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The experience of nurses with boarder babies on an acute-care unit.

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THE EXPERIENCE OF NURSES WITH BOARDER BABIES ON AN ACUTE-CARE UNIT

A Thesis Presented

by

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To

Stuart Golann

1936-1990

Advisor and Mentor

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ABSTRACT

THE EXPERIENCE OF NURSES WITH BOARDER BABIES

ON AN ACUTE-CARE UNIT

MAY 1992

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The role of nurses engaged in the activity of nursing is defined as the care of those who are disabled due to illness, injury, or chronic impairment. The context informs the character of the relationship between nurse and patient and clarifies the contract of care-giving and care-receiving. Changes in the context likely create reverberant changes in one's experience of oneself, and oneself in relation with others. In urban centers across the country, a growing population of well infants are living their first months of life as boarders in acute-care hospitals. Deemed medically fit for discharge, these infants remain in the hospital indefinitely due to parental abandonment, suspected neglect associated with prenatal drug exposure--predominantly to crack cocaine, or unsuitable housing conditions. The majority of literature on this phenomenon emanates from the lay press and focuses on the infants and the plight of their parents, with little said about the nurses. In this study I explore the subjective experience of fifteen nurses with boarder babies on an acute-care unit.

The primary assumption is that being with low acuity, well infants in the context of an acute-care hospital may be a different nursing experience from being with acutely ill children. Data was gathered by means of unstructured interviews, semi-structured interviews, and participant-ready observation. Prominent themes are presented in a descriptive form and include issues of attachment/separation between nurses and infants, thoughts and feelings about the absent parents, thoughts and feelings about nurses' personal and professional interactions with others as an outgrowth of the phenomenon, and the impact on their sense of self. Findings reveal that nurses experience pervasive ambivalence associated with the dissonance created by ongoing role ambiguity. Nurses are challenged to draw upon personal resources to address needs in the professional setting to greater degrees than that which often feels comfortable.

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CHAPTER I

INTRODUCTION

Rationale

The role of a nurse engaged in the activity of nursing generally may be defined as the care of those who are physically or mentally disabled due to illness, injury, or chronic impairment. How the individual understands her or his experience of what it means to act in the capacity of a nurse depends largely on the context within which the relationship between nurse and patient occurs. The context informs the character of that relationship by clarifying the contract of care-giving and care-receiving around such issues as advocacy, management, goal setting, and the degree of emotional investment in the relationship. Changes in one's context imply reverberant changes in one's experience within that context. Thus, any understanding of the experience of nurses must necessarily consider the specific context within which they understand themselves to be acting in the capacity of nurse.

In this study I explore the subjective experience of acute-care, pediatric nurses assigned to an acute-care unit on which the population of hospitalized children has changed from that of exclusively ill patients, to one which includes also non-ill, or well children boarding indefinitely in the hospital. Such an alteration in the population may be

considered a change in the nurses' context, and therefore worthy of exploration.

To me, the issue of interaction between one's roles and sense of self in the world and with others is circular in that, to a large degree, roles simultaneously define relationships and are defined by relationships. Because one's role as a nurse is defined by one's relationship with either acutely or chronically impaired individuals, we may suspect that a nurse in relationship with those who are neither acutely nor chronically impaired may experience his/her current role as different from his/her previously established and defined role. Presuming only the likelihood that being with well children may be a somewhat different experience from that previously experienced by acute-care nurses nursing ill children, I sought to explore the nature of this difference and to learn about nurses' understanding of the impact of such a change on their sense of self in the world, and in relation to and with others.

Models of Nursing

Nursing is an activity which occurs in both lay and professional spheres. While many aspects of nursing a physically or mentally impaired individual are similar whether the nursing is lay or professional, there are also significant differences. Some (Thompson, Melia, & Boyd, 1988) suggest that professional nursing differs from lay

nursing in that the former is motivated not just by feelings of "duty, altruism or necessity" (p.17), but also by the tenets of a formal contract involving specific compensation. Furthermore, whereas lay nurses are often members of the patient's personal network of family and friends and the nurse-patient relationship is superimposed on that primary relationship, the professional nurse-patient relationship is generally the only connection between those involved (Thompson et al., 1988).

The role of the nurse, the nature of the nurse-patient relationship, the goals of that interaction, and the style of case management all vary according to the model of nursing within which the nurse is acting. Murphy (1983) distinguishes between bureaucratic, physician advocate, and patient advocate models in which the nurse's duties, responsibilities, and loyalty are directed toward supporting and maintaining the interests of the institution, the physician, or the patient respectively.

While some aspects of these models are mutually exclusive, other aspects are common to both. For example, whereas the bureaucratic model (Murphy 1983) stipulates less nurse involvement with, and accountability to, patients and patient's families in favor of a focus on the hierarchically organized health care team within an institution, the patient advocate model demands increased nurse involvement with patients in a context of non-hierarchical care, where

nurses gain moral authority in placing the needs of patients above all else. On the other hand, one characteristic that is shared by both models, and is fundamental to the definition of nurse identity and to nursing as a profession, is the assumption of the presence of physical or mental impairment and the motivation to alleviate accompanying suffering. Hunter (1983) writes "...the focus of the nurse's work is on the care of individuals whose own sense of personal wholeness, dignity, and health is in jeopardy through some form of mental or physical distress" (p.31).

Illness, injury, and losses due to natural decline are often experienced as conditions of impairment and distress without which there would be no concept of, or practical need for, nurses or nursing. If nursing is both an institution and a process which helps people gain relief and/or return to health, wellness, and wholeness, what becomes of the practice and philosophy of nursing in the absence of those needs? How do nurses in an acute-care setting think of who they are and what they do if the needs of the physically and mentally distressed are replaced by the needs of well, boarding children?

The Phenomenon of Boarding Infants

In urban centers across the United States of America, an increasing population of low acuity, or well infants and toddlers are living their first months of life in hospitals

as residents on acute-care, pediatric units. Variously known as "infants abandoned in hospitals, boarder babies,...children in limbo, 'long stay' newborns,... and unwanted babies" (Fomufod & Street, 1990, p.137), these children, deemed medically fit for discharge, remain in the hospital due to parental abandonment, suspected neglect, or housing situations which are unsuitable to an infant's needs. The numbers of infants and toddlers boarding in hospitals varies greatly. Their length of stay is indefinite with some (Hegarty et al., 1988) calculating average stays of 339 days and others (Doan-Johnson & McGinley, 1990) mentioning three years.

As the occurrence of boarding infants has expanded both within cities and across this country, most of the attention to this phenomenon has originated in the lay press. News articles focus on individual issues associated with the plight of the abandoned or neglected child, and on the social and medical problems of the mother (Tost, 1989); and raise concerns regarding the dangers of widespread infection to healthy infants due to hospital overcrowding (Slacum-Greene, 1989). Articles focus also on larger system issues of institutional responsibility as hospitals and social service agencies interact and negotiate on problems of placement (Slacum-Greene, January 1990, March 1990); as well as on the long-range impact of suboptimal beginnings on education--both for the individual child and for the

educational system as a whole (Shook, 1990). Meanwhile, the professional press has raised the issue of soaring hospital costs associated with boarding well children for indefinite periods of time (Hegarty et al, 1988).

With the majority of attention centered on stories about the circumstances of individual infants, little has been said about the phenomenon of low acuity boarders from the perspective of adults who interact with these infants throughout their lengthy hospital stay. Headlines such as "Hospital 'Family' Embraces Babies" about hospital employees (Slacum-Greene, 1989), "Men Who Love Babies" about volunteers (Gale, 1989); and titles such as "Filling the void: Boarder babies and the nurses who love them" (Doan-Johnson & McGinley, 1990) raise the issue of an adult perspective and point to networks of relationships as subjects worthy of notice. However, such articles are disappointing in their nearly uniform tendency toward highlighting the tragedy of boarding infants while almost canonizing the adults who interact with them. The accolades, while perhaps deserved, are striking in homogeneity and lead one to speculate on a failure to capture the complexity of this adult experience. Thus, from the perspective of those adults who are with these children the most, that is, nurses on the affected pediatric units, the psychological impact of this phenomenon remains largely unaddressed.

The Study

The study is phenomenological in nature. I explored the subjective experience of nurses who staff an acute-care, pediatric unit with a boarding population of infants displaced from their parents. The primary assumption was that being with a low acuity, long term, boarding population in the context of an acute-care hospital may be a different nursing experience from short term, acute care. It was hypothesized that prominent themes would emerge from self-described accounts of nurse experience including, but not limited to, issues of attachment/separation between nurses and boarding infants, feelings about the boarding infants' absent parents, and feelings of power/powerlessness.

Data was gathered by means of unstructured interviews, semi-structured interviews, and direct, on-site observation of nurses on an acute-care, pediatric unit in an urban community hospital on the East coast. Fifteen nurses participated in the study over a 13 day period. All three shifts were represented.

I chose an unstructured format for the first interview because the experience of these nurses would be new territory and I wanted, as much as possible, to enable subjects to reveal those issues which were of concern to them without inadvertently advancing any preconceived ideas of my own. These interviews were followed by a period of

direct, on-site observation that I have since come to think of as "participant-ready observation", a term which will be elaborated in Chapter II. Subjects were then interviewed a second time in a semi-structured format in which they were asked to respond to a series of specific questions. These questions were drawn both from major themes identified in the first interviews, and from my own thinking. A more detailed description of the methodology appears in chapter II.

In the process of illuminating nurses' experience of what it is like to be with boarding children it became abundantly clear that boarding infants are an integral part of that experience. It is impossible to understand nurses' stories of their experience without understanding something about the children. Consequently, chapter III is a generalized description of characteristics of the boarders involved, by association, in this study. This description of common characteristics is followed by profiles of three individual infants.

Data from both sets of interviews, from context-defining interviews with non-Nursing personnel, and from the periods of direct observation was analyzed for major themes and the findings are presented in chapter IV. Concluding remarks about the findings follow in the final chapter.

CHAPTER II

METHODOLOGY

The Research Site

The Hospital

The study was conducted in an acute-care, private, community hospital which was selected because of a personal connection between myself and a non-Nursing employee who first introduced me to the subject of hospital boarding infants. The hospital holds 450 beds and 44 bassinets, and serves a predominantly minority, urban population in a major East coast city that borders two states.

I approached the Nursing Administration and the hospital's Patient Care Services Research Committee with a proposal to explore the experience of pediatric nurses who are with healthy boarding infants on their acute-care unit. The idea was received enthusiastically by the Nursing Administration, and later by the Head Nurse on the pediatric unit. Their interest seemed to stem from a view they shared with me of a need to investigate an unexplored arena in nurse experience, as well as from general approval of the method. Thus far, nurses' experience around the presence of healthy long-term boarders had been largely ignored as public attention focused on the plight of the infants and their parents. Moreover, from a practical standpoint, data was to be collected by interviews which I would conduct

during work hours, rather than by lengthy questionnaires which hospital personnel had been asked by previous researchers to administer, and which might require unpaid overtime from nurses.

The Unit

The unit in which the study was conducted has 24 beds and serves an exclusively pediatric population, that is, from infancy to roughly the age of legal majority. The unit is organized around a nursing station which faces the only two elevators at one end of the unit. The nursing (or nurse's) station is the focal area of all major activity on the unit; charts for each of the unit's occupants are kept there, terminals which access the hospital computer, telephones, and a variety of care-plan forms among other things are housed in this area. A staff meeting/lunch room opens off of one side of the interior of the station, and a room which holds staffing schedules, medications, and other supplies opens off of the other side. This is an area where staff tend to congregate when not in one of the occupants' rooms. Usually there was age-appropriate infant equipment either within the station or within eyesight such as swings, playpens, and walkers.

Double occupancy rooms run along two parallel hallways, ending with a couple of individual rooms for cases necessitating isolation. The Head and Assistant Head Nurses' office, as well as storage rooms and the staff

nurses' locker room occupy the central core which divides the halls. The playroom is situated near the head of the unit across from the nurse's station and the elevators, and is outfitted with a child playhouse, a TV, and toys appropriate for a variety of ages up to perhaps early adolescence.

The Participants

The Recruiting Process

I introduced participants to the study during regularly scheduled staff meetings. Two such meetings were held: one for the night shift which works from 11:00 pm to 7:00 am, and a second meeting for a combination of the day shift which runs from 7:00 am to 3:00 pm and the evening shift which starts at 3:00 pm and ends at 11:00 pm. (These are approximate times as many nurses come in early and/or leave late in the process of receiving and giving report, that is, transferring census and status information from the departing staff to the incoming staff.) All of the nurses who attended these introductory meetings were invited to participate in order to insure a final count of 10 to 12 subjects with allowances for attrition. They were encouraged to ask me questions to clarify their understanding of the study, and if interested in participating, were requested to read and complete both the

Informed Consent Form (Appendix A), and the Personal Information Sheet (Appendix B).

Prior to addressing the group of potential participants, I decided on specific inclusion/exclusion criteria. First, because nursing education varies greatly from one year certificate training to four year (or more) degree training--with and without post-training specialization--it was my understanding that it is possible to enter a nursing position soon after high school. I was interested in the perceptions of individuals who I supposed might represent a group with greater life experience, and perhaps hold more deeply considered views of themselves, their environment, and their relationships with others. Therefore, I decided to include only those who were 28 years of age and older.

Second, I wanted to learn about the experiences of those who had been on the unit long enough to have been present before the arrival, throughout the entire stay, and after the departure of at least one infant. I learned from a brief conversation with the Head Nurse that the average length of stay was six to eight months, thus I included nurses who had been assigned to that unit for a minimum of one year. Third, to provide minimal homogeneity within the sample regarding a ratio of hours spent on the unit to those spent away from the unit, with the thought that a nurse who was present on the unit for 8 hours per week might report a

conspicuously different experience from that represented by those who were present on the unit for 40 hours per week, I further decided to exclude anyone who had spent less than an average of 20 hours per week on the unit in the previous six months.

The Sample

My original objective was to conduct two interviews with a minimum of 10 nurses. In order to protect against possible attrition between the first and second interview, I planned to interview approximately 10 to 12 nurses in total. Sixteen nurses completed a Personal Information Sheet and signed a consent form. All of these individuals met the required inclusion criteria. This number represented everyone who attended the introductory meetings. I was interested to note what appeared to be such enthusiasm, and I wondered to what extent it represented peer pressure and/or the degree of urgency these nurses felt in having an opportunity to tell their experience and to feel heard. I noted also that the nurses at one meeting in particular questioned my rationale for an age cut-off, expressing concern that the youngest nurse might be excluded. They seemed relieved to learn that she was eligible to participate. Although I did not require 16 participants in my sample, I felt an unspoken pressure to not eliminate anyone who wished to participate.

Fifteen of the sixteen nurses who signed consent forms participated in the initial unstructured interview; the last individual did not indicate continued interest by volunteering her time for an initial interview and she was not pursued. During the course of the follow-up interviews, one individual declined to be interviewed a second time for unknown reasons, and the remaining fourteen participated in the follow-up semi-structured interview.

All of the participants are female. This occurrence was by chance rather than by design; the unit staff did include one male nurse, however he was on vacation throughout the study. Participants ranged in age from 30 to 68 years; a precise mean and median cannot be generated since three subjects either left the appropriate question blank, or wrote "over 28". However, among those who completed the question, the mean age was 46 years.

