by Smith and Nizza (2022). Smith et al. (2012) stated that there are seven types of open-ended questions commonly used in an IPA study; these are descriptive, narrative, structural, contrasting, evaluative, or circular. They also recommended creating prompts that help the participant understand the question's intent but do not lead the participant, and probes that encourage the participant to provide more details and additional depth. Additionally, they noted that the interview schedule is expected to change as the discovery process is organic in nature.

Question Development

Smith and Nizza (2022) discussed the development of the interview schedule as an iterative process that maintains alignment with the research question. The first step outlined by Smith et al. is to brainstorm questions. To do this, I generated a list of questions that I felt could come out of my research question. I then categorized them as

one of the seven kinds of questions Smith et al. identified as appropriate for an IPA study. The next step was to order them in what I considered an appropriate sequence, leaving more sensitive questions for later in the interview schedule. I then reviewed the questions and rephrased or removed any that appeared to be "leading or loaded" (Smith et al., 2012, p. 61). Finally, Smith et al. advised reviewing the interview schedule with others to obtain feedback and make adjustments. They also noted that this step is important to ensure that research bias is identified in the questions and to increase the content validity of the interview schedule.

To increase content validity, I reviewed my interview schedule with multiple experts in treating maternal, opioid-using clients. These include Tamarah Gahlen, Ph.D., LPCC, LADC (director of women's programming at a large urban residential treatment center for pregnant women who have substance use disorders), and Sara Wallentine, RN (trauma nurse at a county medical center and flight nurse). To further ensure the quality of my questions, I also met with a qualitative tutor (Dr. Morris) from Walden University to review my interview schedule and receive feedback.

Data Analysis Plan

Smith (2009) stated that due to the inherent difficulty humans have in making meaning of their experiences, IPA provides researchers with a method to explore participants' reported meaning. For example, one could theorize the lack of research regarding therapists lived experiences when working with pregnant women and using opioids results from the sensitive nature of the phenomenon of client-centered approaches. IPA provides a structure to phenomenological design, which allows for

structured interpretation in an ongoing fashion until saturation has been met through clear themes unfolding by going deeper into the data rather than expanding the number of participants (Smith & Nizza, 2022).

Smith et al. (2012) explained that IPA methodology requires the researcher to avoid developing themes during the interview or transcription process. Through skills practice, I have become proficient at staying in the moment and focusing on the participant's story (Smith et al.); however, as a new researcher, I found this was more difficult to refrain from during the transcription process, as I am a highly visual learner. I tend to notice patterns when I am reading and writing. To accommodate for this, I used a paid transcription service that meets the requirements for Walden University's research security protocols, including having Rev.com destroy their copies of the transcripts and recordings within 10 days of completion.

After transcripts were written and proofread, I followed the analysis steps outlined in Smith and Nizza (2022). I began with reading and re-reading each transcript (p. 82). Next, initial noting will allow free text and observations to be bracketed for later reflection and possible use. I noted exploratory comments before analyzing themes, but thematic language will be bracketed and later reviewed for later consideration (p. 40). After deconstructing and reviewing the initial notes, I identified emerging themes, known as experimental statements (p. 40) and finally seek connections between these themes after each transcript has been coded. Each transcript was approached in the same manner; after each has been completed, I looked for common themes using a chart to determine the frequency of these themes across transcripts (Smith et al., 2012, p. 107).

Issues of Trustworthiness

Shento (2004) asserted trustworthiness is difficult to demonstrate in qualitative studies; however, many approaches have been developed to establish credibility, confirmability, dependability, and transferability. To ensure that trustworthiness meets the criteria for Walden University, I referenced the qualitative guide "Information on Trustworthiness" (Laureate Education, n.d.). The following section explains my approach to address trustworthiness in my research.

Credibility

Stahl and King (2020) conceptualized credibility in qualitative research to be "how congruent the findings are with reality" (p. 26). According to Birt et al. (2016), synthesized member checking is accomplished by having participants review their transcripts and the emerging themes and provide the researcher with corrections and feedback. Brit et al. noted that this approach to validating the data helps to ensure that the researchers' interpretation and coding align with the participants' intended meaning while also offering the participants an opportunity to add to the interpretation of the data.

Transferability

Transferability refers to the contextual aspects of the research which can be applied to broader contexts (Ravitch & Carl, 2016). Transferability is attained by demonstrating how the work changes clinicians personally and professionally (Ravitch & Carl, 2016). Patton (2015) noted that "empirical interpolation and extrapolation" increases generalizability when research findings can be applied to a range of outcomes through thick descriptions (p. 710). Smith and Nizza (2022) argued that IPA is designed

to provide thick descriptions by providing depth through the interviewing process to increase the ability of others to replicate findings.

Dependability

According to Ravitch and Carl (2016), dependability is similar to a quantitative study's reliability (p. 189). Dependability can be achieved through what Given (2008) refers to as an "inquiry audit" (p. 1). This method requires others from outside my research to evaluate my logs and coding, ensure multiple perspectives and quality throughout the process, and follow the interpretive process's guidelines outlined in Smith and Nizza (2022). As part of the dissertation process, I have access to qualitative tutors at Walden University to assist with the learning process of coding my data.

Confirmability

Patton (2015) and Ravitch and Carl (2016) expressed that qualitative studies do not postulate objectivity as a core tenant; in fact, the reverse may be said. Given (2008) explained that confirmability could be addressed through transparency regarding biases as a researcher related to the phenomenon being studied. Transparency is typically achieved through reflexivity, which Bleiker et al. (2019) defined as the self-reflective process of the researcher related to their identity, positionality, and bias. Smith and Nizza (2022) explained that bracketing in IPA is different than in other qualitative methods. In an IPA study, bracketing (setting aside one's personal views and biases) is used during the inquiry process, but rather than removing the research; bracketing is used as part of transparency and integrated into the interpretation process (pp. 25 & 35).

Ethical Procedures

The Walden IRB granted my study permission before participants were recruited or collected data; the approval number is 02-02-22-0661252. My study was conducted in adherence to the ACA (2014) Code of Ethics and the Walden (2021) Institutional Review Board (IRB). My research is considered to have minimal risk to participants as it does not include vulnerable populations. I protected the participants' identities by using pseudonyms and informed consent documents that clearly outline the study's goal, with the option to ask me for clarification at any time. Participants were allowed to withdraw from the research at any time, and their data will be immediately destroyed by deleting from the password-protected encrypted external drive where the data is to be stored. Data was kept on an encrypted password-protected electronic file and locked in a cabinet that only I could access in my personal office. All data will be destroyed five years after the completion of the study.

The Walden University IRB template for informed consent was used for all volunteer participants. The consent document includes information that explains confidentiality and the requirements for me to report any suspected child abuse or vulnerable adult abuse. The document also stipulates that the data, including recordings of interviews and documents containing identifying information, will be stored on a password-protected encrypted external drive kept in a locked cabinet within my home. It discloses that all data will be destroyed after five years according to Walden University policies by physically destroying the external drive that houses the data. To consent to

participate in my study, the volunteer must respond to the informed consent email with "I consent," following the forms directives.

Summary

In this chapter, I have provided specifics for using IPA and a feminist theory as my framework for researching how BH clinicians lived experiences working with maternal, opioid-using clients make meaning of their work. I articulated the rationale for my research and a description of my positionality, including how I view that positionality has developed and needs to be bracketed while analyzing my data. I have also addressed the methodology and issues of trustworthiness and ethical considerations and how I plan to address these items throughout my research. Chapter four will discuss the demographics, data collection, data analysis, results, and demonstrate trustworthiness.

Chapter 4: Results

Moral distress (MD) has been extensively studied in nursing and is beginning to be studied in social work. The purpose of my study was to explore MD in the counseling field. The research question was, how do behavioral health clinicians working in residential or hospital settings experience MD as part of their work with maternal, opioid-using clients? In this chapter, I discuss the interview setting, participant demographics, and my approach to data collection and analysis. Additionally, I explain how trustworthiness was established and describe the themes and sub-themes uncovered through the IPA analytic process.

Setting

Participants offered dates and times they were available to meet for a one-hour interview via the conference platform, Zoom. The researcher was in a private office with a closed door and a white noise machine running outside the door. Similarly, the participants were in a private space in their homes or professional workspace. During the interview, both the participant and the interviewee had their cameras turned off, and the interview audio was recorded. There were no interruptions during the interviews. I placed my microphone on mute while the interviewee was speaking to limit the potential of background or ambient noise that may disrupt the quality of the recording.

Demographics

Although I obtained demographics for informational purposes, minimal demographic information was obtained to secure the anonymity of the participants. I requested they share their preferred gender identification, the number of years they have

been licensed to practice as a mental health professional, and the state of licensure. One participant did not disclose all information. Inclusion criteria included the following: (a) licensed as a professional counselor, professional clinical counselor, or marriage and family therapist; (b) provided a minimum of 9 months of care throughout the participant's career to maternal, opioid-using clients; and (c) provided these counseling services in a residential or hospital setting. Four of the five participants identified as female, and one as male. One participant was a licensed marriage and family therapist (LMFT), and four of the participants were licensed professional counselors/licensed professional clinical counselors (LPC/LPCC). Two participants did not disclose the length of time they have been licensed; the remaining three had been licensed between seven and twenty years.

Data Collection

Five participants participated in the study. I conducted all the interviews synchronously via Zoom in a virtual format. Participants who joined with the video feature turned on were asked to turn this feature off for the recording to protect their identity. My video camera was also turned off during the interview. Participants participated via Zoom from private spaces in their homes or personal offices. Interviews were scheduled in 60-minute blocks between February 16, 2022, and April 25, 2022; however, interviews lasted 36 to 56 minutes. Recordings were downloaded automatically from the Zoom platform to an encrypted (password protected) external drive that was stored in a locked cabinet in my personal office. I used the online transcription service

Rev.com (www.rev.com) human transcription services, which transcribed interviews verbatim (including fillers such as um and hum).

Data Analysis

My interpretation of the transcripts followed the process for IPA as outlined by Smith and Nizza (2022). They outline five steps to the data analysis process when there is more than one interview. Each of the five transcripts was independently analyzed using steps one through four. After I identified themes from all five transcripts, I sent each participant their transcript with exploratory and experiential notes, as well as the list of themes for member checking. Four of the five participants sent back responses. After reviewing the responses, I followed the process for step five, as indicated by Smith and Nizza (2022), for cross-case analysis. This section outlines the exact steps taken throughout the data analysis process.

First, I read the transcripts. Next, I re-read the transcripts while listening to the audio recording to identify and correct any errors. Throughout completion of this first, I made exploratory notes in the margins (Smith & Nizza, 2022). Exploratory notes focus on my understanding and thoughts about the data.

During Step 2, I read through the transcript and in the opposite margin, noted the experiential statements, which are the interpretation of the participant's experiences. The process required me to keep the research question in the forefront to ensure that I was aware of any changes or deviations from the question; as Smith and Nizza (2022) noted, this can happen as a natural aspect of IPA. After completing step two, I reviewed my

journal, noted no changes from the original research question, and proceeded to step three.

In step three, I placed each experiential statement into a Word document and sorted them into clusters. IPA is an iterative process that promotes developing a deeper understanding of the data as analysis. Over time, clusters changed and evolved until I felt this interpretive step was sufficient, and the clusters had clear emerging themes (Smith & Nizza, 2022).

Once the clusters were organized, step four required me to use this data to "compile a table of experiential themes" (Smith and Nizza, 2022, p. 45). Utilizing the hermeneutic process, I began connecting the data and notes I made in the margins for each transcript to the phenomenon studied (Smith & Nizza, 2022). At this point, I consulted with a qualitative tutor at Walden University to determine the need for a second interview; however, there was enough data collected to forgo a second interview. I also consulted with the tutor about whether to conduct synthesized member checking before or after step five. It was determined during that meeting that it would be best to send the documents to the participants before I began to bring the data together for cross-case analysis (step five).

Once I received feedback from four of the five participants and reviewed them for any changes to the experiential statements and themes, I began step five, cross-case analysis, again implementing the hermeneutic process to extrapolate the themes. The process led to the development of seven themes and nine subthemes. The first theme is that MD is a new concept in counseling. The second theme is the MD barriers faced by

clinicians; the subthemes associated with this theme are (a) lack of funding for effective programming, (b) medical bias creates barriers for women who need care, (c) Child Protection Services (CPS) interference with care creates a sense of powerlessness for clinicians, and (d) an inability to protect the mother/fetus. The third theme is seeing the mother and fetus as one. The fourth theme references personal experiences with a vulnerable pregnancy. The fifth theme is that clinicians reported they had no formal education about the population before working in the hospital or residential setting. The sixth theme is that leaders are self-sacrificing to protect frontline staff. Finally, the seventh theme is that mitigating MD can be achieved in several ways; the sub-themes include (a) action through advocacy, (b) holding space, (c) intentional healthy workplace culture, (d) empowering the mother, and (e) having time to provide quality care.

Table 1

Themes and Subthemes by Participant

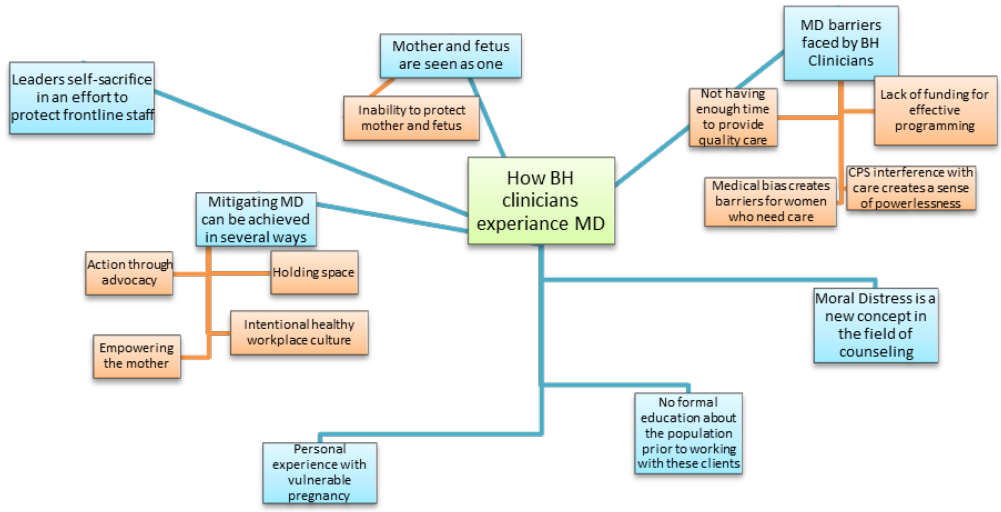
Themes	Participants				
	Katie	Lisa	Tessa	Sarah	Tim
Theme 1: Moral Distress is a new concept in the field of counseling	x	x	x	x	x
Theme 2: MD Barriers Faced by Clinicians	x	x	x	x	x
Subtheme 1: Lack of funding for effective programming	x		x	x	x
Subtheme 2: Medical bias creates conflict for the clinician	x		x	x	x
Subtheme 3: CPS interference with care creates a sense of powerlessness	x		x	x	x
Subtheme 4: Not having time to provide quality care		x		x	x
Theme 3: Clinicians view pregnant women and fetus as one	x	x	x	x	x
Subtheme 1: Inability to protect the mother/fetus	x	x	x	x	x
Theme 4: Personal experience with vulnerable pregnancy impacted the clinician		x	x	x	x

(table continues)

Themes	Participants				
	Katie	Lisa	Tessa	Sarah	Tim
Theme 5: Feeling unprepared to work with the population	x	x	x	x	x
Theme 6: Leaders' self-sacrifice to protect frontline staff	x		x	x	x
Theme 7: Mitigation of MD	x	x	x	x	x
Subtheme 1: Action through advocacy	x			x	x
Subtheme 2: Holding Space	x	x	x	x	x
Subtheme 3: Intentional healthy workplace culture	x		x	x	x
Subtheme 4: Empowering the mother	x	x	x	x	x

Figure 1

Thematic Map of Themes and Subthemes



Discrepancies

The clinicians' lived experiences working with women who were pregnant and had a co-occurring OUD were consistent across most cases. Lisa did not present with themes related to funding, workplace culture, self-sacrificing as a leader, or concerns with CPS involvement. This discrepancy is possibly explained by Lisa's role as a contractor in the treatment setting, rather than an employee of the treatment center(s) as the other participants were. Additionally, Katie was the only participant who did not discuss a personal situation related to a vulnerable pregnancy.

Evidence of Trustworthiness

According to Smith and Nizza (2022), "methodological integrity" (trustworthiness) in qualitative research is complex (pp. 71 -72). They argued that the process involved in IPA meets the standards of rigor to ensure trustworthiness as outlined by the American Psychological Association (APA) in two ways. First, they emphasized the process of purposeful design, which includes a homogenous sample. Second, they argued that for dissertations, the researcher should clearly and methodically describe the steps taken in the analysis process and demonstrate the outcomes of the process in tables, as the visuals and descriptions will aid the reader's ability to evaluate the trustworthiness more readily (Smith and Nizza, 2022). As designed by Smith et al. (2009) and later updated by Smith and Nizza (2022), IPA does not include member checking as part of the methodological integrity approach. I chose to add this step in the process to increase trustworthiness. As noted by Birt et al. (2016), synthesized member checking (SMC)

allows for a "co-constructed" approach to data analysis, thus ensuring that the voice of the participant is accurately interpreted by the researcher (p. 1802).

Credibility

Stahl and King (2020) conceptualized credibility in qualitative research to be "how congruent the findings are with reality" (p. 26). According to Birt et al. (2016), SMC achieves congruency in findings by integrating participant feedback (if any) after the researcher has developed themes from their semi-structured interviews. In my process of analysis, I sent the participants a copy of the transcript with my notes and insights (exploratory notes) and the initial themes (experiential themes) in the margin. I also provided a separate document that listed the experiential themes that were then used to create clusters and broader themes based on the participants' experiences. All five participants responded and stated that they agreed with the experiential statements and subsequent themes drawn from their interviews. I attempted to gain feedback from a fifth participant on three occasions via email over three weeks without response. After checking with the Walden qualitative tutor, they agreed that a majority of responses had been obtained and reached the threshold for responses as outlined by Birt et al. (2016). The participant did reach out after the analysis was completed and reported they agreed with the experiential statements and themes drawn from their semi-structured interview.

Dependability

According to Ravitch and Carl (2016), dependability is similar to a quantitative study's reliability. Synthesized member checking (SMC) was one way in which I increased the dependability of the data and themes, as each participant had an opportunity

to challenge or add to the steps of the theming process. I also took notes and used a document for an audit trail throughout the process. According to Carcary (2020), an audit trail has become one of the gold standards of developing trustworthiness in qualitative research because it allows for a review of the researcher's process to identify if there were changes in methodology, which also promotes "critical reflection" during the analysis phase (p. 171). Throughout collecting and analyzing data, I have kept a document noting the steps I have taken, and insights gained. Should someone request to see my unpublished notes and work, the audit trail can be provided for their review.

Confirmability

Patton (2015) and Ravitch and Carl (2016) expressed that qualitative studies do not advance objectivity as a core tenet. Given (2008) explained that confirmability can be addressed through transparency regarding biases as a researcher related to the phenomenon being studied. Smith et al. (2012) argued that bracketing, or setting aside one's personal views and biases, is part of the interpretative process in IPA. As part of my reflexive journaling, I identified areas where my bias could have interfered with the interpretive process. Beginning with categorizing experiential statements into clusters, then reviewing my exploratory notes and checking those notes against my reflective journaling, I remained objective during the development of themes.

Transferability

Transferability refers to the contextual aspects of the research that can be applied to broader contexts (Ravitch & Carl, 2016). How the work changes clinicians personally and professionally (Ravitch & Carl, 2016) can demonstrate reaching transferability.

Smith et al. (2012) argued that IPA provides thick descriptions by encouraging depth through the interviewing process, which can increase the ability of others to replicate findings. As outlined by Smith and Nizza (2022), each step I completed in the theming process was an iterative process that documented the steps for theme and sub-theme identification; I also cross-referenced them with themes common in research from other fields such as nursing.

Results

The research question asked how behavioral health clinicians working in residential or hospital settings experience MD as part of their work with maternal, opioid-using clients. I answered this question using the IPA process outlined by Smith and Nizza (2022). The steps required me to listen to the recordings of my semi-structured interviews, read, and re-read the transcripts, then develop exploratory and experiential notes for each interview. After creating these notes, I created, developed, and named each cluster. After this step, and before conducting a cross-analysis, I sent the transcript, notes, and themes with clusters to participants for their review and feedback, known as synthesized member checking. After receiving feedback from four of the five participants, I began the final step of developing themes based on a cross-analysis of the five semi-structured interviews. The cross-analysis resulted in seven themes and nine sub-themes.

Theme 1: Moral Distress is a New Concept in the Field of Counseling

All participants in my study noted that MD was a new concept. After learning about MD as part of the semi-structured interview, several stated that they were surprised the concept was not prevalent in the counseling field. Lisa stated,

> I think introducing the topic of MD in Master's programs. Introducing the kinda things that might bring up MD for counselors in training. Maybe as counselor educators, sharing times that we've experienced MD and what we did with that. I even had to stop and think, okay, What exactly do you mean by MD? And fortunately, you gave a definition. But it's a very real thing that I don't think most counselors can put a name to. I don't hear people in the workplace throwing around the term 'moral distress'. So from the very go, recognizing it as a thing. And a thing that we are likely to face at some point in our career.

Others noted it was a struggle to remember that MD was not about ethical dilemmas, but rather barriers to providing care that are distressing. Early in the semi-structured interview, Katie stated, "I don't know that there's anything my institution has in place that would create MD." However, as the interview progressed, she identified several areas of her work that she found morally distressing. Tessa asked directly, "What exactly do you mean by moral distress?" and then verbally worked through the definition. She stated,

> Like you're talking about the moral distress, the interpersonal concerns coming back to what I know to be true and what we need to engage. And then making sure that we're taking the road ahead the way that it needs to be, professionally

and ethically, and with the highest level of support and encouragement for the client in place.

Theme 2: MD Barriers Faced by BH Clinicians

Four of five participants noted that moral distressing scenarios were caused by external systems they did not have control over and compromised their ability to perform their job to their fullest capacity. As a result, participants felt the system infringed on their ability to provide the kind of care they believed was best for the woman. Tim stated,

> Hmm, definitely frustration, definitely curiosity and curiosity in the sense of how can that be possible? We have a code of ethics in our profession that talks about not denying services based on just a number of things. And then something that's a part of life is cause for refusal. So frustration, curiosity, I guess desire, and passion to kind of create a program that is able to meet the needs of these individuals, especially in my local area, because I know after I left that program is no longer specific to pregnant females. So that limits, in my area that limits that population to one facility that is part of a nonprofit that is always booked and the wait list is astronomically long. So just wanting to get back into that work to be able to serve that population.

Others described feeling overwhelmed and stuck as they were expected to help the women enter and maintain recovery during the pregnancy. However, there were many systemic barriers in place by the government, medical providers, and social services that they were unable to spend time providing direct care to address the physical and emotional struggles the women were experiencing.

Sub-theme 1: Lack of Funding for Effective Programming

Four participants noted that the lack of funding from third-party reimbursement and state and federal programs is a primary barrier to providing services for maternal, opioid-using clients. Sarah noted that most women needing treatment have other children who need to stay with their mothers. Sarah reported that it had been over 16 years since their state and reimbursement rate increased for substance use treatment centers. Furthermore, there is little to no reimbursement to the treatment center for the childcare services needed for women to participate in treatment. She noted,

> One of the things that bothers me about child protection and the system we work in is that women in a substance use treatment center don't qualify for daycare assistance, well, for an administrative business part. That grinds my gears, because we don't get paid for the daycare services we have. There's already not enough substance use family programs, so if they just gave us some money for the kids that we help, it'd be great.

Tessa focused on how the lack of funding impacts clinicians directly by requiring large caseloads, which also impacts the ability of the client to receive care that matches the complexity of their treatment needs. Tessa noted,

> Money, money, always money… There are so many programs that would benefit from having more counselors and smaller caseloads and more direct-care staff and better or more peer support. Um, and at the end of the day, there is only so much in the, you know, resource bucket to be able to provide that.

Sub-theme 2: Medical Bias Creates Conflict for the Clinician

Three of the five participants stated that the interactions with medical providers create significant barriers for maternal, opioid-using clients to receiving quality medical care. They noted that engagement with medical providers' bias toward their clients happens so frequently that much of their time is directed towards supporting the mother in seeking medical care leading to MD as the clinician is not able to focus on therapeutic interventions focused on recovery. Katie reported,

> I guess the other thing that comes to mind for me is even within, like, the healthcare realm, I think that there's a lot of misunderstanding about how to provide appropriate, effective medical care for individuals who are pregnant, uh, with an opioid use disorder. Um, and that can be from anything from, like, maybe someone who's on methadone, they're not currently using. Maybe they're prescribed methadone or Suboxone, and maybe a nurse still will, uh, try to, um, try to, like, call CPS or something like that and report this person, even though they're not in active use, and maybe they haven't been since pre-pregnancy.

Sarah recalled experiencing this bias when she visited her local doctor for an ultrasound. She was wearing a t-shirt from the treatment center to the appointment. She described the experience,

> The way that I was treated from the sonogram person, not anyone else at the clinic, but the sonogram person, she thought I was a client at [the treatment center]. That shouldn't be the way that she showed up in my life. She had no idea that I was actually in the role that I am and that I immediately was like, "Here is

> my issue that I just had at your clinic," to their high up board people because those are the connections that I have. It was so disappointing to me that that was her initial reaction to me just talking about [the treatment center], and she thought I was talking about as a client.

Later, Sara added to this story by recounting,

> I think, for me, I can't make sense of it because there's never going to be a rhyme or reason. I mean, stigma of addiction has been on-going, I mean, even the word addiction is stigmatized, but to really just be able to use ... My way of making it right in my brain is like, "This happened to me, I know that it's happened to like 50 other people before me," and those 50 people probably didn't have the privilege or the platform that I have to even know how to.

Despite being in a major metropolitan area, Tim found that very few medical providers were willing to treat pregnant women with a co-occurring OUD. He assumed that part of this reason was a fear of liability. He noted,

> I found an amazing high-risk OB physician that partnered with us. We had an excellent coordination of care. They were in our facility, but we would transport them to him for appointments. There's definitely individuals in place to create a really solid program and to continue to have a solid program. It's just, nobody wants to take the risk.

Katie discussed the complexities of getting care related to bias, the stigma in healthcare about substance use and pregnancy, and the client's fear's impact on her as a clinician.

> Truthfully, it makes me sad, because... um, I'm sad because I empathize... like, I understand that. Not from a personal perspective, but, like, if I were in... if I tried to put myself in that predicament and in those shoes, I would be scared too. And I think that it- it's a little frustrating, because it's like... I feel like we could be doing more as a society to make this... And within like our roles and all of the things, like, we could be doing more to make this care accessible and, like, open to... Like, "We want you to come in. Like, this is, this is good for you. It's good for your child. Like, we're not gonna arrest you. Like, we're not..." (laughs) You know, like, I just think we could be doing more to communicate in our society that this is... it's okay to do this. Um, you know, the biggest thing that I probably hear is like, "I'm not gonna go because they're gonna take my baby from me." Like, I hear that all the time of like, you know, even if use hasn't happened in a long time, or maybe it happened through pregnancy, like, you know, they're just so afraid that that's what's gonna happen. And so they avoid going to get healthcare.