The sample was comprised of the unit's one Head Nurse, three Assistant Head Nurses, and 11 staff nurses. Fourteen participants gave a numerical answer to the question "How many years have you been a nurse?", and one wrote "over 20". The range was 5 to 30 years as a nurse, with a mean of 22 years. Participants reported having worked on their present pediatric unit for a range of 3 to 22 years, with a mean of 13.5 years on the same unit; there was not one mode, but eight people had worked there for 16 to 22 years. Nine nurses reported working on the average 40 hours/week, two

reported more than 40 hours, and the remaining four reported an average work week of 24 to 32 hours. Thirteen of the fifteen interviewed have children, two were pregnant at the time, and several mentioned grandchildren during the interviews. Two reported their marital status as single, nine reported as married, two reported as separated, and one each reported as divorced or widowed.

All of the unstructured interviews were conducted with only the participant and me present. Two of the semi-structured interviews were conducted while the participant was feeding an infant, otherwise these also were conducted in private.

Approximately two weeks after completion of the study all participants were sent hand-written notes thanking them for their participation.

Data Collection

Data were gathered via two face-to-face interviews and on-going, on-site observation over a total period of thirteen days. The first interview was conducted in an unstructured format and the second, follow-up interview was conducted in a semi-structured format. I also interviewed other members of the hospital community in an effort to gain additional background information about the context.

Both sets of interviews were conducted during all three shifts, at the nurse's and the unit's convenience. All of

the first set of interviews took place in the unit playroom within the first three days of my arrival. The second set was divided between the playroom and empty patient rooms depending on whether or not the playroom was in use at the time of the nurse's availability. The one exception to this procedure was in the instance of a subject who, due to illness and resultant schedule limitations, was interviewed the second time over the telephone. With the exception of one other individual who had to be interviewed before a vacation leave, all of the follow-up interviews occurred during the last five days of my stay.

Audio Taping

Each interview was audio recorded with two cassette tape recorders, a primary recorder and a back-up recorder. Both tape recorders were in full view of the participants and I explained the need for each recorder. The subject wore a clip-on, miniature microphone which was connected with the primary recorder. An internal microphone was used in the second recorder which was employed in the event of malfunction of the primary recorder. This system proved invaluable on several counts: in one case, the primary microphone was not correctly set to record throughout an entire interview which would have been lost without the back-up system. In other instances, the back-up recorder was able to register enlightening after-thoughts added once participants formally concluded their interview and asked

that the primary recorder be turned off (several seemed uncomfortable pausing to think and expressed concern that they were wasting my tape). The continuously running back-up recorder eliminated the need for me to interrupt their new train of thought with the distracting action of moving to re-engage the primary machine. Finally, I set the back-up recorder cassette ahead several counts in order to time the length of the primary tape. This enabled me to change cassettes without continuously watching for the end of the primary tape with what I hoped was minimal distraction for the interviewee. It was a system that facilitated my focus of attention and eye contact, and avoided the loss of their voice on either the beginning or the end of a tape. The one exception to this system was in the case of the participant who, due at first to illness and then to scheduling conflicts, participated in her second interview over the telephone. In that instance, I used cellophane tape to attach the microphone to the telephone earpiece and was able to record the full interview with adequate audio quality.

The Interviews

The reasons for conducting two separate interviews were (a) to minimize the time required of participants to be away from regularly scheduled activities at one time, (b) to facilitate increased familiarity with me during interim observation periods, (c) to create time for the participants to reflect on their nursing experience and to supplement or

amplify their first interview as they wished, and (d) to allow time for me to construct the follow-up questions appropriately based on material recorded during the first interview.

The Unstructured Interview. The unstructured interview consisted of a request for the subject to respond to a Principal Statement (Appendix C) which was designed to elicit spontaneous thoughts and feelings. I often explained that I would make very little comment during this interview so as to not interrupt, alter, or influence their train of thought. Participants were encouraged to take whatever time they needed in responding to the statement, and to add whatever came to mind about their own experience. These interviews lasted from approximately 10 or 15 minutes to 45 minutes.

The Semi-Structured Interview. The semi-structured interview (Appendix D) was designed to clarify common themes derived from the sample's initial interviews. Questions originated from areas mentioned in the first set of interviews, from my ongoing observations, and from ideas generated by my own thinking. These interviews ran longer than the first set with no-one exceeding 1 and 1/2 to 2 hours.

Participant-ready Observation

The first set of interviews was followed by a period of observation I have come to think of as participant-ready

observation. Gold (1958, cited in Piotrkowski, 1979) and Schwartz and Schwartz (1955, cited in Piotrkowski, 1979) talk about the various approaches a researcher may take to gathering data by observation. The variations are in the degree of participation with which the observer engages with subjects, and the extent to which subjects are aware of being observed. At one end of the spectrum is the researcher whose identity is obscured to study subjects, and who participates actively as a bona fide member of the group. This approach is commonly referred to as participant-observation. At the other extreme is the researcher who is hidden from study subjects and does not engage in any interaction with subjects whatsoever. Piotrkowski (1979) took a less extreme approach as "observer-as-participant" (p.303) in which observations were made in the presence of study subjects, but with interaction between observer and subjects limited to polite, concise, non-encouraging responses to subject initiations.

I wished to be careful to convey a sense of respect for the training necessary for a career in professional nursing by not presuming to participate in any interaction with either boarding or sick children unless expressly invited to do so by a nurse. I wished to be sensitive to the fact that I was entering a professional field, and to maintain boundaries which, because of the nature of the profession, might at times be easy to cross. Moreover, I wanted to

emphasize by my behavior that my primary interest was indeed in nurses and nurse experiences, and not in the infants which were the focus of every other visitor. For these reasons, I planned on conducting on-site observation similar to Piotrkowski's (1979) stance.

I found however, that my involvement with the boarding infants was invited from several nurses early on. While the possible reasons for this will be addressed in chapter V, suffice it to say that I considered the periods of observation critical to rapport building, particularly since the nature of the unstructured interview required a more reserved presentation of myself. Thus, ready to accept invitations to increase my interaction in unit activities in whatever ways were made available to me, but without initiating involvement on my own, I have come to label my approach to observation as participant-ready observation.

My periods of observation allowed me to gather information from diverse sources. Because I was permitted to observe at any time on the unit, I spent several random blocks of time on each shift observing the activities and asking questions about procedures. I would visit the unit at least two times during any 24 hour period, and sometimes more often. I accumulated anecdotal information about the infants and their social situations as well as held, rocked, fed, and played with healthy boarders. As mentioned, these periods enabled nurses to become familiar with me, and I

hoped it would enhance their comfort during the follow-up interview in which I would be asking them to relate very personal material. Furthermore, my observation periods gave me a contextual perspective within which to understand their experiences.

During the day and early evening shifts I interviewed several non-Nursing personnel including individuals in the Hospital's Financial, Chief Executive Officer's, Public Relations, and Social Work offices. I approached these individuals--sometimes on my own, and other times by suggestion of the Head Nurse--and explained the nature of my inquiry. Individuals verbally conveyed their willingness to speak with me and I neither gathered written consent, nor tape-recorded these interviews. I made extensive hand-written notes from these meetings. I also kept journal-like notes of stories and information nurses related about unit procedure, daily events, historical events, and about the infants and their histories; about their reactions to me; and about my own reactions throughout the thirteen days including my thoughts, emotions and dreams.

Data Analysis

Each of the 15 unstructured interviews was transcribed verbatim. Major themes were drawn from these transcriptions and transferred to index cards. These theme cards were organized to highlight responses given in the semi-

structured interviews. Extensive notes were taken on the 14 semi-structured interviews, and in some sections were transcribed verbatim. Particular attention was given to instituting a system for the retrieval of key illustrative quotes. Responses from the semi-structured interviews were collated by both subject and by question. Results will be presented in chapter IV.

CHAPTER III

"BOARDER BABIES"

The Importance of the Children's Stories

In order to understand the nature of the experience of acute care nurses who are with well children who are boarding in the hospital, one must learn who these children are and under what circumstances they become hospital boarders. The phenomenon seems so unusual in this time and in this country, that one is drawn by a host of feelings to focus on the child. The questions of who are these children?, where do they come from?, how do they come to live in the hospital?, what are they like? and so forth, are inevitably riveting. The reasons for this magnet-like effect on one's attention, while directly associated with the nature of the children's stories, are too complex to be fully elaborated or analyzed in this work. However, we must suspect that that which attracts the attention of the general public is likely to be a part of that which impacts nurses who are with these children, and therefore cannot be dismissed. In my efforts to maintain my focus on the experience of the adults and to explain my findings to others, I found that the adults' stories could not be understood without a generalized explanation of the children's stories as part of the foundation. To a large degree, the two are intricately entwined.

As previously mentioned, the presence of well children boarding in hospitals is a growing phenomenon across the country. The characteristics of a given boarding population vary from hospital to hospital according to several factors including, but not limited to, the surrounding community that the hospital serves, the social circumstances of the child's parents and extended family, and local and state laws which govern the conditions of a child's release. Thus, it is useful to clarify the circumstances which apply to the children on the unit in this study.

Definitions

The Staff's Definition

At the time of my study, the unit had recently passed the third anniversary of the arrival on the unit of the first child to board there. Including that first child, but with the exception of one toddler, all of the succeeding children were infants who had either been born in that hospital, or had arrived at the hospital shortly after their birth for post-delivery care. Most of these newborns suffered some perinatal problem such as prematurity and/or congenital anomalies, much of which could be associated with intrauterine exposure to drugs and/or alcohol. Some children were simply unwanted, while others were born into severe indigence. Thus, for reasons of poor health, parental neglect or abandonment, poverty or frequently a

combination thereof, these newborns would begin the first few weeks of their life in the hospital. The nurses, and much of the rest of the hospital staff, labeled these children "boarder babies", a term which will be used throughout the rest of this work.

To the nurses, boarder babies are infants who are deemed medically fit for discharge, but remain in the hospital awaiting resolution of custody and placement issues for an indefinite period of time. As low acuity infants, they may not be without health problems, but their health care needs are such that can be met fully in a stable, attentive home environment. These are babies who are healthy enough to go home, and no longer need to be hospitalized.

The Administration's Definition

The hospital technically delineates between "extended stay babies"--those whose parents have the intention and a plan to take their child home upon discharge, but are temporarily unable to do so versus boarder babies--whose parents have no plan for appropriate housing or care upon discharge. In the first case, the hospital expects to board the child temporarily. In the latter situation a social worker files a neglect complaint against the parents, and the hospital must expect a longer stay as the child is routed through a lengthy social/protective services process. This distinction appeared to be a bureaucratic one because I

never noticed it among the nurses. That may be because the majority of parents initially express a wish to take their infant home, but then do not. Thus from a nurse's perspective, the child never has any status other than that which is associated with parental abandonment and a prolonged hospital stay.

Society's Definition

As mentioned in chapter I, several other labels have been proposed for boarder babies. The label signifies only that these are children who are boarding in the hospital. The classification says nothing about the reasons for or projected length of their stay, nor does it clarify the child's legal custodial state. Reflective of the society's lack of a consistent title for these children, there is no organized or standard understanding of their status, nor are there clear ideas about how to deal with them. Society--as a system comprised of interlocking institutions or subsystems--is struggling to make sense of this phenomenon on social, legal, economic, political, and health fronts. As will be shown in upcoming chapters, it seems this confusion at the systemic level about how the institutions of society will respond to the developing phenomenon, is mirrored to some degree at the personal level as individual adults confront individual boarder babies.

Boarder Babies

Infants come to be known as boarder babies by a variety of routes. A normal post-partum hospital stay is 24 hours for both mother and child. If the child is premature, shows evidence of prenatal drug exposure, or has any other physical difficulties he or she will be retained for observation and treatment after the mother is discharged.

Prenatal Drug Exposure

In accordance with a national trend, most of the infants who eventually become boarders are born to substance abusing mothers. The vast majority of these mothers are abusing crack cocaine as the primary substance, although at the time of my study the unit was home to one child who suffered the effects of fetal alcohol syndrome. Some neonates have tested positively for Human Immunodeficiency Virus antibodies (HIV), and it usually does not become clear for some time whether the child is indeed positive for the virus, or is merely still circulating its mother's antibodies.

Certainly not all boarder babies have been exposed to crack cocaine, however enough have been to make it a near assumption when a premature baby is admitted. While the risks associated with fetal alcohol syndrome have been documented for some time, studies on the effects of intrauterine exposure to cocaine are relatively new.

Maternal prenatal use of cocaine is associated with poor perinatal outcome both physically and behaviorally. Pregnant cocaine users risk numerous obstetric problems to both self and child including intrauterine growth retardation, abruptio placentae (separation of the placenta from the uterine wall), premature delivery, neonatal and maternal intracranial hemorrhage, and stillbirth (Hume, O'Donnell, Stanger, & Killam, 1989); as well as low birth weight, neonatal seizures, and genitourinary tract abnormalities (Chasnoff, Griffith, MacGregor, Dirkes, & Burns, 1989). Behavioral effects also are discernable in the fetus, neonate/infant and toddler, and raise questions about the psychological development of these children.

Neonates who have been exposed to cocaine in utero often show extreme tremulousness of arms and legs, rapid respiration or both. These children are both hyperresponsive to stimuli and are difficult to arouse. That is, they are hard to rouse and once excited they are inconsolable, demonstrating only brief periods of quiet wakefulness (Chasnoff et al. 1989). At times, an infant's tremors will be strong enough to wake the child from sleep, and nurses find that the only way to soothe him or her is to swaddle the baby tightly--an unusual procedure in this culture for a child older than a few weeks. Several of the nurses I interviewed mentioned that it was their observation these babies tend to have a shrill, unbearably grating cry

that seems specific to babies who have been prenatally exposed to cocaine.

Older infants who have been exposed to cocaine in utero, like neonates, continue to demonstrate hyperreactivity to stimuli as compared with their drug-free counterparts (Cohen, Anday, & Leitner, 1990). Even when compared with drug-free infants who are matched for variables thought to increase perinatal risk, cocaine-exposed infants show lasting signs of increased reactivity. Examples of hyperreactivity include more frequent startle responses, exaggerated reflex response to a glabellar tap (a finger tapped low on the forehead, between the eyes), and magnified blinking in response to a combination of glabellar tap and auditory tone. The differences in reactivity between cocaine-exposed infants and those who are cocaine-free endure through the perinatal period, beyond when cocaine and its metabolites have cleared from the child's urine, and past the period of "neonatal abstinence syndrome" (p.344) (by which Cohen et al. seem to mean withdrawal).

Nurses voiced the observation that these infants seem to pass through two separate periods of withdrawal, one immediately after birth, and then again a few months later. That is, after passing through the period of tremors, irritability and the very shrill cry, they were reported to enter into a seemingly "depressed state" at about 3 months

of age which lasted 2 months, during which the child may be unresponsive and withdrawn.

Social Consequences

Ordinarily, "high risk" mothers are automatically targeted for an assessment interview with the hospital's social worker. High risk might refer to maternal markers, for instance teenagers 16 years of age and younger, homeless women, and/or substance abusers; or might refer to infant markers, for example a preterm delivery, serious congenital anomaly, detection of prenatal drug exposure, or a problem that requires a stay in the pediatric intensive care unit (PICU). When drugs are detected in the neonate, or there are other indications of neglect, abuse, or lack of preparation for the child, a formal home evaluation is ordered before the child may be released to the parents. Because only the parents are the child's legal guardians, the baby cannot be discharged to anyone else's care without transfer of guardianship--a legal process which requires lawyers, a court date etc.. Without someone to whom to discharge, the hospital is obligated to hold the baby. (In those instances when the mother wants to take her child against medical advice, a court order can be obtained within an hour to restrain her.)