Sub-theme 3: CPS Interference With Care Creates a Sense of Powerlessness for Clinicians

Four of the five participants noted that CPS (in some states referred to as the Department of Children's services [DCS]) stood out as a system that causes substantial MD among clinicians. The scenarios each participant related paint different pictures of how CPS creates barriers that prevent the clinicians from focusing on effective care for their clients. Tim noted that the requirements of DCS conflicted greatly with his

treatment recommendations and what funding would allow. He described the MD as follows;

> They [DCS] were requiring her to complete three months of treatment. And insurance companies are like, absolutely not. Insurance companies will barely give 30 days. 45 if you're pregnant. And so this client really needed treatment because she was pregnant. But what prompted her into treatment was the fact that she had an infant. I want to say this baby was probably like six months old and so I was trying to navigate DCS. So I was trying to navigate their requirements, their constraints. I was trying to navigate the insurance company's mandates and what was happening was it was creating distress for the client because DCS wasn't doing their part. And everything that I tried to do to kind alleviate that, we would get her calmed down and refocused, and then someone else would throw a wrench into the treatment process. And so just kind of seeing this client yanked around and she's doing well. And then she gets knocked down a few pegs because DCS or insurance or whatever, that was hard in itself. Just seeing this mom, young mom, I think she was 18, trying to do what's right for her infant that's already born, and then her current unborn child. And then just seeing how that's she was treated my hands were tied, even though we were trying to give her the treatment she needed and as long as she needed, people kept putting roadblocks up for us. And those places are supposed to be, and those organizations and those processes are supposed to be in place to help the person. And I've seen them hinder people, especially the pregnant female population. And so just having to experience that, I

> was definitely working harder than the other agencies were to try to get this client treatment and everything like that. And then burnout is totally a real thing when you're trying to advocate so hard, and then it becomes out of your control. And you see this client get discharged from treatment early because insurance was refusing to pay more. And then that created issues with DCS. And then we had to find an approved, sober living house. And it just, it sucked. I think it's the best way to put it.

Others noted the mandated reporting and efforts to address the woman's fear of CPS involvement and the potential of having their unborn child removed from their care after birth. Sarah reported,

> The system wants me to sell this program of child protection or case management as this amazing, helpful tool when it really is dependent on the county that we're referring to and the CPS worker that we get. If we get somebody who's brand new out of school, ready to change the world, heck yeah, they're going to be really a positive base. If I get someone who's burnt out, has too many clients on their caseload, they might just be like, "I'm ready to take these kids. I've given this person enough chance and I don't have the time and mental capacity to give them another shot." That's the reality of the work we're doing right now.

Sub-theme 4: Not Having Time to Provide Quality Care

Three of five participants highlighted their limited time to provide care and intervention to maternal, opioid-using clients as MD. Lisa stated, "a 28-day program and there's- and there's just not enough time, um, to kinda unpack a lot of the trauma that

these clients come with." Tim noted that the amount of time allowed by the entities providing funding for pregnant woman's care does not last long enough, and there are limited places to refer to when time is up. He stated,

> I worked tirelessly fighting a system that was not going to budge in being able to help clinicians through supervision, like practice acceptance, and we live in a managed care society. So even though someone's pregnant, doesn't warrant them two additional days, unfortunately.

Theme 3: Clinicians View Pregnant Women and Fetus are Seen as One

Each of the five participants used language which indicated they saw the woman and the fetus as a single entity while the woman was pregnant. Throughout their responses to the semi-structured interview questions, participants indicated that they were focused on the woman's health, the pregnancy, and the fetus. A search through each of the transcripts using the find feature showed that each time the participants spoke about the pregnant woman, they included a reference to the fetus she was carrying (e.g., "mother and baby"), and any reference to the fetus was linked back to the pregnant women. Katie discussed her concern about the lack of accurate information provided to pregnant women about medication-assisted treatments to help preserve the mother's health and pregnancy. She explained,

> You know, when we have a, a pregnant woman who's going through opiate withdrawal without any type of MAT services, that actually can be way more dangerous than, you know, someone who is taking methadone or Suboxone as prescribed throughout their pregnancy. Um, it doesn't alleviate all risks, but it

> most certainly can be less risky than just going through, um, you know, full-blown opiate withdrawal. So really just trying to, you know, educate them on, like, the truths of that and allowing them to make the best decisions for, for them and what makes the most sense for them.

Tessa also provided an example of how the clinician's concept of mother and fetus being connected can differ from how the woman receives treatment. She said,

> I expected it to be difficult as somebody who has studied a lot of trauma and understanding the intersectionality of addiction, mental health, and trauma, and coming from a relational cultural model, I understand that, you know, just because somebody's pregnant doesn't mean that life automatically becomes about, you know, the anticipated child.

Sub-theme 1: Inability to Protect the Mother/Fetus

While the client is in a residential or hospital treatment setting, the clinician often serves as a buffer between the client and the outside world while simultaneously working with the client on aftercare planning which includes secure housing, a healthy support system, and employment or state-sponsored income. Lisa noted that societal bias, stigma, and the criminal justice system create barriers to financial security.

> I think how- how society- how society will view them is maybe a part of it. Um, knowing that oftentimes, they have multiple felonies that are gonna keep them from getting a job, maybe, um, can't get a driver's license because of previous, you know, DUIs. Things like that. And- and- and thinking again of the really,

> really high relapse rate with opioids. Um, and- and- and- and just worrying for their future, for the future of the baby, for all of that.

Tessa noted that the inability to advocate for what the client wants when the pregnant woman's family wants something different and has more authority because of their spiritual or cultural beliefs could also cause MD with the clinician. She explained,

> As she was experiencing the, you know, ongoing pregnancy and the way that she became pregnant was not, was not consensual. Um, but because of her family's faith, more so than, than hers and, and some kind of pushing, she was going to maintain the, the pregnancy and then was debating at the time if she was going to keep the child or place it for adoption. And so physical sensations were something that really were difficult for her. And so she ended up leaving the facility and using.

Sarah emphasized how "defeating" it is to make a mandated report to CPS, knowing there is not much that can be done to influence the outcome as the therapist after that call is made. She stated,

> We've had situations where a woman finds out, you're admitting to treatment, you're changing your life, and also, by the way, you're super early in pregnant, maybe you're four weeks pregnant or six weeks pregnant or eight weeks pregnant, and you're finding out that day of admission and how scary that can be in itself. Then for us too, within the system, to say, "Yep, sorry, I've got to go and report this to your home county," how defeating.

Lisa discussed how complex working in a residential setting is in addition to the significant life events that the clients are coming into the facility with. She explained,

> It's tough to think about how many things they are facing at once. Right? Um, trying to get off opioids, which I understand is horrendously difficult. Often in treatment, finding out they're pregnant, um, maybe not having partner support or not being sure who the partner is, um, deciding quickly to, um, to terminate it. Having, really, the whole community, you know, we're a 200-bed facility, having... Word gets out. People talk. People know. So now this client, on top of all these things, returns from an abortion without any real follow-up from the provider, and they're in a- a community where maybe people are judging them. Maybe people are talking about them. Um, how... Where do you even start?

Theme 4: Personal Experience With Vulnerable Pregnancy Impacted Desire to do the Work

Four of the five participants noted that they had experienced a personal situation with a vulnerable pregnancy and that these experiences impacted their experiences of MD when working with pregnant women who had an OUD. Tim explained,

> I actually had a friend who had battled an addiction while pregnant. And just seeing the struggles that she went through in order to try to get help for her and her child was really baffling to me. That someone so at risk would be refused services because they were pregnant.

Lisa described her history with addiction and pregnancy and how triggering working with the population was for her early on. She recounted,

> I went through my own substance abuse issue. It was not opioids. I think it's worth commenting that, um, I don't have children. Um, but I have had, um, I have had an unplanned pregnancy. Um, and- and so I guess I thought my mentality would sorta just be like, this is a disease that could happen to anyone, pregnancy happens all the time. I believed that it wouldn't cloud my work with these women. I could have, you know, unconditional positive regard and it wouldn't- it wouldn't... I didn't think it would bring up any of my own stuff.

Tessa discussed how difficult it was after a miscarriage to hear women speaking "nonchalantly" about their pregnancies. She stated,

> And this group of women is sitting there talking, and this woman is pregnant. And she very nonchalantly is like, yeah, I'm probably not gonna be able to keep this baby. But, you know, it's like, you know, it's like sets of dishes. I keep having sets. This is my third set, and they keep getting taken away, and maybe I'll keep a set someday.

Theme 5: Feeling Unprepared to Work With the Population

Each of the five participants noted that they did not receive formal education about pregnancy and opioid use, nor did they receive training from their employers when they started working in the residential or hospital setting with pregnant women who had a co-occurring OUD. In order to compensate for the lack of training, they expressed their use of resources to self-teach. In some instances, they created opportunities to learn from medical professionals who worked with the population. Tessa explained,

> Looking back on some of the training I had, I, I, I had a lot of folks that had a lot of biases. And we talked about the issues that women would face, but we talked about, you know, concerns with sexual assault and domestic violence and higher incidents of lived trauma. But my training did not prep- prepare me. You know, naturally, I, on my own to go in and, and do the work.

Katie reflected that there may have been a mention of pregnancy and substance use during her formal education. She stated,

> Well, I honestly don't feel like I was prepared from my master's program and anything that I probably did prior to this actual hands-on working experience. Um, you know, I feel like maybe it was discussed in a master's program, in a paragraph, in a textbook somewhere, but it was never anything that, uh, we discussed in detail that really stuck with me. And we actually had somebody come over from the hospital, who worked in the methadone clinic, to actually provide a training for our staff on kind of like, you know, the dangers of opioid use during pregnancy, the danger of withdrawal during pregnancy, why MAT services can really help, uh, you know, bridge that and make it safer. And a lot of that stuff, I really just didn't know. Um, and so I think that that training was probably... I wanna say it's like... was the most helpful start to that educational journey. I mean, I've definitely had other trainings along the way, but that was one that I didn't know probably 80% of what she was sharing. And so for me, that was really, really helpful, just to have that community partner, uh, come and give us some information.

Tim explained his education journey as disappointing when he got out into the field, because there was no attention paid to the issue of pregnancy and opioid use. He reported,

> I will say my formal education, all six years of it. I did three years for my master's and three years from my doctorate, not once was that brought up. So anything that I learned from about this population was things that I read through. I'm a huge Google scholar fan. So I looked for empirical articles through that. So I did a lot of searching in nursing journals. And I did a lot of consulting with the high-risk OB to kind of educate me. And luckily he was very willing to do so. I've never seen any continued education classes on it. And maybe I haven't been looking hard enough. But I've never seen any on that population. So everything that I had to do to teach myself came from my own research or consultation with physicians and psychiatrists and stuff like that.

Theme 6: Leaders Self-sacrifice in an Effort to Protect Frontline Staff

Four of the five participants noted that they had served in leadership roles in residential or hospital treatment settings that provided services to pregnant women who had a co-occurring OUD. All four discussed how they placed themselves, as leaders, in positions to try to prevent frontline clinicians from experiencing burnout due to MD. Also, all four noted how doing so impacted them as leaders, which often included their own burnout. Tim explained,

> I saw many of my clinicians, turnover rate in that facility was so high because I would make a decision and be like, "Okay yeah, you can have a self-care day,"

> and then I would get reprimanded for it. And so when I had to stop allowing those days, people would leave, which I don't blame them. And so, it drastically affects burnout.

Sarah noted she often worries about the work's impact on frontline clinicians. She stated, "I think that a lot of the day-to-day stuff that sometimes our clinical workers get pulled into is around case management or trying to find a place for their client to sleep tonight." She noted that her work is often focused on easing the MD and the clinicians who work for her experience.

Theme 7: Mitigating MD can be Achieved in Several Ways

Four of the five participants discussed the importance of having supervision to help mitigate their experiences of MD, and two noted that when supervision was negative or biased, it increased the distress they experienced. For example, Tessa noted that her first supervisor was biased and provided the following example,

> And her concept is, yeah, a lot of these women just can't get it together and are never gonna give it, get it together, um, but this is something that we do. And so if you might, you know, be able to save one of 'em, but a lot of these are just gonna, you know, keep perpetuating pain. Um, but it was really a tirade about how essentially permanently damaged these women were, um, and that a lot of them were already lost causes. Which for somebody that's supposed to be providing care and nurturing and support to help people overcome challenges was really disturbing on so many levels.

Later Tessa explained that based on poor supervision in the past, she has been "intentional about the people that I engage and, you know, making sure that I feel that they're people of high quality, that have strong moral fiber."

Sarah, the participant who stated they did not have supervision while working with the population, provided examples of how they work through MD. One way was to avoid thinking about it. She stated,

> If I think too much about it, then it probably would get to me. I think about it more in like this is a system that I'm given that has a lot of negatives, but it allows me to also do some positive, and so just providing education. When I do their reports, I will invite the client to be part of those conversations.

Sub-theme 1: Action Through Advocacy

Three participants' stories focused on how they view their advocacy work as a way to mitigate MD. Sarah stated,

> Because I'm a person that likes to, if there's an issue or something that's not working, let's figure out how to make a change. I feel like the Department of Human Services and the Health and Human Services here in Minnesota, just based on a bunch of stuff that they've done the last couple years, there's no way to actually change it, and so then I feel stuck. If it's something that I knew like, Oh, this one worker, this is just one worker, I could help with that. I could talk to their supervisor, I could provide education, I could offer to come out and talk about substance use and the importance of reunification.

Tim reported he is using his position as a counselor educator to help fill in the gaps of missing education about treating pregnant women with substance use disorders. He stated, “I just designed a new addictions counseling course for a different university. And it has a whole section on looking at pregnant females.”

Katie highlighted her feeling that she could not immediately change her clients’ social stigma and noted that it is helpful to focus on what she can do on an individual level. She explained,

> I mean, my mind immediately wants to go to like, Oh, I wanna, like, implement some, like, social change of some sort. Um, and that’s not really what I feel like I do, partially out of my bandwidth, but, you know, there have been times where I have. Like, if there’s been a, a not great experience or if a client is very fearful, you know, I try my best on an individual level to do whatever I can to provide comfort for that client. I wish that there was more that I could do to make this... and maybe there is, but I haven’t pursued it... um, more of a social change opportunity.

Sub-theme 2: Holding Space

Each of the participants talked about their belief that having a way to hold a safe space to process MD is imperative to preventing burnout. Tim noted that not having this space led to his leaving the position he was so dedicated to. He stated, “My people that are supposed to look out for me just obviously don’t understand or don’t care enough to support me and my need for anything unless it’s work-related.”

Sarah stated she and her team created a safe space "on a more micro level, is being able to make a really awesome Mother's Day… by having a, I think they're calling it a mom masquerade ball." On a more personal level, Sarah stated, "on the days that I have a really hard time with the ways that our, what's the word I'm looking for, systems work is I go, and I spend time with my own kids and snuggle them up."

Katie discussed supervision as one time that safe space was held for her to process her MD. She also noted less formal holding of space has been highly effective. She described the need for space to process by stating, "... I think it's so important for clinicians to have their own safe space to be able to share when they're in these types of situations or scenarios." She described the space as,

> If it's been a particularly difficult scenario, you know, I can reach out, um, for either clinical supervision or just, like, some support from colleagues that have been through similar things. I think that that's helpful, to always be able to get out of my own head and just be able to acknowledge and talk about things that maybe are difficult, uh, throughout that process. And I've had my fair share of those moments, um, the last four and a half years, but at the end of the day, like I said, it's, it's just working towards acceptance that those, those views and those values might be different.

Sub-theme 3: Intentional Healthy Workplace Culture

Four of the five participants discussed workplace culture as a contributing factor to helping manage the impact of MD. Tim explained how his negative experiences with a co-occurring unhealthy culture lead to burnout and turnover. He reported that these

experiences have led him to be more thoughtful about creating a healthy culture that supports the workforce's needs. Sarah discussed how their treatment center intentionally creates connections through joyful experiences. She referenced the "mom masquerade ball" and other celebrations of motherhood that they implement as part of the workplace culture. Katie focused on the impact of working in a setting where she is surrounded by other clinicians who support and understand the population. Her emphasis was on a culture where colleagues could seek each other out for support.

Tessa provided insight from a more global perspective on the importance of supervision. She explained,

> I think the best things are to have mandated really strong supervision. I think that if we were to perpetuate a culture where self-care was prioritized, and not just in words but in action, people then have a little bit more reserves to be better in their thought process, more effective in their thinking, more effective in their connecting, and able to self-gauge to respond rather than react.

Sub-theme 4: Empowering the Mother

Each of the five participants discussed how their role as a clinician allowed them to feel positive about their work when they were able to empower the mother. Katie provided several examples, in the first, she talks about her ability to challenge the misinformation women may have provided. She explained,

> I think it's important that individuals are, are given the correct information and then they can make the best decisions for themselves. I think that it definitely helps in autonomy and building self-trust, and feeling like they have... They're,

> like, empowered in that situation to be able to make the best decision, not only for them but for their child.

Katie and Lisa both discussed how their role as a therapist is defined by empowering others. Katie stated

> For me, as a therapist, it's not my job to, to tell people, "This is gonna be the best thing for you." You know, at the end of the day, I want the client to feel empowered to make that decision for themselves. And knowing that they're doing that based on factual information and not on something that's, uh, biased or stigmatized in any way.

Lisa described her role as being a neutral party. She explained, "I would never ever, ever bring to mind, bring to the client things like, are you considering adoption? Are you considering abortion? That would be wildly inappropriate."

The others discussed being limited in the actions they could take at a macro level, such as federal and state government legislation, and focused on what they could do within their treatment centers to create a safe space for the women to feel supported and encourage other clinicians to empower clients.

Summary

In this chapter, I provided an overview of the steps taken to examine the results of the data I collected for my study. I explained how I followed the process for IPA according to Smith and Nizza (2022), as stated in my research plan in Chapter 3. I then presented the findings and provided specific data to support the seven themes and nine sub-themes discovered through the IPA analysis process. The outcomes demonstrated

specific MD experienced by BH clinicians treating maternal, opioid-using clients. Additionally, the data showed how clinicians view the pregnant woman and her fetus, the impact of personal experience with a vulnerable pregnancy, the lack of education about working with this highly complex population, and how leaders working with the population engage in self-sacrificing behaviors to mitigate the impact MD has on frontline clinicians and clients. I also reported how participants described common approaches to reducing MD when working with the population. In Chapter 5, I present my analysis and interpretation of the data regarding how BH clinicians in residential or hospital settings experience MD as part of their work with maternal, opioid-using clients.

Chapter 5: Discussion, Conclusions, and Recommendations

My research aimed to answer the question: How do behavioral health clinicians working in residential or hospital settings experience MD as part of their work with maternal, opioid-using clients? Existing research has primarily focused on the phenomenon of MD in the nursing field; however, recently, the concept is beginning to be explored in social work research. Before my study, I only found one article that focused on MD in the counseling field, and this article focused on the supervisory relationship (Nuttgens & Chang, 2013).

Because pregnancy is unique to biologically female people, and women have been, and continue to be, held to higher standards than their male counterparts, integrating feminist principles into my study helped provide a conceptual framework when developing my study and analyzing the results. I chose IPA as my methodology because the research question was designed to prompt conversations about the lived experiences of clinicians in the context of their personal and social world (Smith et al., 2009). Through the iterative, double hermeneutic process inherent to IPA methodology, I identified seven themes and nine sub-themes from the semi-structured interviews I conducted with five participants. In this chapter, I provide my interpretation of the findings, explain the impact on social change, and provide recommendations for further studies.

Interpretation of the Findings

The findings of this IPA study provide new insights as to how behavioral health clinicians who work with maternal, opioid-using clients experience coping with MD.

Previous research in the field of nursing indicates that systemic barriers contribute to the experience of MD, and that MD is a precursor to burnout. Burnout is known to contribute to high turnover rates in the counseling field (Young, 2015). My findings suggest that factors that cause MD are often different from those reported in nursing journals. The following seven themes and nine sub-themes introduce MD experienced by BH clinicians, as well as the ways BH clinicians have found to cope with these experiences.

Theme 1: Moral Distress is a New Concept in the Field of Counseling

The phenomenon of MD is a new concept in the field of counseling (Nuttgens & Chang, 2013; Turnage-Butterbaugh, 2015). Participants in my study noted that it was difficult to differentiate an ethical dilemma from MD. Lisa stated, "And fortunately, you gave a definition. But it's a very real thing that I don't think most counselors can put a name to." This theme demonstrates the need to consider the impact MD has on clinicians. Putting a name to an experience and understanding the implications can help clinicians and supervisors address the psychological and physical distress before the clinician begins to experience burnout and turnover (Young, 2015).

Theme 2: MD Barriers Faced by BH Clinicians

Smith and Nizza (2022) noted that IPA studies are highly organic by nature, which leads to new insights about phenomena. I have provided services as a clinician to maternal, opioid-using clients in both a hospital and a residential setting. These experiences made me aware of some of the barriers that can lead to MD when providing care to this population. However, my time providing these services was before the declaration of the opioid epidemic. Thus, I was unsure what the data would produce.

There is ample evidence in nursing journals that pointed to MD being related to institutional barriers within hospitals and medical systems. My research has expanded on the existing literature to include counselors' perspectives. The similarities and differences between the fields of nursing and counseling demonstrate a need to explore barriers that lead to MD and how they can be addressed. The following sub-themes provide a baseline for counselor supervisors seeking to reduce burnout of their frontline clinicians.

Sub-theme 1: Lack of Funding for Effective Programming

The data from my study demonstrates clinicians' experience with MD due to a shortage of programming for their clients. Women, in general, face more barriers than men to attaining residential and hospital-based care for substance use disorders. These barriers are most frequently associated with the woman's need to care for her children (Swinth, 2018). Substance use treatment programs that accept pregnant women are even fewer. All five participants noted that the lack of programming creates MD amongst clinicians working with the population. Tim stated, "that population to one facility that is part of a nonprofit that is always booked, and the wait list is astronomically long." Sarah explained, "There are already not enough substance use family programs, so if they just gave us some money for the kids that we help, it'd be great."

Feminist theory is grounded in an ecological perspective, examining how systems oppress and marginalize women (Campbell, 2015). From an ecological level, the shortage of facilities impacts the clients seeking care and the clinical workforce. The lack of sufficient programming, especially during an opioid epidemic, has left clinicians feeling

that there is no way to provide the level of care a woman needs to have a healthy pregnancy and commit to recovery from her OUD.

Sub-theme 2: Medical Bias Creates Conflict for the Clinician

My research shows how the societal stigmatization of substance use impacts BH clinicians working with maternal, opioid-using clients. Stone (2015) explained that women who have a SUD take extreme measures to avoid systems that show bias against pregnant women. Ettorre (1989) explained that substance use during pregnancy is viewed as a failure to motherhood and mothering. Medical providers are not immune to, and often appear to unconsciously embrace, Ettorre's view of society's perspective of pregnant women who use illicit substances. The result is a forced shift of the role of the BH clinician from the therapeutic provider to the role of a case manager. Rather than focusing on how to help the client cope with the shame inherent to being a target of bias, as discussed by Syversten et al. (2021), the clinician's efforts are redirected toward convincing the woman to seek medical care in a system that the clinician does not feel is safe for their client's emotional well-being.

Sub-theme 3: CPS Interference With Care Creates a Sense of Powerlessness for Clinicians

The results of my study illustrate that MD is experienced by clinicians when CPS does not work in collaboration with the BH clinician. CPS involvement is expected for clinicians who work with mothers, including pregnant women, who have SUDs. Tim, Sarah, and Lisa each reported situations where the CPS worker had interfered substantially with the client's care during treatment because of her pregnancy status. The

barriers to care from these disruptions lead to MD, which the participants described as taking an emotional and physical toll.

In her interview, Sarah discussed at length how CPS can provide women and children with interventions that are helpful and provide significant support. However, the degree of support varies between child protection workers. The clinician never knows whom they will work with from the department until a worker is assigned. She further described MD when talking about the expectation from CPS for her to "sell" child protective services to her clients as a helpful program when she does not feel that this is often true. In Tim's experience, the emotional toll of being unable to focus on a treatment plan that would help the woman recover from an OUD became so consuming because of the CPS worker's demands that there was little to no therapeutic work done before the client had to transfer to another program.

Sub-theme 4: Not Having Time to Provide Quality Care

Another outcome of my study demonstrates that the time-limited nature of residential and hospital-based settings cause MD among clinicians. Existing programs are frequently limited in how long the woman can obtain care in these settings; Tim noted, "insurance companies will barely give 30 days, 45 if you're pregnant." Given that a pregnancy lasts approximately 280 days (New York State Department of Health, 2021), and the postpartum phase can last up to 180 days (Romano et al., 2010), 30 to 45 days is not enough time to support the woman through pregnancy and the postpartum period. Payors (e.g., insurance providers, county, and federal funds) are expecting treatment to focus on helping the woman cease illicit substance use; however, the complexity

associated with pregnancy makes the timeframe far too short. In 30 to 45 days, given all that needs to happen to stabilize the pregnant woman, there is little time to work on interventions to help sustain recovery. Laura noted that the amount of trauma experienced by most of the women she works with in the residential treatment center is so significant, it takes much longer than the time allotted to stabilize the woman's mental health. Further adding to the distress is the knowledge that a return to illicit use of opioids often happens within the first month after discharge, and that this post-treatment use often results in an overdose death of the woman and or her fetus (Strang et al., 2003). Because clinicians have to discharge women due to lack of time allowed by funding sources, knowing that they are not stable enough to sustain recovery, causes substantial MD.

Theme 3: Clinicians View the Pregnant Woman and Fetus are Seen as One

When participants spoke about their experiences, they continuously referenced the woman and fetus dyad as one entity. MD was expressed throughout their stories as systemic barriers interfered not only with the woman's recovery, but also with the health of the pregnancy and, by extension, the fetus's health. Viewing the woman and fetus as a single entity is a marked difference from the MD research conducted with participants who were OB/GYN nurses, whose MD was typically only about the impact the woman's substance use had on the developing fetus, and later as a neonate (Fonti et al., 2016; Recto et al., 2020, Shaw et al., 2017). The divergence in perspective demonstrates the importance of understanding the unique experiences of counselor MD, as well as how MD differs from those working in other fields who also provide care to maternal, opioid-

using clients by challenging the assumption that MD can be generalized across healthcare fields.

Sub-theme 1: Inability to Protect the Mother/Fetus

Stories of feeling helpless to protect the mother/fetus dyad permeated all five participants' stories as it led to a feeling of inability to protect their clients. Tess discussed that even the most motivated clients might need to be discharged because of a milieu issue. She explained, "issues that were causing some issues in the milieu, and based on the facility rules, we couldn't keep her." She went on to state that the needs of one client cannot undermine the needs of other clients in the treatment setting; even when the clinician knows that staying is what is in the best interest of the client, they cannot do so to the detriment of others at the facility. The decision on who needs to be discharged for the group's good can cause significant MD. Lisa described her experience with MD as not having the ability to help the pregnant woman overcome issues related to poor social determinants of health (lack of transportation, inability to generate income, have stable housing). She talked about the impact of the women's struggles with meeting basic needs, impacting their ability to provide a healthy space while pregnant and after giving birth. The intergenerational trauma that ensues is impossible for the clinician to stop.

Theme 4: Personal Experience With Vulnerable Pregnancy Impacted Desire to do the Work

While all the participants spoke of their passion for providing care, four of the five talked about how their experiences with pregnancy issues contributed to their work with maternal, opioid-using clients. Their stories demonstrated that MD could also result

from countertransference experienced while providing services. Each of the four participants described substantially different experiences, yet each returned to these experiences driving their passion for working with the population.

For Tim, witnessing someone he cared for experience rejection from substance use treatment because she was pregnant was a driving force for him to take a position that oversaw hospital and residential facilities with dedicated programming for pregnant women. Lisa discussed at length how surprised she was that her work with maternal, opioid-using clients triggered her "bias" when much of the pull to provide contracted services was a desire to support women in these situations. She noted her history of addiction and choice to terminate a pregnancy because she did not feel it was the best decision to carry to term. Tessa recounted that her first experience as a counselor was working with pregnant women in a residential program shortly after a lost pregnancy. Her goal, then and now, is to support women during pregnancy. However, she noted she was not prepared for how emotional working with the population would be, given her pregnancy history. Sarah explained she began working at the residential treatment center four weeks after giving birth to her child and felt driven to ensure that women were getting the care they needed.