Most parents--usually it is the mother who is involved alone--state an intention to return to take their baby after they rehabilitate from drugs, find a home, prepare a space

for the child, buy appropriate baby equipment, etc. Most do not want to relinquish custody for adoption. The social worker I interviewed and some of the nurses proposed several hypotheses to explain this behavior. One idea is that the social stigma associated with child abandonment, described as especially fierce within minority communities, is lessened when one's child is taken by the state, as opposed to if one relinquishes for adoption. Another idea is that as mothers in the community learn that their friends' babies are being better cared for in the hospital than what might be possible at home, the hospital starts to be viewed as an extension of the family, and the idea of leaving one's child for the duration of time the state will tolerate before taking custody becomes increasingly appealing. Finally, one hypothesis related to the economics of the situation--which some felt was cold-hearted to propose, but which they suspect nonetheless--is that because women receiving public assistance receive additional financial support by virtue of having a baby, they may be reluctant to relinquish custody when they can continue receiving support without taking the child. This support continues throughout the time the child is in the hospital and the mother retains custody, which is an indefinite time lasting perhaps 6 to 12 months.

These hypotheses--more than simply interesting sources of speculation--indicate a critical need for further research. The number of unexplored factors which may

contribute to maternal (and paternal) behavior specific to the growing phenomenon of hospital infant boarders indicates a substantial need for additional research which focuses on parental motivation and the context in which those motivations derive.

Commonalities among Boarder Babies

The most frequently described scenario for an incoming boarder is one who is born prematurely to a crack cocaine abusing mother. The nurses reported that, in addition to inducing premature labor, cocaine acts as an anesthetic. Therefore, the nurses related, if the mother is high at the time of her delivery, she may not be aware that she is in labor, and consequently not know she has given birth. While the majority of deliveries are by women who are aware of their pregnancy and labor, the possibility of a mother not being aware of her delivery is striking enough that it is a question many nurses include in inquiring about the conditions of a child's birth. The outcome of this question undoubtedly contributes to a nurse's initial personal evaluation of the mother, as will be seen in chapter IV.

Many of these neonates are seriously underweight and must be weaned from their own addictions with caffeine and phenobarbital. Thus, except during periods of overcrowding when they may be transferred earlier, these babies spend the first several weeks of their life in the nursery until they reach a weight of five pounds and have gone through

withdrawal. At that point they are ready for transfer to pediatrics.

By that time, the child usually is physically ready for discharge. However, if a home evaluation has not been completed, if the parents are unlocatable or their demonstrated interest is existent but negligible, or if their accommodations are considered unfit for an infant, the hospital cannot legally discharge the baby. The delays, whether due to health or social reasons are such that the parents are most likely to have little or no contact with their infant throughout this time. The mother may not be seen by the hospital staff after her delivery, the father may not be aware he has a child, and often the extended family ties have been broken or severely strained by other social and economic circumstances, including possibly the arrival of previous babies.

The Process of Placement

When boarder babies arrive on the pediatric unit they are seen by the nurses, for all intents and purposes, to have been abandoned. They generally receive few or no visits from their family members throughout their stay. In the state from which the majority of the babies come, the process of having them declared legally abandoned cannot be initiated until after there has been no parental contact for 30 days. Once a neglect claim is filed, a child must remain in the hospital until an investigation is completed. A

social worker from the Department of Human Services is assigned to the child and must make every effort to locate the parents and complete a formal home evaluation, steps which might take months to complete due to overcrowded caseloads. At that point, the worker may send the baby home, petition for state custody, or the parent may voluntarily sign for 90 days of emergency foster care. Because boarder babies are considered to be safe and well cared for as compared with neglected/abused children throughout the city in their homes or on the streets, they are considered a lower priority for worker attention and for foster or adoptive placements.

I was told that an average length of stay for a boarder baby in this hospital is six to eight months, although I was struck by the frequency with which nurses described favorite babies who had been there until eight to ten months of age or older. The discrepancy may be explained in that severely underweight or addicted infants may spend their first one to two months in the nursery, and six to eight months on pediatrics after that, hence reaching the noted age of eight to ten months on departure.

Examples of Individual Cases

In an effort to make more concrete and less impersonal the kinds of situations the nurses on this study were responding to, and the infants they were interacting with, I will present a brief sketch of three individual boarding

infants. Each is identified with a pseudonym. These descriptions are not purported to be fact, but reflect as accurately as possible what the nurses conveyed to me.

Eva was the first boarder baby on this unit. She tested positive for cocaine and for HIV antibodies. The nurses in the nursery were reported to be frightened of caring for her and she spent the first months of her life in virtual isolation. The pediatric nurses relate that she blossomed in their care and she was able to recover much lost territory in reaching her developmental milestones. As time passed it turned out that Eva was not positive for HIV antibodies; it is likely that it was her mother's antibodies still circulating in Eva's bloodstream that caused her to initially test positive. Eva left the unit with one of the nurses as an emergency foster placement, and although completely unwanted by her parents, it nevertheless took more than two years for the bureaucracy to complete her adoption by that nurse.

Daniel was perhaps eight months old and had been on the unit for roughly six months when I visited. He suffered the effects of fetal alcohol syndrome. He was the 12th child born to a mother who was 30 years old. She was already pregnant with her 13th and could not take him. Daniel would not have been considered a beautiful child--some described him as 'homely to the point of cuteness'--but he had bright eyes, an engaging smile and a charming personality. He had

a congenital anomaly which made his breathing difficult and raspy-sounding. Daniel would sometimes sit and hit himself, swinging his right fist around to hit the left side of his head. He showed clear social and motoric developmental delays. Social Services was rumored to be trying to place Daniel with a cousin of his mother's, who herself was 18 years old.

Kenny was a new arrival during the time I visited. Some speculated he had been born in a crack house. His mother was rumored to have been high on crack cocaine at the time of her labor, and initially denied having given birth. She gave birth in a locked room in a house where others could hear her screams, but could not reach her. I was told that she put Kenny in a plastic bag and slid him under the bed before opening the room. Seeing the blood in the room, but not realizing its origin, others called an ambulance and Kenny's mother was brought to this hospital. Several hours later, an older sibling of Kenny's heard him crying and found him under the bed. A second ambulance was then called to transport him to the hospital. Kenny was premature, underweight, and likely to go through withdrawal. No one was able to predict how long he might board on the unit. Partly because he was new and the nurses were not familiar with his individual traits, and partly because of the shocking details of his birth, nurses tended to focus on the telling and retelling of his route to becoming a boarder on

their unit, rather than on him as an individual. During the time of my visit, there were rumors that his mother had eventually acknowledged giving birth, and had indicated an interest in visiting the unit to see him. To my knowledge, she did not visit Kenny during my stay.

The Unit's Response

Nurses on this unit saw Eva's abandonment as a highly unusual case. They were neither aware of, nor prepared for, the emergence of the phenomenon of frequent abandonments of newborns. Since that time, the unit has housed as many as 12 to 13 boarder babies at one time, a number which represents half of their total potential census. During the time when half of the unit was occupied by well boarder babies, the hospital was forced to turn away sick children who needed hospitalization, referring them to other sites further away. This was a difficult time for the nurses who reported feeling quite overwhelmed, as will be elaborated in chapter IV.

The unit has responded by developing a printed care protocol which is specialized to meet the needs of boarder babies. I interpret the development of a care protocol specific to boarding infants as an indication of the unit's adaptation to and assimilation of the foreseeable permanency of boarding well infants. The protocol is similar to that developed for commonly seen pediatric problems that necessitate hospitalization, like broken bones and certain

infections. It lists the problem to be dealt with such as bonding with family members; the goals associated with each problem such as reaching proper developmental milestones of social interaction; and the nursing interventions associated with reaching those goals such as providing verbal, tactile, and visual stimulation, and monitoring growth and development. While some of the protocol can be met, other parts are more difficult to accomplish. For instance, nurses can stimulate a child, but cannot assist bonding with the family in the absence of family members.

Finally, the staff has ready a plan to divide the unit into two halls--one for low acuity boarding babies, and the other for high acuity sick children--should the census of boarders ever rise to roughly 50% of the total again. Such a need was not apparent when I visited. It is interesting to note that while I was there, the census of sick children dropped to zero, and the only occupants of the unit were six boarder babies. This had never happened before, and raised an interesting dynamic which will be addressed further in chapter IV.

CHAPTER IV

PRESENTATION OF THE DATA AND DISCUSSION

Introduction

The manner in which the results of qualitative research are presented is determined by an interaction between the investigator and the data. Throughout this chapter, the data is interwoven with my observations and commentary. The chapter begins with a discussion some of the issues inherent in reporting qualitatively gathered and analyzed data. The use of raw data, or original quotes requires an explanation of the issues associated with, and the means used for maintaining, confidentiality.

The data is organized in a system of concentric circles starting in the center with the pediatric nurses and their experience of being with boarder babies. This section begins with nurses' experience of their first contact with an incoming infant who is expected to be a long-term boarder. The first contact evolves into a personal relationship between nurse and infant, which leads to an exploration of the ambiguity of the changing role inherent for nurses in this position. Concurrent with nurses' experience of their own changing role is their experience of infants' absent parents, both father and mother, whose very absence (or neglectful behavior) is experienced as the cause of nurses' being in this situation, overall. The

relationship between a nurse and child is permeated by issues of attachment and separation, which are explored as part of nurses' experience. Separation, in particular, is defined experientially by issues of the child's eventual placement. While most nurses talked about attachment and separation as experiences of which they had knowledge, some talked about ways they had attempted to protect themselves by avoiding relationships in which such experiences would occur.

Moving outward to the next circle, the experience of the nurses in this study occurred in a hospital context. The ramifications of this experience is explored through looking at nurses' associations with others including other hospital personnel, volunteers, visitors to the hospital, as well as nurses' relationship with their colleagues on the unit. The next concentric circle is presented as the intersection of personal and work life and includes sections on nurses' experience of the influence of their family of origin on their experience, the influence of their current family, the availability and effectiveness of outlets and supports, and thoughts about themselves as professional nurses and as individuals in the wake of being a part of this phenomenon.

Finally, nurses were given an opportunity to express their thoughts about the future regarding the phenomenon of hospital boarding infants, and were invited to express their

thoughts and feelings about the experience of participating in this study.

Identification of Themes: Expansion and Condensation

The qualitative analysis of data is a complex task made none the less so by the fact of the researcher's use of self as a major tool in the process. While the objective of exploratory inquiry is to listen to and report back that which subjects tell us, our presence in what is heard, how it is digested and made sense of, and how it is reconfigured for presentation is ever attendant. Piotrkowski (1979) writes:

> ...the object of thematic analysis is to allow the data to "speak for themselves" without the prior imposition of a researcher's schema. But the researcher is not merely a vessel through which the structure inherent in the data is carried into public discourse. Such an analysis involves a dialectical tension between the process of accommodation, whereby the conceptual schemas are created and modified by the data, and assimilation, whereby the data are fit into the emerging conceptual framework. (p.314)

In this sense, the process of interpretation, analysis, and presentation is one of first expansion (accommodation, or the creation of innumerable themes) and then of condensation (assimilation, or grouping subthemes under larger thematic umbrellas). As researchers, we conduct this process as faithfully close to our understanding of the data as possible--at that place in time.

The material gathered for this study from the 15 unstructured interviews and the 14 semi-structured interviews is necessarily combined for presentation. Because the questions for the second interview were devised on themes derived from the first interview, commonalities resonate among the total 29. Therefore, the data from this study are organized around groups of questions from the second interviews, with data from the first interviews used to broaden our view or underscore an existing point.

Many of my questions and observations are intended to reflect the perspective that these nurses' experiences exist within the framework of overlapping systems of the pediatric unit; the hospital; the outside world of the volunteers, the visitors, the absent parents and their social context, and the social service bureaucracy; and individual nurses' families and personal relationships. However, it is not possible to convey the multi-dimensionality of such interrelatedness. Piotrkowski (1979) observes of her data:

> ...qualitative research has no agreed-upon norms to guide the written presentation (Lofland, 1974), for no neat dichotomy between findings and discussion exists. Systems imply interrelatedness; it is fitting that each theme should simultaneously touch on many others. Thus, themes did not emerge in a linear way, nor were "variables" connected in a simple one-to-one relationship. Writing, however, <u>is</u> linear, and so themes had to be treated one by one, as if they were independent, when in fact they are not. (p. x)

This passage highlights two issues of relevance for this work. First, it should be recognized that these data which are organized in a linear fashion should not be understood--at the systemic level or the affective/reactive level--as representative of the nurses' experience as linear. Second, it is inevitable that commentary which would otherwise be suited for a discussion section will at times appear in this chapter as well as in chapter V. In addition, I will use descriptive words such as a few, some, several, many, most, etc. because with such words I am able to more accurately convey the tone and meaning implied by individuals who describe a selected theme, without speaking concretely and risking devaluing an idea by equating its value with frequency. Counting the numbers of times someone states a feeling, or the numbers of people to state that feeling at times will clarify our understanding, but those times are likely to be in the minority.

Finally, because I believe a critical way of understanding the data is for one to enter into it, quotes are used extensively throughout. In order to protect confidentiality according to the contract of the consent form (see Appendix A), certain restrictions will be applied. First, every subject will be referred to by a pseudonym. Infants who are mentioned also have been assigned pseudonyms. Second, in cases where a group is comprised of one subject, as in the case of the one Head Nurse, the one

nurse who adopted a boarder baby etc., they either will be grouped with others or referred to by a descriptive phrase rather than their pseudonym, depending on the circumstance. These precautions are designed to protect subjects' privacy outside of the unit. Maintaining confidentiality in a study where all of the subjects know one another professionally and personally, is a trickier matter. In fact, because so much of their experience hinges on details in either the adult's life or a particular infant's life, complete confidentiality among subjects likely is not possible. With that in mind, I have made every effort to balance the need for complete presentation with a sensitivity for the fact that at the present time these women continue to share relationships with one another, and within the hospital at large.

The nurses are, in alphabetical order: Anita, Donna, Dorothy, Elizabeth, Florence, Gwen, Hallie, Hilda, Janice, Laura, Melinda, Naomi, Ruth, Sophie, and Yolanda. The infants' pseudonyms are, in alphabetical order: Ashley, Bernie, Daniel, Kenny, Eva, Jason, Joseph (or Joe), Ophelia, Tanya, and Tommy.

The Process of Connection

The First Contact

When the nurses on Pediatrics first learn about the admission of a new boarder baby transferred from the nursery

their reactions--three years into the phenomenon of long-term boarding infants--tend toward the lackadaisical, but with some curiosity about both the situation of the mother and the current condition of the child. In contrast to the reported animation of response about the arrival of the first child who became a boarder, Ruth said "...it's gotten so routine", and Gwen, relating that a new arrival has sometimes been exciting said "It's gotten humdrum, now".

Some wonder where the mother is, whether or not she uses drugs and if so what kind, why she left her baby, and whether or not she will be involved with the baby in the future. For nurses, this information is the story behind the individual baby that sets that child apart from others, and subtly positions its mother in the world among other mothers. The story also proposes a prediction for what can be expected for the child's overall physical condition and developmental prospects, that is, whether it is likely to suffer tremors, be difficult to feed, have respiratory problems, be irritable and inconsolable, and worst, have a grating cry; and later, the chances of it being developmentally delayed. While the initial focus is a pragmatic one most closely associated with an interest in what nursing care the child will require, for some, an interest in the child's story demonstrates the implicit question of the potential emotional toll ahead. As Janice said:

> The first thing you think of is what drug was this mother on? What's the home situation like? Will the child be affected a lot?

And at another time:

> ...It really hurts you to see them going through these different stages of withdrawal. When they're shaking all their extremities you can't do anything to console them. Working with normal babies before, and working with [boarder babies] now, it's really crushing to you. It hurts to see them.