Theme 5: Feeling Unprepared to Work With the Population

There was a strong demonstration of MD experienced by the participants early on in their work because they felt underprepared by their educational programs. Based on their reports, the data indicates that BH clinicians, when beginning work with maternal, opioid-using clients, lack the educational foundation to develop competency for working

with the population. One participant noted that "there may have been a paragraph in a textbook" that discussed opioid use during pregnancy. None were aware of any other formal training opportunities such as continuing education seminars, and all reported they engaged in self-education techniques that ranged from reading articles in medical journals to seeking our medical providers for consultation and education. Given the complexity and acuity of the clients accompanying working with the population, all participants felt that the lack of formal education continues to be a problem in counselor education programs.

Theme 6: Leader's Self-Sacrifice in an Effort to Protect Frontline Staff

By happenstance, four of the five participants identified as either currently serving in a leadership position or have served in a leadership position at some point in their work with maternal, opioid-using clients. Thus, my study not only demonstrated themes related to MD that happen when working as a BH clinician but also a glimpse of how MD impacts them as the leaders in these environments. Each of the four participants discussed the difficulty of high turnover rates and clinicians burning out because of caseloads that were too intense. Tessa noted that balance in a caseload for a BH clinician should be less about numbers and based instead on workload. She explained, "I may have somebody that only has seven people on their caseload, and another that has 12. But the person that has seven, those clients are much more higher need. And so, the workload is not equitable." As the intent of this study was not focused on leadership in these settings, I did not probe further on leadership aspects; however, the theme was strong enough

(across all four of the participants who have served in leadership roles) that it warrants further investigation in the future (see recommendations below).

Theme 7: Mitigating MD can be Achieved in Several Ways

My study illustrates that there were several ways to ease the impact of MD. Each of the participants spoke of a variety of experiences that helped them cope with MD. The coping mechanisms they discussed have one thing in common: they each provide a sense of hope. Four themes were identified relating to how clinicians coped with their experiences of MD.

Sub-theme 1: Action Through Advocacy

The data from my study show that when clinicians engage in work viewed as advocating for the well-being of their clients, the experiences of MD are less impactful. The words written in the transcript cannot capture the participants' drastic changes in tone and texture during the interview. When listening to the recordings, one can hear the change from frustration, powerlessness, and exhaustion to what can only be described as a strong, powerful, and sanguine expression of their efforts and accomplishments. Tim recognized the impact of entering work without foundational knowledge about pregnancy and substance use. He is now developing addiction studies coursework for counselors that includes pregnancy and substance use as part of the curriculum. Sarah explained that she does not feel she has the energy or the power to directly change things at the state or federal level; instead, she has invested efforts into developing relationships with state and federal representatives. She leverages these connections to share concerns about funding

needs. Katie has focused her efforts on combating misinformation about opioid use during pregnancy and the treatment options women have, which include MAT.

Sub-theme 2: Holding Space

Nuttgens and Chang (2013) noted that understanding MD as part of the supervisory process is valuable to clinicians. My study demonstrates that supervision, as a general practice, does not provide enough specificity as to what clinicians need to ease the impact of MD. Two participants, Tessa and Tim, discussed experiences where supervision was laden with bias and stigma and focused on work output. They expressed that these supervision experiences were not only unhelpful but could be classified as harmful supervision. All five participants described helpful interactions with supervisors, consultants, and colleagues who were able to "hold space" as being most effective. The data from my study illustrated that this space involved validating the clinician's experiences, listening while suspending judgment, and avoiding trying to fix or problem-solve with the clinician. Additionally, participants noted that the time needed to process the barriers and experiences associated with their MD was 10 minutes or less; by releasing the pent-up psychological discomfort, the participants noted they could return to their work and refocus their efforts on the client.

Sub-theme 3: Intentional Healthy Workplace Culture

One area of strong similarity between counselor reports and those published in nursing journals is the impact of organizational culture. Each of the four participants with themes related to workplace culture included descriptions of harmful and helpful aspects related to MD. Harmful workplace culture examples include caseloads being too high,

senior leadership not supporting time off or time away from the site for respite and a lack of recognition. Participants noted that when they worked for agencies that intentionally focused on creating a healthy workplace environment MD was easier to navigate and less detrimental to their wellbeing. My study demonstrates encouraging the use of time off (Tim), access to supportive colleagues (Katie), and a sense of fellowship (Tessa) created an environment that promoted the clinician's wellbeing, thereby increasing their resilience to MD.

Sub-theme 4: Empowering the Mother

The final theme demonstrates how clinicians' work with the client can be a protective or restorative factor when faced with MD. Each participant noted that when faced with external or internal systems which created barriers to them acting on what they considered the right course for the client's wellbeing, empowering the client proved to be a positive coping mechanism for MD. Katie noted that although she cannot change how women were treated when they sought maternal care, she could empower the woman to seek that care despite the stigma and bias and then be present to help the woman process these experiences. Sarah explained the mothering program she developed to heal historical trauma and teach women how to engage with their children, even when CPS is involved. Lisa focused on using EMDR to do as much trauma work as possible before the client was forced to discharge because of funding. Tessa explained how empowering others to empower the woman has far-reaching implications. She explained, "if you think of a generic Christmas tree drawing and that little star at the top, and then how it kind spreads out in triangle format, right?" She explained the power of the effect, "By helping

one person to understand a concept differently, whatever it might be, they are gonna continue to touch countless lives."

Limitations of the Study

The sample procured for my research is one limitation of the study. Four of the five participants identified as having been in leadership roles in residential or hospital settings that provide treatment services to maternal, opioid-using clients. On the one hand, this unintentional outcome of the sample increased homogony; however, the descriptions of experience may be different from those who are actively working as frontline (non-leadership) clinicians in these settings. Therefore, the sample may not be as generalizable to a broader, less experienced group of clinicians.

The timing of the data collection is another limitation. Since the conclusion of the data analysis, the United States Supreme court overturned the 1973 Roe v. Wade decision, which guaranteed women the right to terminate a pregnancy (Roe v. Wade, 1973). While some women choose to continue with pregnancy despite their substance use, others have, up until recently, had an opportunity to terminate a pregnancy. The loss of this freedom can shift the number of women seeking treatment for an OUD or other substances of abuse during their pregnancy. It is unclear how or if this will add to MD for clinicians.

Recommendations

Moral distress is an established concept in nursing and expanding in the medical field. However, as a new concept in counseling, there is much to be learned from future research. My study provides a grounding for future research related to MD experienced

by counselors, counselors in training, and supervisors of counselors. Additionally, it provides a starting point to develop research that further differentiates the moral distressing barriers experienced by counselors from other professions. These recommendations aim to transcend the current study's limitations and develop a deeper understanding of how counselors experience the phenomenon of MD across settings and when working with different populations.

My study's sample comprised five participants, all of whom have worked as frontline behavioral healthcare clinicians in residential or hospital settings and who, at the time of participation, had also held leadership roles in those settings. I recommend future research limit samples to those who have only worked as clinicians providing direct care, as this data would increase generalizability. I also recommend that future research explore clinicians' experiences working in different settings (e.g., out-patient) and with diverse populations.

Counselors' lack of educational opportunities before working with maternal, opioid-using clients is of great concern. Developing a foundational understanding is important for a foundation of competency. Topics to include in education include an overview of the risks associated with illicit opioid use, medications used to treat an OUD, pregnancy complications when the woman uses opioids before and during pregnancy, and an overview of the systems often involved in the woman's care would aid in establishing core competency for BH clinicians. Additionally, there are opportunities to correct what Katie referred to as "misinformation" about the impact of prenatal exposure and the risks associated with using and ceasing opioids during pregnancy. These opportunities include

continuing education provided to social workers, nurses, and physicians by counselors who are experts in treating women who have an OUD. These trainings would include the evidence-based practices BH clinicians are trained to implement, the role of the clinician, and their experiences of the impact stigma and bias have on women seeking care.

I also recommend that future studies explore how leadership in substance use treatment settings that have programming for pregnant women view MD, their experiences of MD, and how MD impacts their approach to leading BH clinicians who work with the population. Exploring these concepts can expand the literature to help further the findings from my study. As leadership experience was not part of my study's criteria, the theme of self-sacrificing to protect frontline clinicians needs to be explored with the intent to better understand this outcome.

Implications for Positive Social Change

As society begins to recover from the COVID-19 pandemic, counselors are already seeing substantial wait lists for women who are seeking treatment for an opioid use disorder during pregnancy, a trend that is not predicted to change in the foreseeable future. Providing services to those seeking help is an arduous process; by understanding the ways in which BH clinicians experience MD counselor educators and supervisors can focus on ways of reducing clinician burnout and turnover.

In addition to increasing current workforce stability, understanding MD benefits counselor educators as the knowledge can prompt action to better prepare counselors during their formal education to address MD before it leads to burnout. New clinicians to the field will also benefit from supervisors who understand the barriers and factors that

lead to MD, so they can create an intention to monitor new clinicians as they develop their skills prior to licensure, which in turn improves the quality of client care. Improving supervision by being able to name experiences that are not considered ethical dilemmas or compassion fatigue. Through awareness of barriers that cause clinicians to experience MD, supervisors are in a position to identify MD and address the psychological and physical toll they place on the clinician. Keeping clinicians' vitality strong keeps clinicians with a wealth of knowledge working with populations in the field, and pregnant women who need services will have more options to obtain high-quality treatment.

Finally, the outcome data from my study provides insight into the barriers external systems create that lead to MD amongst clinicians. Decreasing the stigma and bias directed towards women, specifically maternal, opioid-using clients, can promote better maternal behavioral health care by directly challenging implicit and explicit bias in American culture. These biases have been shown to directly impact women's fear of seeking medical attention and prenatal care when they use opioids during pregnancy. My study lays a foundation for training and dialogue between providers in various fields to explore ways to combat misinformation regarding maternal opioid use and OUD during pregnancy and address the systemic barriers maternal, opioid using clients face to receiving prenatal healthcare.

Conclusion

Throughout this study, concepts and themes were separated for clarity; however, there is considerable overlap and interplay, as is common with any ecosystem. The societal forces impact the client's experiences, which in turn impact the clinician,

sometimes leads the clinician's respond by pushing back those societal systems through advocacy. This circle can be disrupted by clinician MD and lead to burnout and high turnover rates in residential and hospital settings that provide care to women with substance use disorders who are often in treatment while pregnant. As several participants noted, clinicians are agents of social change. However, change is slow, and clinicians leave their roles and the field in droves. My study provides counselor educators and supervisors with three main considerations. First, the study creates a starting point for researchers, counselor educators, and supervisors to further investigate how MD is impacting BH clinicians. Second, it informs current counselor educators and supervisors about factors that may be contributing to the workforce shortage. Finally, my study demonstrates ways in which clinicians can mitigate the negative effects of MD.

References

Aguayo-Romero, R. A. (2021). (Re)centering Black feminism into intersectionality research. *American Journal of Public Health, 111*(1), 101–103. https://doi.org/10.2105/AJPH.2020.306005

American College of Obstetricians and Gynecologists. (2017). *Opioid use and opioid disorder in pregnancy*. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy

American Counselor Association. (2014). *Code of ethics.* https://www.counseling.org/resources/aca-code-of-ethics.pdf

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., Test Revision). https://doi.org/10.1176/9780890425596

American Psychiatric Association. (2020, August). *Stigma, prejudice, and discrimination against people with mental illness.* https://www.psychiatry.org/patients-families/stigma-and-discrimination

American Society of Addiction Medicine. (2019, September 15). *What is the definition of addiction?* https://www.asam.org/Quality-Science/definition-of-addiction

Ambrosini, A., & Stanghellini, G. (2012). Myths of motherhood: The role of culture in the development of postpartum depression. *Annali Dell'Istituto Superiore Di Sanità, 48*(3), 277–286. https://doi.org/10.4415/ANN_12_03_08

Anderson, E. (1995). Feminist epistemology: An interpretation and a defense. *Hypatia, 10*(3), 50-84. https://doi.org/10.1111/j.1527-2001.1995.tb00737.

Andraka-Christou, B., Randall-Kosich, O., & Totaram, R. (2021). Designing an "ideal" substance use disorder treatment center: Perspectives of people who have utilized medications for opioid use disorder. *Qualitative Health Research, 31*(3), 512–522. https://doi.org/10.1177/1049732320971231

Arter, S. J., Tyler, B., McAllister, J., Kiel, E., Guler, A., & Cameron Hay, M. (2021). Longitudinal outcomes of children exposed to opioids in-utero: A systematic review. *Journal of Nursing Scholarship, 53*(1), 55–64. https://doi.org/10.1111/jnu.12609

Asta, D., Davis, A., Krishnamurti, T., Klocke, L., Abdullah, W., & Krans, E. E. (2021). The influence of social relationships on substance use behaviors among pregnant women with opioid use disorder. *Drug and Alcohol Dependence, 222*(5). https://doi.org/10.1016/j.drugalcdep.2021.108665

Austin, C. L., Saylor, R., & Finley, P. J. (2017). Moral distress in physicians and nurses: Impact on professional quality of life and turnover. *Psychological Trauma: Theory, Research, Practice and Policy, 9*(4), 399–406. https://doi.org/10.1037/tra0000201

Austin, W., Rankel, M., Kagan, L., Bergum, V., & Lemermeyer, G. (2005). To stay or to go, to speak or stay silent, to act or not to act: Moral distress as experienced by psychologists. *Ethics & Behavior, 15*(3), 197–212. https://doi.org/10.1207/s15327019eb1503_1

Azuine, R. E., Ji, Y., Chang, H.-Y., Kim, Y., Ji, H., DiBari, J., Hong, X., Wang, G., Singh, G. K., Pearson, C., Zuckerman, B., Surkan, P. J., & Wang, X. (2019).

Prenatal risk factors and perinatal and postnatal outcomes associate with maternal opioid exposure in urban, low-income multiethnic US population. *JAMA Network Open, 2*(6), e196405. https://doi.org/10.1001/jamanetworkopen.2019.6405

Bada, H.S., Langer, J., Twomey, J, Bursi C., Lagasse, L., Bauer, C. R., Shankaran, S., Lester, B. M., Higgins, R., & Maza, P. L. (2008). Importance of stability of early living arrangements on behavior outcomes of children with and without prenatal drug exposure. *Journal of Developmental Pediatrics, 29*(3), 173–182. https://doi.org/10.1097/DBP.0b013e3181644a79.