During the previous three years, nurses had been acquiring a certain expertise in identifying those infant behaviors they associated most with prenatal drug exposure. The arrival of a new boarder to the unit no longer constituted a novelty, or stimulated a spectrum of affect, as had the first two abandoned children in particular. Instead, the initial nursing focus was primarily on what physical problems could be anticipated. Early on, nurse responses convey a sense of emotional distance bred seemingly by habituation; for the most part their responses represent a professional approach which seems protective of one's personal investment.

The response of several nurses to a new transfer from the nursery have evolved to where they are related to the current census. When asked about her thoughts and feelings on hearing about a new arrival, Anita said:

> [It] depends on what the census is. If it's 20 we get resentful. [We think] how can we take another baby? But when the census is six we welcome the baby with open arms (she laughs). Right now we're glad to have them because we have such a low census we have to justify us being here.

After a winter during which the census was for a period at maximum capacity--half of which were well infants--the unit was at a low of zero sick children and six boarder babies. If the boarders had not been there, nurses told me the unit would have been closed. I was aware that on at least one shift, a nurse was called and asked to stay home. While the unit census can change dramatically within even one shift, this event seemed to intensify expressed feelings of ambivalence along job-related lines regarding the presence of boarders on the unit.

Boarder Babies versus Sick Children

As a matter of course, nurses have come to identify several distinctions between their relationships with boarder babies and their sick counterparts. Sick children are usually on the unit for an average of two to three days. Often parents and/or other family members will accompany the sick child and serve as his or her advocate in procuring and monitoring appropriate health care interventions--which the nurses administer--as well as assisting in the child's basic care. For nurses, attending to the sick child's physical needs are the first priority, and supercede ordinary schedules and home routines. Furthermore, the child's emotional needs are generally best met by those with whom he or she shares family bonds.

Boarder babies, on the other hand, have no individual advocate within the health care system. Getting their

formula changed requires a physician's order; for liability reasons, receiving age-appropriate vaccinations requires either locating the mother for permission, a court order if the child is in the custody of the courts, or collecting signatures from two physicians--all of which are often arduous tasks. In an attempt to treat them as the normal, healthy infants they are, nurses try to train them to be on a regular schedule of eating, bathing, sleeping etc.. This inflexibility places additional strain on nurses who must simultaneously fulfill the demands of the erratic schedules of sick children. Moreover, whereas parents are in the best position to enable a sick child to reach his or her physical and social developmental milestones in their ongoing, daily interactions, nurses provide the most consistent adult presence in the lives of boarder babies for the duration of their 6 to 10 month stay. As the most accessible adults, it is nurses who feel called upon to meet those developmental needs of boarder babies. While perhaps trained to recognize basic deficits and to enhance pre-existing developmental skills, the nursing staff of an acute care facility would not ordinarily expect to address these needs on a long-term basis. Finally, as a boarder baby's primary caretakers, nurses are the first to face the less visible, but perhaps most critical need of a boarder baby, that is their emotional development.

When asked about how they organize their priorities, all of the nurses said that their first priority is meeting the needs of a sick child before those of a boarder baby. Many, however, said that if the care schedule for a sick child was not interrupted, they preferred to schedule their responsibilities to get their assigned boarder babies settled first, that is, bathed, dressed, fed etc. before attending to the changeable needs of a sick child. On the practical side, the staff had worked hard to get the boarding population on a regular schedule which also they wanted to not disturb. More than that, though, was the desire to establish contact early in the shift with one's assigned boarders, who it was felt needed the social and emotional attention they would not otherwise receive. Several noted how frustrating it can be to be busy and feel one is unable to attend fully to the well babies. As Laura explained:

> When you have sick patients who require acute care needs it's very difficult to set your priorities...you have a child who has the normal needs...they need to eat, and be dressed, and fed, and played with, and interacted with, and yet you have a sick child who needs to have their medicines...they're here because they're sick. Sometimes it's a battle as to who requires their needs met first. Logically you can say the person who's sick...but when you have 6 to 12 boarder babies, and you've gotten them into the routine of sleeping through the night, when they wake they generally wake at the same time and want to be fed. And you have a unit of screaming babies, screaming for your attention...and yet you have a sick child that needs your attention, too.

Anita talked about how she felt when a well baby had been fed and was dry, but she didn't have time to hold and play with the baby:

> I feel very torn about that. I don't like to close the door and let the baby cry. I have a real difficult time with that. When we're <u>really</u> busy, it's <u>really</u> frustrating!

Florence elaborated on this point and added the issue of the demand for the missing parental presence:

> If you have a really sick child you cannot really give the care to the boarder baby that that baby needs. That baby needs a parent, needs a mother. It needs to respond to one voice, and I really have a lot of concerns about this. Sometimes we find we are spending more time with our boarder babies than we are with our regular kids who are really sick...and may need our care. If you're a baby who's not just sick, you're growing. You need your parent at some time of the day to just hold you. So we've been having a lot of conflicts.

The conflicts Florence refers to are multiple. In addition to the conflict of meeting the simultaneous needs of sick and well children, there is the conflict of nurses who prefer to spend more of their time with boarders versus those who prefer to spend more of their time with sick children. Perhaps that which creates the greatest personal struggle is the internal conflict between the nurse in the role of a professional doing her job, versus the nurse in the role of a mother. Hilda explained the difference for her,

> [As a nurse] I'm trained to help the parent and the child get better, and hopefully they'll go home in a day or so. You feel like you're doing what you're here to do, what your education is all

about. Not that you're not using that with the boarders. You are. But you're putting a lot of emotion in the boarder babies every day. You don't get that emotionally involved with your sick kids because they have parents, so you don't have to give that aspect of yourself every day. I think that's the difference. With the boarder babies, you're a mommy. You can't just be a nurse. you're a mommy, and if you can't be a mommy every day then.... A lot of times I can't be.

As the number of boarders increased and the duration of their stay lengthened, this group of nurses was forced to make central the task of negotiating the nature of their changing role. The demand for something different from the role to which they were accustomed was one that reached these women on both the educated/trained, professional nurse level, as well as on a deeply personal level as illustrated in their descriptions of their individual relationships with particular boarding infants.

A Personal Relationship

The longer a boarding baby remained on the unit, the greater the opportunities there were for nurses to begin to identify personally attracting or repelling characteristics, and to connect emotionally with favorites. They struggled to articulate some of the distinctions between more or less appealing infants:

Melinda: The only thing that really bothers me is that shrill cry.

Sophie: It's nothing you can put a name on. It's like you're own kids. You just love them.

Donna: Their disposition. After a while they all grow on you. Even at first if you don't like one, eventually that one grows on you, too.

Hallie: It's a personal preference. I can't really pick out anything special...I like a lot of the cry-babies. My little boy that I fell in love with, he was a cry-baby. He had a very irritating cry.

For Naomi it was the baby's "personality" that determined a baby's attractiveness. Dorothy and Yolanda seemed drawn to those children who were most physically impaired. Anita said she could not abide a nerve wracking cry or a baby who was "wiggly and jiggly" in one's arms; a baby did not have to be cute, but she like babies who smiled a lot and felt cuddly when held. Elizabeth said being cute "doesn't hurt", and noted some were so ugly that they were cute. She summed up what all of them seemed to be saying was essentially an arbitrariness in what made one baby special over another when she said, "I don't know, I guess it just depends on what gets you where you live."

The issue of an infant's special appeal was evident when nurses talked about "favorites" and "my baby". One nurse related her experience in soothing and creating a connection with a frequently inconsolable microcephalic infant:

> I like the sickest babies, maybe because of the acute care. Ophelia was brain damaged. They called Ophelia my baby. She had big eyes like flashlights--could look right through you. Doe-like. The doctors said any movement was [due just to] her brain firing. They said she'd never have any emotional response to us, but...I felt she did. Sometimes I put her inside my jacket and

> carried her around at night. I loved her. I felt it was the heart beat [that soothed her].

And another recounted:

> My little boy, his name was Tommy. I would spend extra time on my days off...with him. If I was [assigned to] one side and he was on the other I would still bathe him and feed him and put him to sleep. Even if he wasn't my child they would say "Come and get your baby", and I would come and get him, unless I was extremely busy [then] of course I couldn't. I was forever going shopping for him. I had considered fostering him, but due to certain circumstances I didn't. If they had told me I could take him home he would have been my child, without having to go through all the formalities. He definitely would have been mine. He was my most special.

When I probed about her attraction to Tommy, this nurse added that she was instantly captivated by him when she accepted him from the nursery and that recognizing that, she claimed the prerogative to select a name for him, declining input from others. Clearly, Tommy was special to her from the beginning.

A few nurses described their connection with a favorite in terms of the baby having chosen them. One woman related:

> Ashley. She started choosing me, I guess. Big button eyes--really tears you up (she begins to cry). She'd smile when you walked in, and [she'd] hear your voice and turn over and peek out.... She started walking in the walker and she was pushing everybody out of the way to get to me.

There were also a few nurses who said they had not had a favorite, by choice. One nurse said:

N: I [haven't] gotten real attached to any one particular child.

A: Why do you think that might be?

N: I've seen how they're taken away very abruptly. Although [a boarder baby's stay] is for a longer period of time, it is just temporary. Because of that, I could never be a foster mother. Because you have to separate.

This nurse's decision to not allow herself to share an attachment with a boarder baby seems like a defensive measure to protect herself from the pain of a sudden separation. Another nurse echoed this sentiment:

> I haven't gotten involved-involved with them like other people on the floor have gotten really attached. I think I did that purposefully. I have my own children. I didn't think I needed to get real involved or attached to the babies up here. After I saw how [Social Service workers] just called up and took them away I decided not to get too involved.

For some, the prospect of an abrupt separation is too painful to risk engaging in the intensity of a relationship which could be described as an attachment. It is not coincidental to hear from this woman that her alternative to being "involved" with boarder babies is her relationship with her own children, that is, in her role as mother. Similar sentiments are explored in a later section on emotional self protection.

The Changing Role

In response to the demands of non-nursing needs, nurses were experiencing a transformation in their role from nursing the acutely ill, to a new role with well infants. Their labels for this new role tended to be in a category of

either babysitting, some form of mothering, or a combination thereof.

Not knowing what to call this new role contributed to a sense of uncertainty and ambivalence about their new relationships. As nurses, one's first priority is a child's physical needs, and secondarily their social and emotional needs. What then, is the function of a professional nurse--herself a mother, aunt, grandmother, etc.-- who observes these pressing social and emotional needs in the absence of the infant's parents? Elizabeth:

> I feel like a day care worker. Certainly don't feel like a nurse. Temporary mother [maybe]?

Dorothy, Hallie, and Donna said they felt what they do with boarder babies is "babysitting", but two of these women at another time referred to themselves as a baby's "mommy". Sophie and Melinda said they label what they do as 'giving the babies love'. Laura said, "we give them a home"; Gwen and Florence termed themselves as "surrogate mothers"; and Yolanda said, "No mommy shows up for a very long time. You become their mother". Perhaps Naomi captured the way many felt in their ambiguous role when she answered that what she does with boarder babies is:

> Babysitting. By the same token, I feel I'm the substitute mother. I'm the one he sees in the morning. I change his Pampers, I feed the baby, bathe the baby, play with the baby. I'm not here all the time, but deep inside I feel like the mother.

Gwen elaborated on her role:

I like the closeness, and I feel that's what babies need. The touching, and the hugging, and the teaching. All the things that mothers do for their children. I feel like that's what it is: an extension of my family, here. Children that we don't have at home. We just leave home, come to work, and be a mother at work.

The boundaries of this new, confabulated role, were blurry and indistinct. For some, incorporating a mothering component into their nursing role was comfortable:

Hallie: It's fun. I love it. Each one, I accept as if they were my own. I cry a lot when our babies leave us.

For others, it was dystonic to their view of themselves as professional nurses, and they worried about a detrimental effect on their nursing skills--an issue to be elaborated later.

Several nurses shared with me how the overlap of mothering and nursing roles was influencing their interactions with one another. At times the nurse in an individual would dominate, and at other times it would be the mother:

Gwen: ...You fuss with each other, "Why did you dress him in this?" (she laughs) "You didn't do the hair right." Or, "the baby's still got pajamas on and it's 12:00". It's like old women bickering at each other. (She laughs, again).

Melinda: ...You find you have a variety of mothering instincts. This mother raised her kid this way and this mother raised her kid [that way]. It can be quite a problem sometimes (she laughs). Some nurses will say they should have a bath in the morning, or they should have a bath at night. It's strange because they're not sick kids, but people are still babying, or <u>nursing</u> them is what

> they're doing. "You can't take him outside." If he were home, you'd take him outside. Why not? Some people feel you can't let him sleep all night. [Now] we're more inclined to let them sleep. "You have to wake him up and feed him...or change him." Would you do that if he were home?! (She laughs, again).

While their differences were described most times in a good-natured way, one can imagine that such minor variations in approach would at times create friction. However, conflicts among nurses may be thought of as a reflection of that which is within nurses as they sort out their new identities. Florence described one of the dilemmas inherent in trying to negotiate one's position in terms of balancing issues of self protection regarding entering into emotionally taxing relationships, versus making an unrestrained effort to meet the observed need:

> It's like a Catch-22. You're involved with your babies, and yet you're not. From Social Service on down we're told "These are not your children". But they <u>are</u> our children. Because we have to take care of them. If they don't bond, or establish some kind of trust and affection with some one, what is left for them? They become like their parents?

The stakes seem very high to these women as they consider their own well being and that of the infants.

<u>The Absent Parents</u>

The nurses on this unit individually and collectively struggle with how those characteristics which are generally attributed to the roles of nurse and of mother will

commingle in one person, given the professional context. This struggle exists not only by virtue of the presence of well infants on their unit, but also by the absence of the infants' parents. The parents' absence, or inconsistent presence, thrusts nurses into the position of having to make decisions regarding to what degree they will attempt to meet the various perceived physical, social, and emotional needs of an infant that are not otherwise met by a parent.

To those at both the social service/legal system level, and at the interpersonal level of the nurses on this unit, the parent whose behavior seems to be of primary consequence and concern is that of the mother. Accounts from the social worker and from the nurses indicated that a child's mother had greater, or more overriding, custodial rights regarding the child than did that child's father. Substantiating those accounts was not within the scope of this study. However, whether the view that mothers are considered to be a child's primary custodian is an accurate representation of where the legal system places its values or whether it is more of a social construction, nurses' spontaneous--and most intense--talk tended to be about the absent mother, and to a much less degree about the absent father. The less elaborated experience regarding the fathers is presented first, followed by their thoughts and feelings about the mothers, who seemed to figure more prominently for these nurses.

The Absent Father

During the first interviews, the fathers seemed to me to be conspicuously missing from nurses' spontaneous talk regarding their thoughts and feelings about boarder babies' parents. Later, when asked directly during the second interviews, thoughts about the absent fathers emerged. These thoughts and feelings were generally--although not unanimously--either neutral or supportive of the absent father. They focused on either the father's unknown identity and the idea that the pregnancy resulted from an exchange of sex for drugs (thus including a subtle indictment of the mother as well), or focused on a father's total lack of involvement with either mother or child for unexplained social reasons. In two cases about which the nurses spoke supportively about the fathers, the mother's unknown whereabouts had hindered the father's efforts to gain custody of his baby with the help of a female relative (the implication being that the infant in each case went to the care of a woman on the father's side of the family, rather than remaining in the direct care of their father). While not totally absolving fathers for their absence, nurses tended to simply diminish their importance as primary custodians. Ruth illustrated the different expectation of fathers versus mothers when she said:

> A lot of the babies we get don't have a father that's interested, but it's hard to understand how a mother could just abandon a baby.