Barlem, E. L., & Ramos, F. R. (2015). Constructing a theoretical model of moral distress. *Nursing Ethics, 22*(5), 608–615. https://doi.org/10.1177/0969733014551595

Barlow, J. N., & Johnson, B. M. (2021). Listen to Black Women: Do Black Feminist and Womanist Health Policy Analyses. *Women's Health Issues, 31*(2), 91–95. https://doi.org/10.1016/j.whi.2020.11.001

Barnett, E. R., Knight, E., Herman, R. J., Amarakaran, K., & Jankowski, M. K. (2021). Difficult binds: A systematic review of facilitators and barriers to treatment among mothers with substance use disorders. *Journal of Substance Abuse Treatment, 126*(7). https://doi.org/10.1016/j.jsat.2021.108341

Barthwell, A. G., Brown, L. S., Allgaier, J., & Crants, M. E. (2019). The treatment of addiction: An overview. In S. Miller, D. Fiellin, R. Rosenthal, & R. Saitz (Eds), *The ASAM principles of addiction medicine* (pp. 409-422). Wolters-Kluwer.

Baum, D. (2016, April 1). Legalize it all. *Harper's Magazine, 332*(22), 24–32.

Baxter, L. E., Seltzer, M. F., & Wilford, B. B. (2019). Consent and confidentiality issues

in addiction practice. In S. Miller, D. Fiellin, R. Rosenthal, & R. Saitz (Eds), *The ASAM principles of addiction medicine* (pp. 1717-1723). Wolters Kluwer.

Benoit, C., Magnus, S., Phillips, R., Marcellus, L., & Charbonneau, S. (2015). Complicating the dominant morality discourse: mothers and fathers' constructions of substance use during pregnancy and early parenthood. *International Journal for Equity in Health, 14*(72), 1-11. https://doi.org/10.1186/s12939-015-0206-7

Bernard, H. R., Wutich, A., Ryan, G. W. (2017). *Analyzing qualitative data: Systematic approaches*. Thousand Oaks, CA: Sage Publications.

Berger-Greenstein, J. A. (2018, April 4). *The counselor's role in assessing and treating medical symptoms and diagnoses*. Counseling Today: A Publication of the American Counseling Association. https://ct.counseling.org/2018/04/the-counselors-role-in-assessing-and-treating-medical-symptoms-and-diagnoses/

Bergly, T. H., Hagen, R., & Gråwe, R. W. (2015). Mental health and substance use problems among patients in substance use disorder treatment as reported by patients versus treatment personnel. *Journal of Substance Use, 20*(4), 282–287. https://doi.org/10.3109/14659891.2014.911975

Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member Checking: A Tool to Enhance Trustworthiness or Merely a Nod to Validation? *Qualitative Health Research, 26*(13), 1802–1811. https://doi.org/10.1177/1049732316654870

Blakey, J. M. (2014). We're all in this together: Moving toward an interdisciplinary model of practice between child protection and substance abuse treatment professionals. *Journal of Public Child Welfare, 8*(5), 491–513.

https://doi.org/10.1080/15548732.2014.948583

Blehar, M. C., Spong, C., Grady, C., Goldkind, S. F., Sahin, L., & Clayton, J. A. (2013). Enrolling pregnant women: Issues in clinical research. *Women's Health Issues, 23*(1), e39–e45.

Bleiker, J., Morgan-Trimmer, S., Knapp, K., & Hopkins, S. (2019). Navigating the maze: Qualitative research methodologies and their philosophical foundations. *Radiography, 25*, S4–S8. https://doi.org/10.1016/j.radi.2019.06.008

Bellou, A., & Cardia, E. (2016). Occupations after WWII: The legacy of Rosie the Riveter. *Explorations in Economic History, 62*, 124–142. https://doi.org/10.1016/j.eeh.2016.03.004

Blencowe, C. P. (2011). Biology, contingency and the problem of racism in feminist discourse. *Theory, Culture & Society, 28*(3), 3–27. https://doi.org/10.1177/0263276410396918

Bloor, M. & Wood, F. (2006). Keywords in Qualitative Methods. SAGE Publications, Ltd. https://doi.org/10.4135/9781849209403

Bogusz, G. B. (2020, March 13). *Health insurers still don't adequately cover mental health treatment.* National Alliance on Mental Illness. https://www.nami.org/Blogs/NAMI-Blog/March-2020/Health-Insurers-Still-Don-t-Adequately-Cover-Mental-Health-Treatment

Bridges, K. M. (2020). Race, pregnancy, and the opioid epidemic: White privilege and the criminalization of opioid use during pregnancy. *Harvard Law Review, 133*(3), 770–851. https://harvardlawreview.org/wp-content/uploads/2020/01/770-

851_Online.pdf

Brill, S. (2015). *America's bitter pill: Money, politics, backroom deals, and the fight to fix our broken healthcare system*. Random House.

Brisolara, S., Seigart, D., & SenGupta, S. (2014). *Feminist evaluation and research: Theory and practice.* The Guilford Press.

Brunell, L. (2021). Feminism. Britannica. https://www.britannica.com/topic/feminism

Campbell, N. D. (2015). "What would my life look like under a magnifying glass?" Reading "Feminist standpoint epistemology" into substance use and misuse. *Substance Use & Misuse, 50*(6), 806–809. https://doi.org/10.3109/10826084.2015.978632

Carcary, M. (2020). The research audit trail: Methodological guidance for application in practice. *Electronic Journal of Business Research Methods, 18*(2)I, 166 -177. https://doi.org/10.34190/JBRM.18.2.008

Centers for Disease Control (CDC). (2020, December 17). *Opioid deaths accelerating during COVID-19.* https://www.cdc.gov/media/releases/2020/p1218-overdose-deaths-covid-19.html

Centers for Disease Control. (2021, February 16). *Suspected nonfatal drug overdoses during COVID-19.* https://www.cdc.gov/drugoverdose/data/nonfatal/states/covid-19.html

Chamberlain, A. (2018). Moral suasion and political action. *American Political Thought, 7*(1), 57–85. https://doi.org/10.1086/695642

Chang, C.-C., Chang, K.-C., Hou, W.-L., Yen, C.-F., Lin, C.-Y., & Potenza, M. N.

(2020). Measurement women and substance use abuse towards a feminist perspective of invariance and psychometric properties of perceived stigma toward people who use substances (PSPS) among three types of substance use disorders: Heroin, amphetamine, and alcohol. *Drug and Alcohol Dependence, 216*(11). https://doi.org/10.1016/j.drugalcdep.2020.108319

Chazen, M., & Baldwin, M. (2016). Understanding the complexities of contemporary feminist activism: How the lives of older women activists contest the waves narrative. *Feminist Formations, 28*(3), 70–94. https://doi.org/10.1353/ff.2016.0044

Chiesa, A., & Serretti, A. (2014). Are mindfulness-based interventions effective for substance use disorders? A systematic review of the evidence. *Substance Use & Misuse, 49*(5), 492–512. https://doi.org/10.3109/10826084.2013.770027

Chou, J. L., Cooper, S. S., Diamond, R. M., Muruthi, B. A., & Beeler, S. S. (2020). An exploration of mothers' successful completion of family-centered residential substance use treatment. *Family Process, 59*(3), 1113–1127. https://doi.org/10.1111/famp.12501

Cornfield, Z. A. D., & Hubley, A. M. (2020). Counselors' attitudes towards working with clients with substance use disorders. *The Counseling Psychologist, 48*(5), 630–656. https://doi.org/10.1177/0011000020915451

Council for the Accreditation of Counseling and Related Educational Programs [CACREP]. (2016). *2016 CACREP Standards*. http://www.cacrep.org/wp-content/uploads/2018/05/2016-Standards-with-Glossary-5.3.2018.pdf

Council for the Accreditation of Counseling and Related Educational Programs [CACREP]. (2018, February 9). *CACREP Board of Directors delays Implementation on 60 Semester Credit Hour Requirements*. http://cacrepdev.wpengine.com/wp-content/uploads/2018/02/CACREP-Special-Announcement-48-to-60.pdf

Council for the Accreditation of Counseling and Related Educational Programs [CACREP]. (2021). *Professional Counseling as a career choice*. https://www.cacrep.org/for-students/

Council on Foreign Relations. (2018). *Legal barriers*. https://www.cfr.org/legal-barriers/barriers/

Coupland, H., Moensted, M. L., Reid, S., White, B., Eastwood, J., Haber, P., & Day, C. (2021). Developing a model of care for substance use in pregnancy and parenting services, Sydney, Australia: Service provider perspectives. *Journal of Substance Abuse Treatment, 131*(12). https://doi.org/10.1016/j.jsat.2021.108420

Cosden, M., Sanford, A., Koch, L. M., & Lepore, C. E. (2016). Vicarious trauma and vicarious posttraumatic growth among substance abuse treatment providers. *Substance Abuse, 37*(4), 619–624. https://doi.org/10.1080/08897077.2016.1181695

Davidson, S. M. (2010). *Still broken: Understanding the U.S. health care system*. Stanford University Press.

Dalmolin, G. de L., Lunardi, V. L., Lunardi, G. L., Barlem, E. L. D., & Silveira, R. S. da. (2014). Moral distress and burnout syndrome: are there relationships between

these phenomena in nursing workers? *Revista Latino-Americana de Enfermagem, 22*(1), 35–42. https://doi.org/10.1590/0104-1169.3102.2393

Davis, K. (2020). Who owns intersectionality? Some reflections on feminist debates on how theories travel. *European Journal of Women's Studies, 27*(2), 113–127. https://doi.org/10.1177/1350506819892659

Delker, B. C., Van Scoyoc, A., & Noll, L. K. (2020). Contextual influences on the perception of pregnant women who use drugs: Information about women's childhood trauma history reduces punitive attitudes. *Journal of Trauma & Dissociation, 21*(1), 103–123. https://doi.org/10.1080/15299732.2019.1675221

Dobbs v. Jackson Women's Health Organization, 597 U.S. 19-1392 (2022). https://www.supremecourt.gov/opinions/21pdf/19-1392_6j37.pdf

Doyle, C., Cicchetti, D., Georgieff, M. K., Tran, P. V., & Carlson, E. S. (2018). Atypical fetal development: Fetal alcohol syndrome, nutritional deprivation, teratogens, and risk for neurodevelopmental disorders and psychopathology. *Development & Psychopathology, 30*(3), 1063–1086. https://doi.org/10.1017/S0954579418000500

Drug Policy Alliance. (2015, June). *The drug war, mass incarceration and race*. https://www.unodc.org/documents/ungass2016/Contributions/Civil/DrugPolicyAlliance/DPA_Fact_Sheet_Drug_War_Mass_Incarceration_and_Race_June2015.pdf

Earle, K. (2019). Tapping tribal wisdom: Providing collaborative care for Native pregnant women with substance use disorders and their infants. *National Center*

on Substance Abuse and Child Welfare. SAMHSA. https://ncsacw.samhsa.gov/files/tapping_tribal_wisdom_508.pdf

Eby, L. T., & Rothrauff-Laschober, T. C. (2012). The relationship between perceptions of organizational functioning and voluntary counselor turnover: a four-wave longitudinal study. *Journal of Substance Abuse Treatment, 42*(2), 151–158. https://doi.org/10.1016/j.jsat.2011.10.008

Elms, N., Link, K., Newman, A., Brogly, S. B., & The Kingston House of Recovery for Women and Children. (2018). Need for women-centered treatment for substance use disorders: results from focus group discussions. *Harm Reduction Journal, 15*(1), 1–8. https://doi.org/10.1186/s12954-018-0247-5

Ekstrand, L. E. (2005). *Adult Drug Courts: Evidence Indicates Recidivism Reductions and Mixed Results for Other Outcomes: GAO-05-219.* In GAO Reports (p. 1). U.S. Government Accountability Office.

Epstien E. G., & Delgado S. (2010). Understanding and addressing moral distress. *Online Journal of Issues in Nursing, 15*(3), 1-1. https://doi.org/10.3912/OJIN.Vol15No03Man01

Eschle, C. & Maiguashca, B. (2010). *Making Feminist Sense of the Global Justice Movement*. Rowman & Littlefield Publishers.

Evans, E. (2016). What Makes a (Third) Wave? *International Feminist Journal of Politics, 18*(3), 409–428. https://doi.org/10.1080/14616742.2015.1027627

Falletta, L., Hamilton, K., Fischbein, R., Aultman, J., Kinney, B., & Kenne, D. (2018). Perceptions of child protective services among pregnant or recently pregnant,

opioid-using women in substance abuse treatment. *Child Abuse & Neglect, 79*, 125–135. https://doi.org/10.1016/j.chiabu.2018.01.026

Figley, C. R., & Ludick, M. (2017). *Secondary traumatization and compassion fatigue. In APA handbook of trauma psychology: Foundations in knowledge*.,1. (pp. 573–593). American Psychological Association. https://doi.org/10.1037/0000019-029

Fink-Samnick, E. (2021). The social determinants of mental health: Definitions, distinctions, and dimensions for professional case management: Part 1. *Professional Case Management, 26*(3), 121–137. https://doi.org/10.1097/NCM.0000000000000497

Fonti, S., Davis, D., & Ferguson, S. (2016). The attitudes of healthcare professionals towards women using illicit substances in pregnancy: A cross-sectional study. *Women and Birth, 29*(4), 330–335. https://doi.org/10.1016/j.wombi.2016.01.001

Fordor, A., Tímár, J., & Zelena, D. (2014). Behavioral effects of perinatal opioid exposure. *Life Sciences, 104*(1–2), 1–8. https://doi.org/10.1016/j.lfs.2014.04.006

Frazer, Z., McConnell, K., & Jansson, L. M. (2019). Treatment for substance use disorders in pregnant women: Motivators and barriers. *Drug and Alcohol Dependence, 205*. https://doi.org/10.1016/j.drugalcdep.2019.107652

Friedan, B. (1963). *The feminine mystique*. Norton & Company. https://nationalhumanitiescenter.org/ows/seminars/tcentury/FeminineMystique.pdf

Frost, N., & Holt, A. (2014). Mother, researcher, feminist, woman: reflections on "maternal status" as a researcher identity. *Qualitative Research Journal, 14*(2),

90–102. https://doi.org/10.1108/QRJ-06-2013-0038

Gadamer, H. G. (1989). *Truth and method* (2nd Ed.). Continuum. https://mvlindsey.files.wordpress.com/2015/08/truth-and-method-gadamer-2004.pdf

Gallo, A. (2019). How to Master a New Skill. Harvard Business Review, 35–37.