Her language illustrates a subtle, but unmistakable dismissal of the father whose actions represent less interest and an implied indictment of the mother whose actions represent abandonment. In accordance with the mores of this and most cultures, a father's connection to his infant child is easily assumed to be less strong than that of the mother. Obviously, in the case of a well boarder baby, either parent could be doing for and with their child that which the nurses do--and more--if they were available and acting in the capacity of parent. However, the value these nurses placed on mothering was powerful and unmistakable, and clearly overshadowed the responsibility attributed to fathers. Intuitively, one might reason that this difference reflects an identification nurses felt with mothers and which is inevitable given the nurses' shared gender with mothers. Determining reasons for these nurses' views about the absent fathers versus the absent mothers is outside of the realm of this work. One might hypothesize, however, that their feelings likely represent a combination of social mores, legal constructs, and resultant gender and role identification. Whatever the explanation, this group of nurses clearly placed the burden of the consequences of parental absence squarely on the shoulders of the infants' mothers.

The Absent Mother

More so than the absent father, the absent mother is a parallel counterpart to the nurse. Despite very little contact with mothers overall, in listening to these nurses, it was as if there was an invisible relationship between these two groups of women which somehow connected them. As women, many mothers themselves, they inevitably compared the actions of their counterparts with their own understanding of motherhood and mothering. By that measure, the mothers remained incomprehensible to the nurses.

The struggle to ascribe meaning to a mother's apparent abandonment was evident throughout, and was marked by alternation between indictment and condemnation, and an effort toward empathy and understanding. While in some instances the later stood alone, frequently it immediately preceded or followed the more negative feelings of condemnation and thus seemed to serve as a defense against the fearsome quality of some of the subjects' more vituperative feelings. Such negative feelings run counter to the foundation of charity and compassion which are assumed to be an indelible part of the nursing tradition and are thereby internalized as part of one's identity, thus clearly it was difficult for some to acknowledge aloud to themselves and to me the intensity of their feelings toward these absent mothers.

Sharing one source of ambivalence felt toward the absent mothers, the Head Nurse noted:

> I think we've had..(pause)..I think we have had a hard time, as parents ourselves, with the concept of a mother being able to abandon their child. Or walk away. I'm very proud of [the nurses on this unit]...because you're initial reaction when one of these parents does show up...would be to very politely tell them to go to hell.

Yolanda demonstrated the pendulum swing between censure and empathy that others expressed, too:

> I could never treat my child the way the drug-abused moms treat their kids. But then, you have to remember that they're on drugs. They're not in the right frame of mind that I'm in. But at one point they were.

Hilda, searching for a way to understand why mothers leave their children for so long focused on the cocaine addictions:

> Unlike the heroin mothers--we used to get those mothers, but they didn't leave their babies--....[They're] unlike these people that get on the crack, will hang out in crack houses and remove themselves from their families.... So, it's really sad. The drug is unbelievably destructive. But to think that anything that's strong enough to destroy the mothering instinct...that's powerful. That's one of the most powerful instincts there is. And these mothers don't have it. It's got to be the drug. It's the only thing it could be.

Laura echoed:

> I understand that the cocaine, which a lot of them are on, obliterates that part of you...that maternal instinct.... It knocks it out. [Even so,] then when they show up again, it's real hard to understand. It's very hard to have empathy and understanding for them.

Florence spoke in even broader terms stating that she saw the mothers of these babies as victims in their own right:

> I have feelings for the parents. I feel we're not doing enough to take care of the parents so they won't have to leave the babies in the hospital.

And later:

> We are so readily able to say well, the moms shouldn't have [their babies]; the mom is an unfit mother. But the mother is a victim, too. The moms need help.

She explained that drug addicted mothers have no resources to help them deal with their addictions because there are not nearly enough programs, and those in existence are directed toward men. Florence and others spoke of the intergenerational effects of cocaine and how family ties--particularly with grandmothers--are either dissolved or overburdened with children born previously to the same mother. This explained why other family members generally do not take the boarding child home. Nevertheless, efforts to understand and feel empathy for an absent mother easily give way to feelings of anger. Melinda shared:

> ...Somebody told me I shouldn't be angry or upset with these people because they're drug addicts. But there must be <u>somebody</u> in the family who can take this baby. To let it stay in the hospital for months and months is awful. I resent that. I resent that they're allowed to do that. Like Gregory: she tries to kill him. Puts him in a plastic bag under the bed and leaves him for dead, and then she's going to come here and hold him?! No. There's something wrong there. I would have to exercise great restraint if I were to see that mother.

Anita painfully described a tragedy which was such an outrage for her as to eradicate any sense of empathy she had had for the mother:

> I had an experience where I had sent um...(pause) a mother home with a child, and I had gone over everything. She had had her CPR. She had had her monitor training. I packed her up--we always give them clothes and formula and diapers. And she had showed she wanted the baby. She stayed here the night before and was all ready to go. [She] had left by cab that night about 7 o'clock, and they brought the baby in dead the next morning at 3 a.m.. She had taken the baby immediately to a crack house. They never did find the monitor from the baby. [I feel] such resentment--you could not believe.

Gwen described the same account from her view, highlighting her anger at the loss of this child and at feeling duped by his mother:

> I got involved in one case. The mother was using drugs. We got pretty close and talked. Later on I found out it was part of her act. I tried to teach her parenting skills, provided her with food and clothes and toiletries because she would stay for 3 to 4 days at a time. She was homeless. I was mad at the system because they wouldn't allow her to take the baby home. They see things on the outside we don't see. I said she really wants her baby. She was here, up at night, singing and walking the baby. The baby was not gone 7 hours after discharge, the baby was brought in DOA. I did go down and tell her I was angry and mad. I wanted to hit her because all those things she told me were lies.

Hearing these stories, one is struck by not only the anger for the loss of the child's life, but also in the enormous betrayal felt by the nurse on behalf of her investment, and on behalf of the children who suffer so much. Sophie noted:

> If [the mother] is doing crack and it's her 3rd, 4th, or 5th child, I think that's despicable.

> Everybody can make a mistake. My personal feeling is if... you have a child that's going 5 miles per hour on tremors, your tubes ought to be tied. You forfeit your right to have children. I have no respect for them.

And Hilda added:

> Sometimes I get so angry about the situation. If a mother's had one crack baby, hey, get those tubes tied. Don't let it happen again. That's how strongly I feel about it.

Having, and verbalizing, such feelings toward other women--admittedly troubled women--is difficult to acknowledge. As Yolanda demonstrated:

> How many chances do you give a mother before you decide how many babies is she going to have? It gets to the point where I get cold sometimes. If you're given one chance [and produce a drug addicted baby]...okay...I can make a mistake, too. ...The second time, if it happens, like I said, then you're going to jail...yank out the uterus. It sounds cold, but that's how angry I get. There are a lot of mothers out here who want to have babies and can't have babies. The ones who probably don't deserve to have babies, they're the ones who get them in abundance. ...[I have a] lot of mixed feelings about it. You go home and you cry.

A few minutes later, in reflecting on the intensity of feelings she had revealed:

Y: Am I terrible? I mean, am I...I don't know what.

A: It makes you question yourself.

Y: Yeah! Yeah, yeah, yeah. You do. You question yourself. Because when you...they're <u>kids</u>. I have one child, but the same kind of treatment I want for my child I want for everybody else's kid. That's why it hurts so much.

Yolanda's description of her feelings illustrates how intimately close are anger, hurt, and sadness in her

experience. The same could be said about the anger, resentment, and disgust toward these mothers expressed earlier by others. That is, those feelings are the flip side of hurt, sadness, and feelings of helplessness as demonstrated in the expression of desires for exaggerated retribution, and the withdrawal of empathy. As Naomi put it:

> I feel really disgusted. [I feel] mad at them for what they have done to themselves and their baby. Look what they missed. They didn't get to see them smile or turn over. I get all the satisfaction. They lost.

Several nurses talked about sadness, for instance, Dorothy described how she hates to see children taken from their parents and wishes the mothers could receive treatment for their addictions. When asked about her feelings she said what she felt was "not hatred, [I] feel sad about it". Janice said she felt sad that, knowing they were on drugs, mothers would nonetheless put their baby "through such a miserable first days of their life". Finally, Laura and Naomi talked about being willing to help parents, if they would show what Laura called "the slightest interest".

A few nurses conveyed a preference that the boarder babies had been left in the hospital. Hallie said:

> For some of them I'm thankful that [the mother] left the child in the hospital because who knows what could have happened to them. I'm thankful that some mothers leave with no trace. Even though the process is long through DHS (Department of Human Services), at least one day they can be

adopted. I don't have a lot of sympathy for these parents.

Knowing how difficult it is for the nurses to have these babies on the unit, it seems that being glad they are there because they are then <u>not</u> with their parents is among the greatest indictments of the absent parents. For many, angry, conflicted feelings were permeated with a sense of anguish felt on behalf of these infants. As Elizabeth tried to explain:

> As a mom--you know, we're all moms, basically, in one stage or another--you do a lot of sacrificing as a mom and it just comes with the territory. You don't think about it too much. But there's nothing you wouldn't do for you own child. I mean,...I see working women do heroic things. They work nights, they split shifts, the do overtime on this weekend so...they're off [for] the kid's recital next weekend. And you could no more--I'm going to cry (she begins to cry)--you could no more abandon your own child than you could cut off your arm! ...It just doesn't make sense to you after a while. I realize these women are in terrible situations, and they suffer terrible addictions...but...maternity supercedes so much of what you are that I can't (she pauses) you just can't figure it. I think that's one of the very hardest aspects of this. I think if you're not a mother there's a part of you that can't (she pauses) even if you're a woman, you can't understand. I mean, you can have some intellectual understanding, but emotionally, you can't understand.

A: It seems inconceivable to you.

E: Oh yeah. It's beyond, it's beyond the pale.

The multitude of feelings about these absent mothers seems to stem from deep personal sources as well as outrage at the practical aspect of their drug abuse behavior. The

confluence of personal and professional perspectives blurs the distinction ordinarily more easily defined, and these nurses are left to struggle on their own with the task of making meaning of their complex experience without the benefit of either socially or professionally ordained patterns of response.

Nurses in Association with Others

In the process of describing the range of their experience of being with boarder babies, nurses talked both spontaneously and on request about their sense of self and their relationship with others who also were involved with boarder babies either directly or by association. In general, their feelings toward volunteers were quite positive, and more mixed toward physicians and administrators. They tended to convey more negative affect toward social workers, although they were making attempts to contain, reduce, and redirect these feelings toward the amorphous "system" as communication increased about the overall process of boarding children's custodial status, departure, and placement. Visitors were separated into three groups: the media, politicians, and sightseeing civic groups. These groups were seen to wield certain influence in those arenas which determined the nature and duration of boarders' stay, thus each group drew mixed affect depending on the outcome of their visit. Finally, the feelings they

expressed about their relationships with one another illustrated the greatest complexity, with notable emphasis on a sense of camaraderie and family.

Non-Nursing Hospital Employees

In the course of talking about their experiences with non-pediatric and/or non-nursing hospital personnel, specific to shared interactions around boarder babies, nurses made distinctions between physicians, administrators, social workers, and informal volunteers from other departments.

Physicians. A few nurses talked about the difficulties they had experienced in dealing with physicians around the care of boarding infants. One nurse mentioned over-zealous medical residents who were eager to order tests for common ailments for which one might otherwise employ home remedies, and another complained of needing almost an "Act of Providence" to get doctors to attend to boarders who got sick--perhaps, she speculated, because these children are under the care of other physicians, or perhaps because of liability issues associated with treating a child without its parent's express consent. On the other hand, some voiced a positive view as illustrated by one nurse who said, "a lot of [the doctors] get involved and recognize the babies". Finally, a few nurses expressed outrage that two infants with debilitating congenital anomalies, who had withstood premature birth and withdrawal, were transferred

to the pediatric floor with "no-code" status. That is, they were not to be revived in the event of heart or other system failure. Both children who were classified as no-codes were nearly a year old--thus proving to the nurses their survivability--when they were finally discharged and placed in chronic care facilities. The feelings of outrage perhaps represent the discrepancy between the pull on nurses to become deeply emotionally engaged with a child, yet in a context in which others would not use even minimal efforts to prolong the child's life.

Administrators. The hospital and nursing administrations received mixed reviews. One nurse said:

> One of the resentments I feel is that I don't feel that the people who are higher than us--not the Head Nurse...the administration--I don't feel like they realize how much work is involved taking care of [boarder babies] because they always make little statements like "Oh, it's nice to sit around [and] feed a baby", or "You don't have anything to do". I don't think they realize all the care that goes into 24 hours a day taking care of them. A lot of time and effort's put in by us. Unless you're up here and seeing it, you don't [understand]. I don't think I'd understand if I wasn't part of it.

And later:

> They want the nurses to be on command for when they bring up [visiting dignitaries]...but yet, they're budget cutting....to leave us with three nurses, It's just impossible.... [Being understaffed] tears you up [because boarders get less attention than they need]. I'm not a perfectionist, but I like to do the best I can do, and when you can't do that, you feel frustrated. I feel so bad if I hear a baby crying and can't do anything about it.

The Head Nurse had a different view from her vantage of increased interaction with the administration:

> HN: The administration has been incredibly supportive. I think the boarder baby situation has put pediatrics back on the map around here, because of the media focus. The thing I like about this hospital is that we haven't gotten on the band wagon of the quick fixes. A lot of people have said "We need to get a house [for boarders], we need to raise money..." The hospital's been very responsible and looked at what we can do to help the causes of this.
>
> A: What are you referring to?
>
> HN: How to get in with churches--which are very strong in this area--to help them devise educational programs to help young women who are going to be the cause of boarder babies.

Here, the Head Nurse is talking about ways in which the hospital can contribute to stemming the flow of infants who are either held by the hospital or left by their parents.

Social Workers. Lastly, nurses voiced their feelings about social workers. With few exceptions, it seemed difficult for them to express their feelings overtly. This is likely due to the fact that only one individual occupied the position assigned to all pediatric cases, including the boarder babies, and to say negative things about social workers was the same as speaking about the specific individual--an uncomfortable task particularly to a stranger. Nevertheless, nurses did convey their thoughts as was illustrated in an earlier section, and their feelings toward the social worker ranged from empathy for the strain of an enormous work load, to anger and resentment at what

nurses perceived as the social worker's unwillingness to share information about a child's custodial and departure status. Most acknowledged that the hospital social worker had started sharing more information at the unit's "discharge planning" meetings, but wished they were told more. They continued to express criticism toward the state social workers for their seeming lack of interest as exhibited by them rarely visiting to even meet the child whom they represented. Moreover, nurses cited instances when a child had been misplaced in the system and their boarding status at that hospital had been unknown to the assigned worker. Finally, nurses understood, but disapproved of delayed efforts to place a child in a home due to the prevailing view that infants who were hospitalized were safer and receiving better care than other children throughout the city who were being neglected or abused. As Elizabeth said:

> I get very frustrated with a system that doesn't see--they really don't see that these children have an immediate need, because they're not starving to death.

It was hard on nurses to feel that they were the only ones who recognized and cared about the emotional needs of these infants to be placed somewhere where they could develop firm bonds early in life.

Volunteers

Hospital employees from other departments and regular volunteers from outside the hospital were generally received warmly on the unit. They contributed to the pool of volunteers who eased the burden of feeding, holding, and giving attention to infants during times when the nursing staff was busy with a high census of sick children. They seemed to be treated as trusted members of the extended hospital "family", and were appreciated as welcome babysitters--ironically, like mother's helpers to the nurses. Occasionally they might take a child outside to the playground, or to visit other areas of the hospital. As mentioned in earlier sections, several of these individuals developed firm attachments of their own to favorite children, and a few became either adoptive or foster parents. At Christmas time the previous year, every floor had taken an assignment of one child to be the designated recipient of gifts, in place of staff gift exchanges. A few nurses reported having experienced instances of mild jealousy around the bond a favored infant developed with a volunteer, but conceded feeling either happy that the child had found someone with whom to bond, and/or relieved that they themselves would not have to go through the process of dismantling their own strong attachment when the child left, and thus felt able to "share" the child, as it were.

Visitors

Most of the nurses spoke about their experience of visitors from outside the hospital. Visitors differed from volunteers in that they came into the unit to view the babies and the overall situation in a limited fashion, whereas volunteers returned to the unit and offered their ongoing assistance. The nurses tended to divide outsiders into more discrete subgroups including civic groups, politicians and the media, and others.

Civic Groups. Visits from civic-oriented groups were appreciated early on because they so often resulted in the donation of clothes, toys, and other much needed baby equipment like swings, mobiles, and playpens. Later, as the unit became fully stocked, these visits became more of an inconvenience because they sometimes disturbed infants' sleeping or eating routines, and became what felt to many nurses like an invasion of infants' privacy. Laura said:

> [I] have a lot of feelings about people wanting to see these babies....social groups on the outside who are very well meaning, want to see the babies and donate things. The attention is appreciated, but...there's been such a series of them that they come when it's convenient for them. They don't come when it's convenient for the babies. Depending on how...politically important the group is that comes, these babies are awakened from sleep--from nap times--whether they're eating or not eating, they're supposed to be dressed and set for display...ready when this group comes. It generates a lot of feeling that these children's lives are put on display. It takes away from their right of being, from their right for privacy.

Media and Politicians. Similar feelings applied to visits from the media and from politicians; hopes that their visits would result in significant changes for the boarders--and by association for the nurses--frequently were disappointed.

Ruth: Some of the media coverage has gotten the system working a little faster in terms of finding a place for these babies. Makes the public more aware of what's going on.

Naomi: At first I thought [their visits] were ok--the media could help the situation. But in the end I don't welcome them. I'm tired of them. [It's just] publicity for the politicians. Their pictures are flashing all over, but nothing has been done. I don't like them to come anymore.

Sophie: Media and politicians are not interested in [the babies'] plight. They're interested in using this as a means of furthering their own goals.

Florence communicated her thoughts that visits from politicians were designed to enhance the public relations image of politicians who had their photographs taken with the infants, and she felt that the babies were on display as if in a zoo. Melinda commented:

> I keep hearing what somebody said one day, "They're not on display and they're not in a zoo!", but I don't really feel that way. A lot of people come to do things for the babies and donate things--I think that's great. It's nice that somebody cares. You can't help people's curiosity. I don't get angry or upset. It's great that they want to help.

Laura: It wouldn't be as annoying if when they came around, if anything really changed as a result of their visit. But truly, nothing really has changed. [We don't need more donations] what we really need is a home for these children. These

> children need to leave the hospital. That's what they need.

The Head Nurse and the one staff nurse who adopted the first boarder baby on the unit had extensive experience with the media. Both had been interviewed many times, and had testified about related issues before government committees. The Head Nurse talked about how some of her experiences with the media had been rewarding when emotionally touching pieces had been aired on television news, when a viewer in Australia had sent booties, when a quilting club had donated baby quilts, when the Vice-President's wife demonstrated genuine concern and interest, etc.. She also talked about an emotionally moving, massive baby shower given to the unit by an entire government agency. However, other experiences had not been as rewarding. For instance, the visits by this country's Vice-President and a 1988 presidential candidate left her feeling used and she elaborated saying, "It was so trite, so superficial, so non-caring. I felt like I was in a zoo. You feel exploited [at those times]. The kids are exploited. It kind of makes you sick". Her frustration was apparent when in referring to all of the media attention she said, "It really doesn't change anything".

Yolanda questioned how either the babies or the nurses benefitted when outside visitors, including researchers entered the unit:

> I watch the visitors come in and out, and everybody's interested in the boarder babies. I'm not personally attacking you, but other people

> like you are wanting to do some kind of research for their own personal gratification. [The Vice-President came and] I'm waiting. Ok, you've seen the boarder babies, you've seen the nurses perform and take care of them. What are you guys doing for the boarder babies?!

Yolanda was courageous in expressing her disappointment and frustration to me directly about how outsiders have felt to her to use the plight of these infants for the advancement of personal agendas.

These nurses, while required by the hospital to accommodate the demands of the media and outside visitors, nevertheless did so in good faith hoping that their efforts would bring changes that would effect permanent, long-term changes that would ultimately diminish the flow of boarder babies or decrease their length of stay. Their frustration and disappointment that this had not happened was evident and understandable. Acting in the capacity of nurse/mother, these women were interested in the overall welfare of the infants--and by extension themselves, and in protecting the sanctuary of their unit or hospital home.

The Relationship with Colleagues

The relationship nurses shared with each other, not surprisingly, exhibited the most complexity. All of the nurses who participated in the study had been on the unit before the arrival of the first boarding child, and together they had endured the transition of their unit and their individual roles. They had developed a collective approach

to the changes demanded by the new phenomenon with resilience and enough patience to incorporate one another's differences and still continue as colleagues.

The majority of nurses said that having boarder babies on the unit had brought them closer together. Some said the staff had been together for so long that they had felt cohesive already, and that the phenomenon of boarding infants had not altered that feeling one way or another. Most talked about the camaraderie engendered in sharing similar concerns and difficult times associated with the infants. They noted issues of different mothering styles and territorial feelings about favorites, and they generally likened themselves to a family. Ruth: More or less being a mom to the same kids has brought us closer.

Hilda: Overall, [dealing with them] has brought us closer together. All [of us] in general feel the same way about what the problem is, and how little we can do about it. We've been together on the unit a long time.

Janice: We're kind of like a close, happy family. We work well together.

Others contemplated more specific changes they had noticed in their relationships with one another:

Sophie: A lot of instances it's made for comradeship. We talk to the kids and [through them] we're really talking to one another. You run out of things to talk about--like mothers. It's more of a homey atmosphere instead of a hospital.

Anita: In some ways it's drawn us closer because we all share the same things--worry and concern and separation from them. We're a close knit group anyhow, because we've all been here so long. I

think I've gotten to know a different side to everybody since the boarder babies, that you didn't see with just sick children. More caring and more involved. Like it's their child. It was a side of [one nurse] I had never seen before until with Eva.

Several talked about issues of territoriality and the care of their favorites. Melinda talked about sharing a favorite child, Tanya, with another nurse who also was close to her. She talked about feeling irritated with other nurses who she felt "try to make the babies grow up before its time". She continued:

> There are a lot of different mothering instincts, and everybody wants to do their own thing. Most of the time I don't get involved; let them fight it out. On the whole, it's brought us closer together because it gives us something in common we can talk about...it makes us close, like a family. Once in a while you think someone isn't doing something right and if you say something they get an attitude. But on the whole, it brings us closer.

Gwen: You get quite possessive. You get jealous. I've heard the rumors, "Gwen doesn't want to take care of anything but boarder babies". How in the world could you say that? I realize I do spend a lot of time with boarder babies, but I try to get my other patients taken care of [first]. If I'm on Team 2 and the baby I'm crazy about is on Team 1, I'm going to go over and see my baby and take care of him. But then they get jealous because I guess their space is being invaded, too. We get resentful and jealous and angry. You can sort of feel it in the air. [But] we all get together and are happy when one rolls over, or stood up, or started crawling, or the first tooth came in. We <u>all</u> celebrate then. So it's a mixture of all feelings. (She laughs) There's a closeness. It's brought us closer together because the main concern is the babies.

Laura explained how nurses attend to the territorial feelings of their colleagues:

> There are a few nurses who have developed a special relationship with the children, so we identify them as their surrogate mother. It's a teasing back and forth--if that particular mother hasn't been [here] for a while...we make sure the baby has nice clothes on, or looks nice and neat when she comes so that we don't "get in trouble" or get reprimanded because we haven't taken care of her child when she hasn't been [here]. I think we're empathetic. When we get a call that [the baby is] getting ready to leave--usually it's within a couple of hours--and [if] that [nurse] hasn't been notified, we call them at home. If they want to, they can come in. At least they know that [their baby has] gone before they come in. I think we're real considerate of each other's feelings.

Dorothy confirmed Laura's description of nurses' efforts to support one another's attachments:

> [While I was off] everybody cared for Jason. They said "We took good care of Jason--you weren't here yesterday".

Hallie echoed the view that nurses tried to respect and support existing attachments, but denied these efforts had affected their work relationships:

> We might joke around. They always get on me about dressing the babies. They'll say "We're not going to put this on...because Hallie isn't going to like this". And I'll come in sometimes and I <u>will</u> change [the] baby's clothes because I don't like it, or it's too big. But it's in a joking way; it hasn't affected the work relationship with other staff members at all.

Hallie, too, talked about being assigned to the opposite team as that to which her favorite might be assigned, and stated she, like Gwen, would care for her special child in

addition to her regular caseload. Finally, expressing a somewhat different view, Donna felt the presence of boarders had had little impact on her relationship with other nurses:

> [Their presence] hasn't really done anything. We get along now as well as before. They haven't made anybody closer.

Clearly the staff experienced a spectrum of feelings about the degree to which boarder babies had impacted their relationships with their colleagues. It is unclear what it meant to these women to acknowledge an impact or to feel there had been no change. In either case, it seemed clear that these nurses saw themselves as a cohesive group that is to a degree aware of dynamics among the group's members, and which remains protective of the nature of the group as a stable and enduring entity.

Managerial Concerns

The three assistant head nurses and the head nurse talked to some degree about how the presence of boarding infants created new managerial problems. Mainly, the difficulties seemed to be focused on the problem of balancing assignments. Their efforts were directed toward organizing assignments such that infants would be afforded the greatest amount of contact with a consistent group of nurses, and yet the sick to well ratio per nurse would balance across the shift so that no single nurse would be assigned only sick children or only well children on a regular basis. Several issues were at play regarding

assignments including consistency of nurse/mothering figures for the infant, evenly distributed workloads--sleeping boarders are easier than sick children and awake infants are more time consuming than a sleeping sick child whose mother is present--and finally the issue of maintaining one's nursing skills through contact with sick children. This balance was not easily achieved, especially since some staff were perceived to prefer one type of assignment over another, and pulled for those assignments. The second area of concern was to create a standard of care for the well infants, and to minimize variations in care which Melinda concluded were due to "different mothering instincts".

The Intersection of Personal and Work Life

The themes of pseudo-mothering and sense of hospital family were evident throughout most of the interviews and raised questions about how nurses' individual histories and current family relationships contributed to both their personal style with infants and manner of coping in their new environment. Inevitably, contrasting questions were simultaneously stimulated, that is, how might nurses' evolving experience with boarder babies impact their relationships with others, and/or contribute to their sense of self both professionally and personally?

Influences of Families of Origin

While many nurses said they did not think their family of origin had much impact on the way they experienced the phenomenon of boarder babies, others commented that having grown up with both two parents and a host of siblings, they were surprised and disturbed to come face-to-face with the concept of infants being abandoned by their mothers. (As explained in Chapter III, most of these infants are held by the hospital initially for health or social reasons, but by the time they are transferred to Pediatrics and remain there for months without visits from family members, it is perceived as abandonment by the nurses.) Ruth talked about her own family:

> I was raised in a family that was intact. There was a mother and father, and bothers and sisters. These babies really don't have anybody to bond to. Not any one person. Even if they manage to bond with somebody here, when they leave it's somebody else and somebody else. It's not a stable family.

Florence talked about growing up in a family in which there was a "strong work ethic" rooted in the Episcopalian faith and children were expected to go to school, attend college, "and take your place in society". She said she grew up in conditions worse than those the mothers of these infants were dealing with, and that she could empathize, but not sympathize with them. She hoped they would get help for their addictions, but decried welfare because she felt it ultimately engendered dependency. Anita talked about the

influence the early expectations of others had had on her, also:

> I came from a Catholic home. In my era--no premarital sex. Sometimes I become astounded when I think of the morals today. It's hard for me [to deal with the minority] culture. How can they have babies and not get married? It's just a different culture. [We] got married.

Given the narrow population this particular hospital served, it was difficult to separate the issue of race/culture from the morals that would permit abandonment. Elizabeth talked about how it took a conscious effort to remember that infant abandonment was not limited either to that population or to her city, and that the phenomenon could be found in every major city in this country:

> I've always worked in poverty areas. I think it's hard to keep your focus. I'm dealing with 98.9% [minority] children all the time. It's hard to focus that this is a problem that <u>is</u> crossing racial and ethnic lines because I only see one racial group involved. So you have to work to raise your consciousness. I'm Catholic and I share a level of faith with [people in the community] that is real common, and that helps. [The mothers] are not bad; they come from horrible situations and they never dig out.

Several talked about the impact of witnessing the dissolution of families and the influence of their religious values. Janice said:

> I grew up in a family with both parents and a large family. We were very, very close. Still are. To see families divided...it's really touching to me that this happens. When I was growing up I didn't realize this could happen. You learn a lot about how other people live. [Their] morals are different. Being Christian--

> most of the babies are born out of wedlock--I think it's really kind of bad that this happens.

Naomi and Hilda spoke generally when they said the values they had adopted from their families of origin and their religious faiths directed them to love all children. Others addressed themselves more to the issue of injustice regarding the distribution of children when they talked about the unfairness of women who could have babies, and abandoned them, when so many women who want children can not have them. Yolanda is quoted in an earlier section when she talked about women who could not have babies, while those "who probably don't deserve to have babies...get them in abundance". As Ruth said:

> It's hard to think that we have all these babies that no-one wants and there are so many other people who would like to have children or can't have children.

Elizabeth concurred when she stated:

> There are people on this unit who have fertility problems. By all the middle class standards they've done everything right, yet they can't have children. And these people are tossing [their babies] aside.

Influences on Current Families

Nurses talked about the intersection between their current families and their experience of being with boarder babies. As heard in previous sections, several talked about their feelings in terms of their own children. One woman recounted feelings about her own child, and expressed not being able to understand the actions of mothers of boarders:

> When [the first boarder babies] came to us we were angry because how could these people leave their babies to somebody else and forget about them? I always think about my own baby. I said [to myself], "What if I [had] left this baby to somebody?" It just made me cry inside.

Another woman spoke from her experience as an adoptive mother:

> In a very real sense, the fact that I have two adopted children affects the way I feel because I know how difficult it is to have a child, and how difficult it is to adopt.

One nurse talked about the differences she observed between her infant granddaughter's development and that of most of the boarder babies, and she spoke of how sad it was to observe the emergence of severe developmental lags in the boarding population, despite nurses' efforts to counteract the effects of early deprivations.

The boundary between the work place and family relationships was permeable and nurses talked about visits their husbands, children, and other family members had made to the unit. It seemed that these visits occurred most often during the nurse's off-duty hours, thus requiring additional trips to the hospital, and unpaid time spent on the unit. Nurses shared stories with me about the responses of both their young and adult children who became familiar with the progress of individual infants through the news the nurses took home. One nurse who was pregnant at the time of the study related an interaction with her young son:

> It was interesting when my son asked me if our baby was going to be a boarder baby. I explained

> "No, our baby will come home". One day we were going along in the car and he asked, "What is that thing?". It was a port-a-john...at a construction site. So I said, "It's a port-a-potty". He said, "Oh, like a port-a-baby?" As portable as a facility--a water closet--is, that was his idea that [boarder babies] were portable. It was odd.