Ghertner, R., Waters, A., Radel, L., & Crouse, G. (2018). The role of substance use in child welfare caseloads. *Children and Youth Services Review, 90*, 83–93. https://doi.org/10.1016/j.childyouth.2018.05.015

Given, L. M. (2008). *The SAGE encyclopedia of qualitative research methods* (Vols. 1-0). SAGE Publications, Inc. doi: 10.4135/9781412963909

Gray, M. & Littlefield, M. B. (2002). Black women and addictions. In S.L.A. Straussner & S. Brown (Ed.), *The handbook of addiction treatment for women* [ebook edition]. Jossey-Bass. https://download.e-bookshelf.de/download/0000/5869/71/L-G-0000586971-0002327005.pdf

Greenfield, S. F. (2018). Women and opioid use disorders. *The American Journal on Addictions, 27*(8), 646–647.

Grella, C. E. (2010). Women in residential drug treatment: Differences by program type and pregnancy. *Journal of Health Care for the Poor and Underserved, 10*(2), 216–229. https://doi.org/10.1353/hpu.2010.0174

Geyman, J. (2021). COVID-19 Has revealed America's broken health care system: What can we learn? *International Journal of Health Services, 51*(2), 188–194. https://doi.org/10.1177/0020731420985640

Guttmacher Institute (April 1, 2021). *Substance use during pregnancy*. guttmacher.org/state-policy/explore/substance-use-during-pregnancy

He, A. S., Lizano, E. L., & Stahlschmidt, M. J. (2021). When doing the right thing feels wrong: Moral distress among child welfare caseworkers. *Children and Youth Services Review, 122*(3). https://doi.org/10.1016/j.childyouth.2020.105914

Heidegger, M. (1962; 2010). Being and truth. Indiana University Press. https://search-ebscohost-com.ezp.waldenulibrary.org/login.aspx?direct=true&db=cat06423a&AN=wal.EBC588789&site=eds-live&scope=site

Holbrook, A. M. (2015). Methadone versus buprenorphine for the treatment of opioid abuse in pregnancy: science and stigma. *The American Journal of Drug and Alcohol Abuse, 41*(5), 371–373. https://doi.org/10.3109/00952990.2015.1059625

Howard, H. (2015). Reducing stigma: Lessons from opioid-dependent women. *Journal of Social Work Practice in the Addictions, 15*(4), 418–438. https://doi.org/10.1080/1533256X.2015.1091003

Husserl, E. (1931). *Ideas: general introduction to pure phenomenology*. [Trans. by W. R. B. Gibson]. Macmillan.

Jacob, C., Wildermuth, D. L., & Thomas, A. (2021). *A practical ethics worktext for professional counselors: applying decision-making models to case examples*. Springer Publishing Company.

Jameton, A. (1984). *Nursing practice: Ethical issues*. Prentice-Hall.

Jameton, A. (2017). What Moral Distress in Nursing History Could Suggest about the

Future of Health Care. *AMA Journal of Ethics, 19*(6), 617–628. https://doi.org/10.1001/journalofethics.2017.19.6.mhst1-1706

Jansen, T.-L., Hem, M. H., Dambolt, L. J., & Hanssen, I. (2020). Moral distress in acute psychiatric nursing: Multifaceted dilemmas and demands. *Nursing Ethics, 27*(5), 1315–1326. https://doi.org/10.1177/0969733019877526

Johnson, E. (2019). Models of care for opioid dependent pregnant women. *Seminars in Perinatology, 43*(3), 132–140. https://doi.org/10.1053/j.semperi.2019.01.002

Jones, E. B., Staab, E. M., Wan, W., Quinn, M. T., Schaefer, C., Gedeon, S., Campbell, A., Chin, M. H., & Laiteerapong, N. (2020). Addiction treatment capacity in health centers: The role of medicaid reimbursement and targeted grant funding. *Psychiatric Services, 71*(7), 684–690. https://doi.org/10.1176/appi.ps.201900409

Kagan, C., Burton, M. & Siddiquee, A. (2017). *Action research*. In The SAGE Handbook of qualitative research in psychology (pp. 55-73). SAGE Publications Ltd, https://www-doi.org/10.4135/9781526405555

Kara, N., & Baydar, H. (2021). The influence of sowing and planting seedlings at different dates in autumn on the yield and quality of the opium poppy (Papaver somniferum L.). *Journal of Applied Research on Medicinal and Aromatic Plants, 21*. https://doi.org/10.1016/j.jarmap.2020.100290

Kirsch, D. (2019). Burnout syndrome has been recognized for the first time as an official medical diagnosis. *The American Institute of Stress*. https://www.stress.org

Knopf, A. (2012). Is compulsory education for counselors on the way? Addiction counselors face a de facto master's degree requirement by 2014. *Behavioral*

Healthcare, 32(2), 34-37.

Knopf, A. (2019). Strategies to help identify and treat pregnant women with OUD. *Brown University Child & Adolescent Behavior Letter, 35*(12), 4–5. https://doi.org/10.1002/cbl.30430

Knudsen, H. K., Ducharme, L. J., & Roman, P. M. (2006). Counselor emotional exhaustion and turnover intention in therapeutic communities. *Journal of Substance Abuse Treatment, 31*(2), 173–180. https://doi.org/10.1016/j.jsat.2006.04.003

Kominski, G. F., Nonzee, N. J., & Sorenson, A. (2017). The Affordable Care Act's impacts on access to insurance and health care for low-income populations. *Annual Review of Public Health, 38*, 489-506. https://doi.org/10.1146/annurev-publhealth-031816-044555

Krautscheid, L., Mood, L., McLennon, S. M., Mossman, T. C., Wagner, M., & Wode, J. (2020). Examining relationships between resilience protective factors and moral distress among nursing students. *Nursing Education Perspectives, 41*(1), 43–45. https://doi.org/10.1097/01.NEP.0000000000000471

Kuip, M. M. der. (2020). Conceptualizing work-related moral suffering: Exploring and refining the concept of moral distress in the context of Social Work. *British Journal of Social Work, 50*(3), 741–757. https://doi.org/10.1093/bjsw/bcz034

Lafrance, M. N., & Wigginton, B. (2019). Doing critical feminist research: A Feminism & Psychology reader. *Feminism & Psychology, 29*(4), 534–552. https://doi.org/10.1177/0959353519863075

Lamiani, G., Borghi, L., & Argentero, P. (2017). When healthcare professionals cannot do the right thing: A systematic review of moral distress and its correlates. *Journal of Health Psychology, 22*(1), 51–67. https://doi.org/10.1177/1359105315595120

Lester, B. M., Das, A., Bauer, C. R., Bada, H. S. & Seetha, S. (2016). *Maternal lifestyles study*. ClinicalTrails.gov https://clinicaltrials.gov/ct2/show/NCT00059540

Levine, S. (2015). The Feminine Mystique at Fifty. *Frontiers: A Journal of Women Studies, 36*(2), 41–46. https://doi.org/10.5250/fronjwomestud.36.2.0041

Lichtman, M. (2011). *Understanding and evaluating qualitative educational research.* SAGE Publications, Inc.

Linehan, M. M. (2014). *DBT Skills Training Manual* (2nd Ed.). Gilford Press.

Lloyd-Hazlett, J., Knight, C., Ogbeide, S., Trepal, H., & Blessing, N. (2020). Strengthening the behavioral health workforce: Spotlight on PITCH. *Professional Counselor, 10*(3), 306–317.

Lurigio, A. J. (2008). The first 20 years of drug treatment courts: A brief description of their history and impact. *Federal Probation, 72*(1), 13–17.

Luty, J., Nikolaou, V., & Bearn, J. (2003). Is opiate detoxification unsafe in pregnancy? *Journal of Substance Abuse Treatment, 24*(4), 363–367. https://doi.org/10.1016/S0740-5472(03)00035-7

Lynch, D., & Forde, C. (2016). 'Moral distress' and the beginning practitioner: preparing social work students for ethical and moral challenges in contemporary contexts. *Ethics & Social Welfare, 10*(2), 94–107.

https://doi.org/10.1080/17496535.2016.1155634

Ma, A. (2017, May 16). *Women recover from Substance abuse: New female-only programs provide safe spaces to explore gender structures.* Vice. https://www.vice.com/en/article/gvzk5q/feminism-is-helping-women-recover-from-substance-abuse

MacKain, S. J., & Noel, N. E. (2020). Master's-level psychology training in substance use disorder treatment: One model for expanding the workforce. *Training and Education in Professional Psychology, 14*(1), 27–33. https://doi.org/10.1037/tep0000251

Mane, R. L. C. (2012). Transmuting grammars of whiteness in third-wave feminism: Interrogating postrace histories, postmodern abstraction, and the proliferation of difference in third-wave texts. *Signs: Journal of Women in Culture & Society, 38*(1), 71–97.

Martin, C. E., Longinaker, N., & Terplan, M. (2015). Recent trends in treatment admissions for prescription opioid abuse during pregnancy. *Journal of Substance Abuse Treatment, 48*(1), 37-42. https://doi.org/10.1016/j.jsat.2014.07.007

Martin, C. E., Parlier-Ahmad, A. B., Beck, L., Scialli, A., & Terplan, M. (2021). Need for and receipt of substance use disorder treatment among adults, by gender, in the United States. *Public Health Reports, 1*. https://doi.org/10.1177/00333549211041554

Mann, S. A. (2013). Third wave feminism's unhappy marriage of poststructuralism and intersectionality theory. *Journal of Feminist Scholarship, 4,* 54–73.

McCarthy, J. J., Leamon, M. H., Finnegan, L. P., & Fassbender, C. (2017). Opioid dependence and pregnancy: minimizing stress on the fetal brain. American Journal of Obstetrics and Gynecology, 216(3), 226–231. https://doi.org/10.1016/j.ajog.2016.10.003 Mee-Lee, D. & Shulman, G. D. (2019). The ASAM criteria and matching patient to treatment. In Smith, S. C., Fiellin, D. A., Rosenthal, R. N., Saitz, R. *The ASAM principles of addiction medicine* (pp. 433 – 447). Wolters Kluwer.

Mei, X., van Wormer, J. G., Lu, R., Abboud, M. J., & Lutze, F. E. (2019). Collaboration: A Mechanism of Drug Court Model Adherence. *Journal of Drug Issues, 49*(2), 253–278. https://doi.org/10.1177/0022042618821196

Mennis, J., Stahler, G., & Baron, D. (2012). Geographic barriers to community-based psychiatric treatment for drug-dependent patients. *Annals of the Association of American Geographers, 102*(5), 1093–1103. https://doi.org/10.1080/00045608.2012.657142

Moldovan, B. R. (2012). 'Opioiphobia' past and present. *Practical Pain Management, 5*(1). https://www.practicalpainmanagement.com/treatments/ pharmacological/opioids/opiophobia-past-present

Morley, G., Ives, J., Bradbury-Jones, C., & Irvine, F. (2019). What is 'moral distress'? A narrative synthesis of the literature. *Nursing Ethics, 26*(3), 646–662. https://doi.org/10.1177/0969733017724354

Moynagh, M., & Forestell, N. (Eds.). (2012). *Documenting First Wave Feminisms: Volume 1: Transnational Collaborations and Crosscurrents*. University of

Toronto Press. https://doi.org/10.3138/9781442664098

National Advocates for Pregnant Women. (2021, October 13). *Oklahoma prosecution and conviction of a woman for experiencing and miscarriage is shameful and dangerous.* https://www.nationaladvocatesforpregnantwomen.org/oklahoma-prosecution-and-conviction-of-a-woman-for-experiencing-a-miscarriage-is-shameful-and-dangerous/

National Council for Mental Wellbeing. (2021, March 4). *New report: 40% of mental heat and addiction treatment organizations will survive less than a year without additional financial support*. https://www.thenationalcouncil.org/press-releases/new-report-40-of-mental-health-and-addiction-treatment-organizations-will-survive-less-than-a-year-without-additional-financial-support/

National Institute of Drug Abuse [NIDA]. (2021, March 11). *Opioid overdose crisis*. https://www.drugabuse.gov/drug-topics/opioids/opioid-overdose-crisis

Neale, J., Tompkins, C. N. E., Marshall, A. D., Treloar, C., & Strang, J. (2018). Do women with complex alcohol and other drug use histories want women-only residential treatment? *Addiction, 113*(6), 989–997. https://doi.org/10.1111/add.14131

New York State Department of Health. (April, 2021). *Why is 40 weeks so important?* https://www.health.ny.gov/community/pregnancy/why_is_40_weeks_so_important.htm#:~:text=How%20long%20is%20full%20term,born%2023%20through%2028%20weeks

Nuttgens, S., & Chang, J. (2013). Moral Distress Within the Supervisory Relationship:

Implications for Practice and Research. *Counselor Education & Supervision, 52*(4), 284–296. https://doi.org/10.1002/j.1556-6978.2013.00043.x

Office of Disease Prevention and Health Promotion [ODPHP]. (2020). *Social determinants of health*. https://health.gov/healthypeople/objectives-and-data/social-determinants-health

Office of the Surgeon General. (2016). *Facing addiction in America: The Surgeon General's report on alcohol, drugs, and health* [internet]. https://www.ncbi.nlm.nih.gov/books/NBK424848/

Oliver, C. (2013). Including moral distress in the new language of social work ethics. *Canadian Social Work Review, 30*(2), 203–216.

Osborne, S. (2001) *Feminism: The pocket essential guide*. Summersdale Publishers Ltd.