Several nurses talked about the encouragement they had received from their adult children to bring a boarder home to join their family. These nurses talked about wanting to adopt or foster parent one of these infants, and the various impediments to fulfilling that desire. For instance, more than a few nurses were inhibited by the weeks of evening classes for foster parenting that were required by the government before they could be eligible to receive a child, others said the bureaucratic process of adoption was too arduous--and voiced the concern that the infant's mother could return at any time and demand her baby, several said their husbands were unwilling to parent for a variety of reasons, and a few mentioned feeling too old to again become a full-time mother.

While it would be inaccurate to convey that the families of nurses visited the unit continuously, family members sounded to have been at times deeply interested in, and intimately connected with individual boarder babies. It is interesting to note, moreover, that nearly all of the nurses had at one time or another, seriously considered taking one of the boarder babies home with them on a

permanent, or foster parenting basis, and had discussed the possibility with one or more members of their family.

Nurses in Relation with Oneself

One defines oneself, and is defined by others, by the roles we embody in relation to others. The women I interviewed occupied numerous roles simultaneously. These women are in relation with specific individuals in the roles of daughters, sisters, wives, mothers, grandmothers, etc.. In relation to institutions, they are employees, acute-care pediatric nurses, participants in a research project etc.; and in relation to society at large they presumably are tax-payers, citizens, and so on. Changes in the nature of one's environment--and in one's interaction with environmental demands--at times require changes in the configuration of one's constellation of roles. As a consequence, such reconfigurations may alter the way in which we define who we are.

Given the changes in their work environment and the resultant alteration in demands associated with meeting the needs of well boarder babies, the nurses were asked to reflect on what changes, if any, they had noticed in their perception of themselves since the time of the arrival of the first boarding child. Their responses were varied and included observations about their experience of themselves both as private individuals and as professional nurses.

The Personal Self

Some seemed not to have considered how their perception of their self may have been affected by the presence of boarding infants, or they did not admit to an effect. As Donna said, "You got me hanging there; I don't get deep and heavy." Although she declined to advance any speculation on possible changes in self-perception, others spoke from spontaneous reaction to the question. Several talked about an impact on their sense of a maternal self. As one nurse said:

> [I] really haven't given that any thought. I guess I perceive myself as being--since I'm not a mother--as being a mommy, now. [I] feel good about myself because I enjoy caring for boarder babies. I've learned a lot from them. I feel very good about myself. ...Get a lot of compliments from other people: "Oh, you all are really good to take care of these babies like they are your own". That makes you feel good. Peps you up. People forget that you're supposed to be a nurse, taking care of sick babies, not well babies.

At another point, in talking about the changes in herself, this same nurse spoke about giving thought to adopting, and to becoming a foster parent--ideas she had not before considered for herself. Others noted themselves to be more maternal:

Naomi: To me, I became more (pause) loving. I can give love without reservation. With the parents here I'm just a caregiver, a nurse. But without a parent, I am [their] mother.

Ruth: It's nice to have those nurturing, mothering feelings brought out again after so many years.

Another nurse talked about how her relationship with boarding infants had altered her view of her ability to interact with infants in a meaningful manner:

> I have a real knack with toddlers...that's my favorite group. Before we had boarder babies I used to bathe and feed and wrap [them] and put them back to bed, but I didn't seem to have the rapport that I seem to have now.

Later, she related this new capacity for rapport to self-confidence and issues of esteem:

> When you have a child that's obviously attached to you, and you don't have any children, it makes you feel good about yourself. I guess that's one of the reasons it's hard when they leave. I must not be too bad of a person; the babies like me. Makes it worse because I <u>don't</u> have any children. These are like my substitutes, I guess (she cries).

Sophie talked about how having boarder babies on the unit was enabling her to meet a need which originally propelled her into nursing:

> I've enjoyed having [boarder babies on the unit]. ...I guess why I became a nurse is because I like to give. It fulfills a need in me and hopefully...I can fulfill someone else's needs. I guess having boarder babies tops the list.

However, not everyone felt as positively. A few nurses commented on having noticed negative feelings that felt specific to the phenomenon. Some expressed explicitly or implicitly the observation that they had learned to compartmentalize their feelings of frustration, anger, sadness and helplessness. In Hilda's words:

> Maybe it's brought out the best and worst. I don't know. [It's] brought out all the negative feelings I have toward others about these mothers and what they've done to their kids. [I've]

> expressed more anger than I ever thought I had. And anger toward these people who probably can't help themselves. When I'm here, I try to be what [the infants] need: mother, caretaker, nurse. But when I leave...I don't think about work anyway, when I leave. Except for bringing out a lot of negative feelings, I don't think it's changed me a great deal...and I'm pretty much over it now, even though there are days when I could strangle these mothers! These mothers have chosen crack cocaine over their babies.

Elizabeth talked about her feelings, and the difficult, stressful feelings associated with having boarding infants on her unit:

> I find it amazing that I can leave here and by the time I hit the car, it's gone. I often wonder where it goes. What amazes me is my ability to compartmentalize my life. It amazes me that when the kids leave, I can kind of mentally disappear them. Maybe that's my self protection.

Dorothy said the presence of boarders hadn't changed her in any way she had noticed, except to make her wish she was very wealthy so that she could afford to open a home for the infants. Another nurses said the situation hadn't changed her views about herself, but she felt helpless that there was little she could do to intercept the flow of infants into the unit; she volunteered for duty at a local clinic, talked to young women in her neighborhood and at church, and attended various meetings, but she continued to feel that her endeavors had minimal overall impact.

The Professional Self

The majority of nurses expressed that the change they had experienced most keenly was in the deterioration of their nursing skills.

Sophie: I've noticed that my nursing skills have gone downhill, because you don't really need nursing skills. Seems like it's not really a hospital.

Janice: Sometimes it feels like you're not doing what you were taught to do. One day [this week] we only had boarder babies. So you say "Well, I'm going to do my babysitting job today" (she laughs).

Anita: After a while [I] think "I'm losing all my skills". We've all been frustrated by that.

Gwen: It's really not nursing any more. It's like babysitting. I feel like my nursing skills are being swept out the window because we hardly ever have any acutely ill patients anymore. When you do get them you're so overwhelmed because everything has been so lax--you have to get yourself pumped up to get back to work.

The unit's Head Nurse explained some of the affect she had noticed among the staff nurses around this issue:

> With the frustration, there's a lot of anger. And it's not directed at the children, it's just directed at a circumstance which we are powerless to change. I think it's very hard on my nurses. They didn't go to school, and they didn't pursue degrees to take care of well children.

She added later:

> I've talked about frustration and anger. [With those feelings,] there's a certain aspect of guilt. The guilt comes from feelings that you really feel (she pauses) terrible about expressing. [They've said to me], "...I'm just sick of these boarders. I don't care if I ever take care of them again. I'm just sick of them!". I think that's an expression of frustration, but I

also think people, when they express that kind of frustration at a child, I think they feel very guilty about it. You know, 'How can I say I'm sick of this child who needs'?

Others talked about their feelings of ambivalence around the dilemma of not wanting to have boarding infants on the unit because of the emotional drain and loss to their professional skills, while simultaneously recognizing that the presence of these children, at times, secured them work.

Anita: I take care of [boarder babies], but I prefer not to in many ways. Sometimes I resent taking care of them because it takes me away from what my skills are supposed to be for. Then when we're not busy I feel thankful that they're here (she laughs).

This was particularly noticeable during the time of my visit when at one point, for a period of roughly 36 hours, the unit held only 6 occupants--all of whom were boarding infants.

Dorothy: If we didn't get boarder babies we wouldn't have any patients.

Donna: If it weren't for the boarder babies this weekend, we would not be here.

Naomi: If they were not here the last week the unit would be closed. We would not come to work or get paid. So they help us.

While no one expressed serious concern about the security of their job, at least one nurse was asked to stay home rather than work during this slow period. In addition to the possibility of fewer shifts, there seemed a general awareness that the hospital was bearing an enormous cost to

keep these children indefinitely. Furthermore, there was an awareness among the nurses that they were being paid the wages of professional nurses, but were being asked to perform tasks far less technically demanding than expectable for their position. Practically, if the census of boarders had risen dramatically, there was a plan in place to divide the unit in half. One half would be an acute facility for sick children to be staffed with an appropriate compliment of nurses, and the other half would become a boarding facility for well infants to be staffed with technicians and only one nurse. An Assistant Head Nurse assured me that no one's job would change as a result of this plan; one may only speculate how a full staff would be accommodated on a unit half the original size.

Recognition

Aside from the monetary compensation associated with their employment, a few nurses talked about feeling inadequately acknowledged for their efforts to meet the myriad of developmental needs of these children at the expense of their own emotional and professional well-being. Speaking with some hesitation and awkwardness (pauses, rather than omissions, are indicated here with "..."), Yolanda said:

> I don't know about the other nurses.... Our Head Nurse would pat us on the shoulder from time to time because we've done a great job. This might be...it's not a monetary thing...but we seldom get any kind of...I don't know if you should say 'thanks' or 'recognition'.... Somebody could say,

> "These nurses have really done great for these kids". If not maybe a bonus (she laughs) for these nurses--maybe you're not the person I should talk to about this--something so that we are aware that "Yes, we do appreciate what you've done". We hear it, but not often enough.

Laura added her thoughts about feelings about how nurses' extra efforts go unacknowledged. She described the visit of this country's Vice-President:

> I think what angered me so much is that the nurses here, who put in so much of their time and care...they buy brand new clothes for these kids, they bring toys for these kids, they come in on their own time to see these kids to take them outside, to see that they have nice holidays or birthdays. These are the people that really should be acknowledged, and should have the benefit of seeing some individual who's coming to see these children. And yet, it was one of these residents who stood right up at the nurse's station and shook [the Vice-President's] hand, as if he were a part of all this. And he wasn't a part of any of it. ...It generated a lot of feelings that people who--I don't want to say get the benefit, or reap the benefit--but people who [should be] acknowledged in some way for being a part of this situation--for trying to take care of [the babies]--really aren't.

These accounts speak to nurses' feelings of being overlooked and under-appreciated. Those who spoke of these feelings struggled with how to identify the means by which they might feel acknowledged. However, neither financial bonuses, access to visiting dignitaries, administrative pats on the back, nor praises in the media and from the public seemed to capture for them a true understanding of their contribution. It seemed that praise which idealized their role with boarder babies diminished the cost with which they performed

that role, as did being ignored with the assumption that they were simply doing their job. As Elizabeth said:

> We've even had [DSS] social workers--[this] is kind of a kick in the head--come and say "We love picking up the kids here because <u>you</u> guys...you've really put your hearts into this. ...You really take care of the kids and you really respond to their emotional needs." I guess I'm supposed to be complimented by that, but it's bizarre! It's clearly by virtue of our laws, it's in your courts to do something on a permanent basis with this child. And [yet] they seem to be very happy just to dribble the ball our way and say 'hey, do the best you can with it'.

To be commended without the acknowledgement both of the personal/professional tolls seemed to only enhance their feeling of being not fully recognized. When others downplayed or ignored the fact that nurses were acting without choice, in a situation in which they had no power to modulate the influx of boarders, the duration of stay, the post-discharge placement, or even access to on-going follow-up was a constant reminder of others' lack of understanding of nurses' experience.

<u>Power and Powerlessness</u>

Powerlessness, or a lack of influence, permeated the interviews. These women tended to place all of the power for the decisions regarding a child's duration of stay and eventual placement in the hands of what they commonly referred to as "the system"; the locus of control was experienced as entirely external. The system generally referred to the larger, extra-hospital

legal/political/social bureaucracy. It was held responsible for the inordinant amount of time a child was hospital bound, and was variously described as inept, overburdened, illogical, insensitive, unsupportive, and inhumane. Nurses described cases in which relatives wanted to take a child home, but the inability to set a court date prevented completion of the custody paperwork and prolonged the child's stay by months. In another case, a child was "misplaced" for several weeks while workers believed the baby was at another hospital. Still, one of the greatest outrages was the seemingly mercurial support for those who wished to be foster parents--a biological mother who had shown no interest could usurp an infant at any time from foster parents who had cared for the child for months--and this alone was a major deterrent to nurses who considered foster parenting.

The only area under internal control was the management of their own feelings. Again, whereas some felt successful in regulating their emotional availability for attachments, others did not. If the only area in which one has influence is in the area of emotion--a highly nebulous arena as compared with the concreteness of say, child placement choices--it is not surprising that many felt they had no power at all.

One choice nurses might have exercised would have been to transfer to another unit. In general, there was little

mention of the possibility of leaving pediatrics, and those who spoke of having considered the thought said it was not a desirable option. Perhaps this was due to some of the nurses having specialized pediatric training, or to a reluctance to give up the familiarity and family-like environment that comes with membership on a unit where one has worked for many years, and where the staff turnover has been remarkably low. The only real alternative then, as Hallie said:

> You just sort of say "Oh well, it's beyond our control". It's what the system says is going to be, so you accept it.

The rewards for these nurses rested for the most part in the personal satisfaction of striving to reverse the detrimental effects of early deprivations which were evident in these infants in the form of motor, social, and affective developmental lags. The toll, however, was some atrophy of their acute-care nursing skills, and the emotional drain of investing in deep attachment relationships with no influence over the duration or outcome of that tie.

Coping Strategies: Outlets and Supports

The outlets nurses found for expressing some of their feelings and the sources of support they used were strikingly similar among the individual participants. Virtually everyone reported that their most frequently used outlet was through verbal exchange with either their

colleagues on the unit or with family members. A few talked about using activities such as writing and bowling, talking to personal friends, attending church or doing volunteer work, and working with elderly populations as ways in which they released feelings about the overall boarder baby situation. Nurses seemed to find the most support in sharing their thoughts and feelings with each other, and/or telling family members about particular infants. In one woman's words:

> Florence: We have informal discussions on the unit. Hash out any feelings. I have a close knit family. [I] talk to my mother and my family about how I feel. Mostly talk about it with other nurses on the unit because they're here. They're going through the same thing. Ventilation keeps us going!
>
> Yolanda: When we can talk about it among ourselves it feels better. At least I don't think I'm that cold because there are other nurses who share the same feelings.

Even those who preferred to not speak about their own feelings, benefitted from hearing others share theirs:

> Laura: I generally don't talk about it. I think that's why when I first talked about it with you I was a little surprised that I got tears in my eyes. I really don't talk about it. I guess...because bothers me.

And later:

> The other staff members are real supportive. I usually keep it pretty much inside. But others are more verbal. I guess a way of acknowledging my own feelings is when I hear someone else express theirs.

Two nurses reported the presence of a counseling service within the hospital, but neither had made use of it. Nurses said there were no other formal supports, and that they depended heavily on talking with one another to deal with feelings of grief and anger. While such exchanges seemed to be a working solution for these women, I got the sense that for many it had not been enough at one time or another to fully assuage difficult feelings. While not stated explicitly, there seemed to be an unspoken limit as to how long one might feel comfortable expressing the personal grief, or worry, about a discharged infant and still retain a remnant of professionalism. It seemed that that time limit did not always coincide with the individual's internal experience; while talking with colleagues mitigated some feelings it was not always enough, and many had felt the need to conceal persistent feelings of anguish from their coworkers. At these times, nurses turned to their husbands, to their adult children, and to their siblings for relief. Again, they struggled to maintain a balance between seeking support and sharing so much that family members would become attached vicariously, and themselves feel upset upon hearing the stories of neglected/abused infants, abrupt departures, and questionable placements.