Pantell, M. S., Baer, R. J., Torres, J. M., Felder, J. N., Gomez, A. M., Chambers, B. D., Dunn, J., Parikh, N. I., Pacheco-Werner, T., Rogers, E. E., Feuer, S. K., Ryckman, K. K., Novak, N. L., Tabb, K. M., Fuchs, J., Rand, L., & Jelliffe-Pawlowski, L. L. (2019). Associations between unstable housing, obstetric outcomes, and perinatal health care utilization. *American Journal of Obstetrics & Gynecology MFM, 1*(4). https://doi.org/10.1016/j.ajogmf.2019.100053

Patterson, J. E., Edwards, T. M., Griffith, J. L., & Wright, S. (2021). Moral distress of medical family therapists and their physician colleagues during the transition to COVID-19. *Journal of Marital and Family Therapy, 47*(2), 289–303. https://doi.org/10.1111/jmft.12504

Patton, M. Q. (2015). *Qualitative research and evaluation methods* (4th Ed.). Sage

Publications, Inc.

Pendry, P. S. (2007). Moral distress: recognizing it to retain nurses. *Nursing Economic$, 25*(4), 217–221.

Powell, D. J. (2006). It's time for a national approach on staff development: the substance abuse field needs to harness existing training resources to prepare for a major personnel crisis. *Behavioral Healthcare, 26*(3), 42.

Ravitch, S. M., & Carl, N. M. (2016). *Qualitative research: Bridging the conceptual, theoretical, and methodological.* Sage Publications.

Recto, P., McGlothen-Bell, K., McGrath, J., Brownell, E., & Cleveland, L. M. (2020). The Role of Stigma in the Nursing Care of Families Impacted by Neonatal Abstinence Syndrome. *Advances in Neonatal Care (Lippincott Williams & Wilkins), 20*(5), 354–363. https://doi.org/10.1097/ANC.0000000000000778

Reddy, Q.M., Davis, J., Ren, Z., & Greene, M. F. (2017). Executive summary of a joint workshop by the Eunice Kennedy Shriver national institute of child health and human development, American College of Obstetricians and Gynecologists, American Academy of Pediatrics, Society for Maternal-Fetal Medicine, Centers for Disease Control and Prevention, and the March of Dimes Foundation. *Obstetrics and Gynecology, 130*(1),10-28. https://doi.org/10.1097/AOG.0000000000002054

Roe v. Wade, 410 U.S. 113 (1973).

Romano, M. Cacciatore, A., Giordano, R. & LaRosa, B. (2010). Postpartum period: Three distinct but continuous phases. *Journal of Prenatal Medicine, 4*(2), 22-25.

Roth, B. (2004). *Separate roads to feminism: Black, Chicana, and White feminist movements in America's second wave.* Cambridge University Press.

Roy III, A. K., & Miller, M. (2012). The Medicalization of Addiction Treatment Professionals. *Journal of Psychoactive Drugs, 44*(2), 107–118. https://doi.org/10.1080/02791072.2012.684618

Saldana, J., Leavy, P., & Beretvas, N. (2011). *Fundamentals of qualitative research*. Oxford University Press, Inc.

Sawyer, W. & Wagner, P. (2020, March 4). *Mass incarceration: The whole pie 2020*. Prison Policy Initiative. https://www.prisonpolicy.org/reports/pie2020.html

Schieber, L. Z., Guy, G. P., Seth, P. & Losby, J. L. (2020). *Variation in adult outpatient opioid prescription dispensing by age and sex – United States, 2008 – 2018*. Centers for Disease Control and Prevention, https://www.cdc.gov/mmwr/volumes/69/wr/mm6911a5.htm

Schuster, J. (2017). Why the personal remained political: comparing second and third wave perspectives on everyday feminism. *Social Movement Studies, 16*(6), 647–659. https://doi.org/10.1080/14742837.2017.1285223

Shaw, M. R., Lederhos, C., Haberman, M., Howell, D., Fleming, S., & Roll, J. (2016). Nurses' perceptions of caring for childbearing women who misuse opioids. *MCN: The American Journal of Maternal/Child Nursing, 41*(1), 37–42. https://doi.org/10.1097/NMC.0000000000000208

Shento, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information, 22*(2), 63–75. https://doi.org/10.3233/EFI-

2004-22201

Short, V. L., Hand, D. J., MacAfee, L., Abatemarco, D. J., & Terplan, M. (2018). Trends and disparities in receipt of pharmacotherapy among pregnant women in publicly funded treatment programs for opioid use disorder in the United States. *Journal of Substance Abuse Treatment, 89*, 67-74. https://doi.org/10.1016/j.jsat.2018.04.003

Shorter, D. & Kosten, T. R. (2019). The pharmacology of opioids. In S. Miller, D. Fiellin, R. Rosenthal, & R. Saitz (Eds), *The ASAM principles of addiction medicine* (pp. 136-149). Wolters-Kluwer.

Sieger, M. H. L., & Haswell, R. (2020). Family treatment court-involved parents' perceptions of their substance use and parenting. *Journal of Child & Family Studies, 29*(10), 2811–2823. https://doi.org/10.1007/s10826-020-01743-z

Šlamberova, R. (2013). Drugs in pregnancy: The effects on mother and her progeny. *Physiological Research, 62*, 1–13.

Smith, J.A. (2009). *Qualitative psychology: A practical guide to research methods* (2nd ed.). http://med-fom-familymed-research.sites.olt.ubc.ca/files/2012/03/IPA_Smith_Osborne21632.pdf

Smith, J. A., Flowers, P., & Larkin, M. (2012). *Interpretive Phenomenological Analysis*. Sage Publications.

Smith, J.A. & Nizza, I.E. (2022). *Essentials of interpretive phenomenological analysis.* American Psychological Association. https://doi.org/10.1037/0000259-000

Stahl, N. A., & King, J. R. (2020). Expanding approaches for research: Understanding and using trustworthiness in qualitative research. *Journal of Developmental*

Education, 44(1), 26–28.

Staudt, M. (2018). Best practices for enhancing substance abuse treatment retention by pregnant women. *Best Practices in Mental Health, 14*(2), 48-63.

Steinmetz, K. (2020, February). *She coined the term 'intersectionality' over 30 years ago. Here's what it means to her today*. Time. https://time.com/5786710/kimberle-crenshaw-intersectionality/

Stone, R. (2015). Pregnant women and substance use: Fear stigma and barriers to care. *Health & Justice, 3*(2). https://doi.org10.1186/s40352-015-0015-5

Strang, J., McCambridge, J., Best, D., Beswick, T., Bearn, J., Rees, S., & Gossop, M. (2003). Loss of tolerance and overdose mortality after inpatient opiate detoxification: Follow up study. *BMJ: British Medical Journal, 326*(7396), 959–960. https://doi.org/10.1136/bmj.326.7396.959

Strong, T., Pyle, N. R., deVries, C., Johnston, D. N., & Foskett, A. J. (2008). Meaning-making lenses in counselling: Discursive, hermeneutic-phenomenological and autoethnographic perspectives. *Canadian Counsellor, 42*(2), 117–130.

Substance Abuse and Mental Health Services Administration. (n.d.) SAMHSA – *Behavioral Health Integration*. https://www.samhsa.gov/sites/default/files/samhsa-behavioral-health-integration.pdf

Substance Abuse and Mental Health Service Administration [SAMHSA]. (n.d.) *Strategic plan: FY2019-2023.* https://www.samhsa.gov/sites/default/files/samhsa_strategic_plan_fy19-fy23_final-508.pdf

Substance Abuse and Mental Health Service Administration [SAMHSA] (2016). *A collaborative approach to the treatment of pregnant women with opioid use disorders: Practice and policy considerations for child welfare, collaborating medical, and service providers.* https://ncsacw.samhsa.gov/files/Collaborative_Approach_508.pdf

Substance Abuse and Mental Health Service Administration [SAMHSA]. (2020). *TIP 42: Substance use treatment for persons with co-occurring disorders.* U.S. Department of Human Services. https://store.samhsa.gov/product/tip-42-substance-use-treatment-persons-co-occurring-disorders/PEP20-02-01-004

Substance Abuse and Mental Health Services Administration. (2021, January 4). *Medication Assisted Treatment (MAT).* https://www.samhsa.gov/medication-assisted-treatment

Substance Abuse and Mental Health Services Administration [SAMHSA]. (2021, 13 September). *SAMHSA awards $123 million in grants for multifront approach to combat the nation's overdose epidemic.* https://www.samhsa.gov/newsroom/press-announcements/202109130300

Substance Abuse and Mental Health Services Administration [SAMHSA]. (2021, October 5). *Behavioral health workforce report. U.S. Department of Human Services.* https://www.samhsa.gov/workforce

Swinth, K. (2018) *Feminisms forgotten fight: The unfinished struggle*. Harvard University Press.

Syvertsen, J. L., Toneff, H., Howard, H., Spadola, C., Madden, D., & Clapp, J. (2021).

Conceptualizing stigma in contexts of pregnancy and opioid misuse: A qualitative study with women and healthcare providers in Ohio. *Drug and Alcohol Dependence, 222*(5). https://doi.org/10.1016/j.drugalcdep.2021.108677

Thomas, N., & Bull, M. (2018). Representations of women and drug use in policy: A critical policy analysis. *International Journal of Drug Policy, 56*, 30–39. https://doi.org/10.1016/j.drugpo.2018.02.015

Thomas, M., Vieten, C., Adler, N., Ammondson, I., Coleman-Phox, K., Epel, E., & Laraia, B. (2014). Potential for a stress reduction intervention to promote healthy gestational weight gain: Focus groups with low-income pregnant women. *Women's Health Issues, 24*(3), e305–e311.

Tiwari, A., Saraff, S., & Nair, R. (2020). Impact of Emotional Labor on Burnout and Subjective Well Being of Female Counselors and Female Teachers. Journal of *Psychosocial Research, 15*(2), 523–532. https://doi.org/10.32381/JPR.2020.15.02.14

Travis, T. (2019). Toward a feminist history of the drug-using woman and her recovery. *Feminist Studies, 45*(1), 209–233.

Turnage-Butterbaugh, I. S. (2015). Development and validation of an instrument to measure moral distress among counselors working with children and adolescents. [Ph.D. in Counselor education and Supervision, University of Mississippi]. eGrove. https://egrove.olemiss.edu/etd/1375/

Turner, L. H. (2013). The Feminine Mystique and Me: 50 Years of Intersections. *Women & Language, 36*(1), 67–69.

U.S. Department of Health and Human Services Health Resources and Services Administration, Bureau of Health Workforce. (2016*). National projections of supply and demand for selected behavioral health practitioners: 2013-2025.* https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/behavioral-health-2013-2025.pdf

U.S. Department of Health and Human Services. (2017, October 26). *HHS acting secretary declares public health emergency to address national opioid crisis.* https://public3.pagefreezer.com/browse/HHS.gov/16-09-2020T14:35/https://www.hhs.gov/about/news/2017/10/26/hhs-acting-secretary-declares-public-health-emergency-address-national-opioid-crisis.html

U.S. Department of Justice Bureau of Justice Statistics. (2018, April). *Probation and parole in the United States*, 2106. https://bjs.ojp.gov/content/pub/pdf/ppus16.pdf

Vanderplasschen, W., Rapp, R. C., De Maeyer, J., & Van Den Noortgate, W. (2019). A meta-analysis of the efficacy of case management for substance use disorders: A recovery perspective. *Frontiers in Psychiatry, 10*. https://doi.org/10.3389/fpsyt.2019.00186

Villarreal, Y. R., Spellman, M. L., Prudon, J., Northrup, T. F., Berens, P. D., Blackwell, S., Velasquez, M. M., & Stotts, A. L. (2020). A brief, hospital initiated motivational interviewing and acceptance and commitment therapy intervention to link postpartum mothers who use illicit drugs with treatment and reproductive care: A case report. *Cognitive and Behavioral Practice, 28*(1), 92–106. https://doi.org/10.1016/j.cbpra.2020.05.005

Welborn, A. (2019). Moral distress of nurses surrounding neonatal abstinence syndrome: Application of a theoretical framework. *Nursing Forum, 54*(4), 499–504. https://doi.org/10.1111/nuf.12362

Wilson, H., & Donachie, A. L. (2018). Evaluating the effectiveness of a Dialectical Behaviour Therapy (DBT) informed programme in a community perinatal team. *Behavioural & Cognitive Psychotherapy, 46*(5), 541–553. https://doi.org/10.1017/S1352465817000790

Young, S. (2015). Understanding Substance Abuse Counselor Turnover Due to Burnout: A Theoretical Perspective. *Journal of Human Behavior in the Social Environment, 25*(6), 675–686. https://doi.org/10.1080/10911359.2015.1013658

Zedler, B. K., Mann, A. L., Kim, M. M., Amick, H. R., Joyce, A. R., Murrelle, E. L., & Jones, H. E. (2016). Buprenorphine compared with methadone to treat pregnant women with opioid use disorder: a systematic review and meta-analysis of safety in the mother, fetus and child. *Addiction, 111*(12), 2115–2128. https://doi.org/10.1111/add.13462

Zhou, B., Bliss, H., Jarvis, T., & Geary, M. (2021). Facilitation of Coordinated Medical Care for Women in Residential Treatment for Substance Use Disorder. *Rhode Island Medical Journal, 104*(8), 39–42.

Appendix: Interview Schedule

1) Please tell me how and when you began working with pregnant women who have an OUD.
~What were your expectations about the work before you started?
~How are your views about the work different now compared to when you first started?

2) Thinking back through your educational journey, formal education and continuing education and informal learning experiences, What best prepared you to work with pregnant women who have an OUD?

3) The term *Moral Distress* happens when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action. Tell me about a situation, in your work with pregnant women who have an OUD, where you experienced this.
~ How did you respond to the situation
~ Why did you respond that way

4) How would you describe the experience of moral distress that occurs as part of your work with pregnant women who have an OUD?
*Discriminate between professional ethics and personal values of the clinician
*Discriminate between psychological and physical manifestations
*If epistemic injustice is noted ask more about this
*If integrity concerns are noted develop further

5) When you experience situations where Moral Distress is a factor, what steps do you take to resolve the distress?
*If ignoring and moving on ask about
~How did you learn to use that technique?
~ How effective is the technique?
*If using other resources explore
Who has been most helpful & how?

6) What are some ways you believe we could help other clinicians cope with moral distress?

7) What else would you do you feel is important for me to know about your experiences working with pregnant women who have an OUD?

The ~ denotes specific probing questions to ask
The * denotes instruction to the researcher further develop based on response
See pg. 60 Smith et al. (2012) for question examples