In general, most felt they had no outlet for their feelings that would result in significant change in the

situation. Thus they felt largely unheard--again, a reminder of their experienced lack of power. Hallie seemed to convey this when she spoke about how the system continued with its agenda unperturbed by nurses' complaints:

> You really don't have any outlets. You get frustrated and you fuss and fuss and fuss, and it doesn't help. You complain and it doesn't make a difference. You learn not to complain--go with the flow. We talk amongst ourselves. We sit and complain to each other. We might verbalize some of our complaints to the social worker which most of the time doesn't help. We might bring it to the attention of the Head Nurse. Most of the time its beyond her control also. So that's probably the end of it.

In addition to talking among themselves, talking with their relatives, and engaging in a variety of activities, another outlet seemed to be in the formulation of ideas and suggestions for change which they proffered when asked. These ideas went hand in hand with concerns not only about the future potential of particular infants and the impact of nurses' efforts, but also the long-range effects of abandoned infants on society at large.

Making Sense of the Present by Considering the Future

Several shared their fantasies about the impact of their interactions with these children in the future. Sophie hoped the babies would remember "in the back recesses of their mind" the attention they had been given and that it would serve to protect them from future trauma. Naomi hoped they would remember that during one period, someone repeatedly said "I love you". Melinda grieved that they

would never remember all of the extra love and attention they had been given, and derived comfort from her husband's view that they may not remember nevertheless the nurses were providing a "basis for [those children's] lives". Yolanda, Hilda, Elizabeth and others talked about wishing they could see these children as adolescents and young adults. Their fantasies ranged from images of doctors and lawyers, to drug abusers like their parents. These fantasies demonstrate the ambivalence ascribed to their own investment in these infants.

On a broader societal scale, a few of the nurses talked about their concerns for the family unit and for the future of a society which abdicates its responsibility to respond to groups in need of extensive aid. Florence observed that by not providing enough treatment programs for drug abusing parents early on, society was shifting its responsibility to hospitals. She further worried that infants who were put into the foster care process would never be reunited with their families. Her view was that removing children from their parents without offering treatment that would enable the parents eventually to care appropriately for their own children was only a "bandaid effect". She suggested funding more treatment programs and mandating contact between infants and parents--specifically mothers--as part of the treatment. Elizabeth, too, expressed her concerns for the future and spoke in stark terms:

> I get frustrated with a system that doesn't see...that these children have an immediate need. I think, in the long run, we're going to pay dearly for our lack of response as a society. And...it's not just here. It's at three or four hospitals here [and in cities across the country]. We have made a decision to just throw away a whole group of kids. That, to me, is unconscionable. There are people in the Third World that don't have the economic resources, that care more...for the family unit...than we do.

And later, while talking about the racial/ethnic imbalance seen in her hospital and her fears for society at large:

> It scares me. How do you ever create a society where there's any kind of equilibrium between the races or between ethnic groups when clearly one is so much harder hit [by drugs] than another? If these children ever get the idea...which I'm sure they will eventually, that they were abandoned, where are they going to put that anger? Who are they going to direct it to? It's very scary. I can see all sorts of maladaptive behaviors and growing frustrations.

Suggestions for Change Serve as an Outlet

One way in which nurses seemed able to manage feelings of anger, sadness, and powerlessness was to channel those feelings into constructive criticism of the system and to create ideas for remodeling the process. Several women suggested changes in the system's philosophical approach which they thought would diminish infants' extended stays and improve the situation for themselves and for the infants.

Gwen suggested that the foster and adoptive process be streamlined such that infants could be placed with desirous families sooner, and their status in that family made

permanent with dispatch. In the following statement, she illustrates the progression from the value of her impact on an infant, her hope for that child's future, her underlying anxiety, and finally the employment of constructive criticism to manage those feelings.

> You teach them developmental milestones, you help them get on a good foot, and you hope that they will grow from this experience. And then you wonder, what will these children think of when they grow up and they get older and realize that the first year of their life was spent in a hospital? How will it effect them? And even once they leave to go from foster home, to foster home, to foster home, maybe back to their original home. I feel like there should be more adoptive homes and I think the...rules...should be revised and cut down and more people should be given a chance to adopt these babies and get them out of the hospital and give them more of a sense of permanency.

Elizabeth spoke disapprovingly of limitations which required that children be placed for adoption with families who were matched for race/ethnicity; she reasoned that it would be better for a child to be with a family of any origin who wanted him or her, as compared with remaining in the hospital or entering the foster care system. Hilda and Dorothy said more volunteers and nurses would take infants home if there were fewer requirements, less bureaucratic red tape, and if there was less risk that a neglectful, biological mother would be given custodial preference anytime during the process. They, along with Anita and Sophie talked about the need to establish group homes or to revitalize orphanages. At least, they said, these children

would be out of the hospital, have ample access to the outdoors and other more normal living conditions, and they would have a modicum of stability.

Few nurses spoke positively about the possibility of reuniting infants with their parents. Rather, the focus tended to be on instituting shorter limits on the length of time between a parent's (usually mother's) last contact with her child and the automatic relinquishment of custody. It seemed that the process of searching for a parent, negotiating parental release to foster care or for adoption, setting a court date for a hearing on custody etc., began only after a child had gone through withdrawal, reached a minimum weight, and been approved for discharge for several weeks--all of which might have already required months of hospitalization. Several nurses suggested that this time frame be reduced, and that those mothers to whom custody was eventually awarded be obligated to demonstrate significantly more than the minimal interest presently required. For instance, a few nurses reported that present state laws held that a child was not considered legally abandoned until 90 consecutive days had passed without contact from the parents beginning from the time the infant was dischargeable. Their suggestion was that the time frame be reduced to 30 days and that the count begin at birth, rather than when the child reached his or her birthweight. Several nurses suggested mandating that verbal statements of interest and good

intention from the mother be supported by regular and frequent visits throughout a child's hospitalization, that a mother learn CPR and receive monitor training, that she apply for the appropriate public funding in a timely fashion, show her child love and attention, and so on. In the event that she failed in any of these areas, custody would be awarded to a foster or adoptive parent without reprieve. Practically, these nurses view themselves as more than adequately qualified--because of their accessibility--the most accessible to observe and record the competency with which each mother meets the requirements, and to offer an opinion on her merit as a mother. Ruth, when asked what changes would make the overall situation better or easier, said:

> Maybe if we could have some input into where they go when they leave here, instead of them going to places we didn't think were good places for them to go.

It is not coincidental that these suggestions for legal changes which obligate more of a commitment from the mother would necessitate confirmation from the very nurses who feel unheard in the process of infant admission, discharge, and choice of placement. Such fundamental changes in the requirements for custody would provide a critically important voice to nurses and diminish their sense of powerlessness. It seems expectable that those whose voices are unvalued and who feel so unheard would wish to alter the

process to reverse those conditions. As the "sometimes surrogate mothers", they would be in a position to evaluate the worthiness of their counterparts, the biological mothers. This time, however, they seemingly would be backed by not only the power of their moral convictions, but also by the power of the system which awards custody.

Whether or not to inject nurses' opinions into the custody into the process is a discussion beyond the scope of this work, and one might wonder, beyond the scope of nurses' understanding. The ramifications of influence of this nature to nurses and their personal and professional sense of self, to infant boarders, to parents, and to the system overall is largely unexamined. Nonetheless, it would seem that the pressing desire to have their ideas and observations heard is an expectable by-product of the complexity of nurses' new, confabulated role, and the need to establish structure and parameters for that role.

Regardless of the variety of ideas for changes in the placement process, there was general agreement that the situation would be better for the infants and for the nurses if the babies were placed sooner. While the hospital was considered preferable to having a child placed with uncaring parents, this was naturally a distant second choice to placement in a stable, enduring home environment.

The Experience of Participating in this Study

Toward the end of the second interview, when the nurses were invited to reflect on their experience as participants in this study it became clear that for many, being able to talk about their experience had served as an outlet for their very complex feelings. Simply being asked to speak about their experience seemed to confer importance where they had previously felt overlooked and undervalued. In their words:

Melinda: Nobody's ever asked us our opinions before. Nobody's ever considered that it's a problem for the nurses. ...They talk about the boarder babies all the time, but this is different for us.

Hilda: I think your project is interesting...because nobody ever asks how [nurses] feel about anything. Well, not that much.

Hallie: The media seems to focus on the boarder babies, on the volunteers, on the mothers, but never on the nurses. ...To me, that's the main focus. The nurse. Because the nurse is the care provider. The 24-hour care provider. But...everyone seems to forget about the care provider. They focus in on the hospital and the drugs that the babies were on, but never on the nurse. And I do truly believe that we--as nurses--we should get some of the attention, and we should get a pat on the back. We are the ones, I truly believe, that deserve it. I think more attention should be--or some attention should be--focused on us. And a big Thank You to be given us. I don't know if anything is going to come out of this [study], but it would be interesting to see something as far as the nurse perspective and the focus being on the nurse in particular, instead of the boarder babies.

Laura: Thank you for the opportunity to express a lot of this. It's valued information that a

lot of people don't realize. The perspective from which you're doing your paper--it's really appreciated that someone would even think it was important. The focus is quite naturally on the babies and the system. There really has been little acknowledgement that there's been an impact on individual nurses. I've enjoyed the opportunity to share my feelings or views of certain things with you. As I said before, I really appreciate that someone acknowledges, or feels it's important.... At least I feel like someone feels that--not that we're special--but that we're an important part of [the phenomenon].

Naomi: It is a good thing that you are doing this study. The focus before was all on the boarder babies. They are not very sensitive to our feelings. We are forgotten...we are the one's who brought [the babies] up in the beginning.

For several others, participating in the study seemed to serve as an outlet for people to vent their difficult feelings. After expressing feelings of anger and bewilderment, the Head Nurse said, "[This experience] is mind blowing. So, I told you you were going to do us a favor. I think I've vented my spleen."

Later, she shared her thoughts about the usefulness of the study to the staff:

> I think it's been healthy for people. I think you've given them an opportunity to really say some things that they needed to say. It's been there all along. Every time we've had an interview I've asked for [a] focus on nurses. These children don't live in a vacuum. I don't think anyone's been quick enough to say "That's a real issue!". The impact on our lives as nurses has just been tremendous. Most people who are in acute-care are in it for a reason. If you want chronic-care, you go work at other places. It's a real leap from acute to chronic--and these are <u>well</u> children. [In addition, there's] always

> [job] insecurity at the back of your mind: "No one would pay me to do this outside of this situation, and maybe somebody will decide that I'm not necessary". So there's a threat component as well.

Others spoke of the restorative effects of the interviews:

> Yolanda: I'm glad I could talk about this. I mean, we get mad. It builds up to the point where you just slam charts and say "I've had it for the day!".
>
> Anita: I think it's been very therapeutic.
>
> Melinda: This study of yours will probably be the best thing that ever happened to us as far as venting feelings and frustrations.
>
> Gwen: [Participating] has allowed me to think deep (sic). I've thought about it, and written it down, but never talked about it, one-on-one talked it out. It's been good. It's been like a cleanser.

Hilda, when reminded to please not speak with her co-workers about the content of her first interview until others had completed their own, said, "No, I won't mention [anything]. Everybody knows that we're going to finally get a chance to vent our feelings. I think that's important".

While there seemed to be a considerable need to tell the stories of their experiences, some nevertheless found it difficult. Donna acknowledged she had felt awkward, particularly during the unstructured interview. Yolanda and Hilda noted that while it was helpful to express old feelings they thought they had resolved, it was also hard to uncover--or in Hilda's words, "dredge up"--those feelings. Anita thought she had "held back" in areas that might

produce difficult feelings, and it sounded as if she wished she had felt more able to express more. Florence captured the ambivalence her colleagues seemed to feel:

> [I was] a little apprehensive about [the study]. But, in a way, I'm kind of glad because I was able to express some feelings that I had deep down that I hadn't really told anybody. When I talk with [other nurses, I] say things in a joking way that [I] really mean [like] "Don't overfeed that baby" [and] "You shouldn't really, completely blame the parents". Because they are victims, too.

Florence's comment on her need to employ a tone of humor in order to convey serious concerns is informative in that it speaks to the limits these nurses feel as supports for one another, as well as the need at times to censor unpopular thoughts and feelings such that professional relationships remain intact and unbruised. Even though nearly all of the participants reported that their colleagues served as their primary support via verbal exchange, several expressed interest in the findings of the study specifically to learn to what degree their experience was shared with others. This interest in one another's views is perhaps another indicator of ways in which nurses feel not entirely understood in their experience.

With everything said, the most salient messages were that nurses felt profoundly that others did not understand the complexity and difficulty of being a part of this phenomenon.

As Gwen said:

> I don't think people realize how having to take care of boarder babies affects us, as nurses. We are put through these traumatic experiences over, and over, and over. People don't realize--even people in the hospital say "I'm not coming up to see those babies any more because the last time one left, it tore me apart". They have the choice of staying away or coming up. We don't have a choice. This is our job. So we are subjected to the pain and trauma of building new relationships, and being broken up again. It's because they are hospitalized for so long....And you're not even aware that [you are becoming attached] until it's too late, so you can't just cut yourself off. You don't have a choice.

Elizabeth summed up her view of the situation and put words to a larger systemic problem with which the nurses seemed to struggle:

> The hospital right now is the warehousing limbo. Some of these children we have--they don't belong to the parents anymore, they don't belong to the DHS yet--the court system yet, they don't belong to the hospital. Truly, they have no legal status. They are non-people! And to us, they're very real. We know they're real.

She added her view that people who were not intimately involved with these infants tended to lump them together under the title of Boarder Baby, with the subsequent obliteration of the identity of individual infants and the consequential loss of their humanity. She poignantly describes her affective experience:

> It's probably the strangest place I've ever been in nursing, I mean strange in terms of emotional space. Mother Theresa says there are many things worse than poverty...she said loneliness is the worst poverty. You know, that's what I feel like with these kids. This is the worst kind of poverty.

While others used different words, it seemed that most nurses shared Elizabeth's view that the particular quality of emotional involvement generated by the presence of boarding infants, permeated their work environment in a way that was uncommon and unsettling.

CHAPTER V

CONCLUSION

Breaking New Ground

Roles are specific to context and provide a means of negotiating interpersonal exchanges. When the rights and responsibilities which denote the structure of roles are clearly established, individuals function with a sense of systemic, interpersonal, and internal consonance. When the structure and demands of roles are ambiguous or changeable, individuals are likely to experience internal conflict or dissonance, that is, dis-ease--conscious or unconscious--that is commonly associated with change. Changes in one's context will necessarily alter the nature of the established roles operating within that context. In the process of dealing with contextual changes through adapting one's role appropriately, individuals are likely to experience a sense of heightened dissonance.

The acute-care nurses who participated in this study talked about being confronted by a change in their work environment created by the presence of well, boarding infants. Their stories illuminate a pervasive feeling of dissonance as they grapple with defining their new role in relation to boarder babies. Their struggle to make meaning of this ambiguous role is made all the more difficult in

that models of similar, familiar roles do not accurately match their experience of the contextual demands. In relation to boarder babies, these women are not strictly acute-care nurses, chronic-care nurses, babysitters, day care workers, mothers, surrogate or substitute mothers, or foster mothers. Despite the ease with which one might wish to apply one of these labels, none quite fits these nurses' experience. Each term, while similar in some respects, deceptively cloaks fundamental differences.

Nursing, lay and professional, is an endeavor in which the practitioners serve to correct or ameliorate an impairment caused by illness, injury, or natural decline. Professional nurses are defined as such by their actions toward that end. In the case of boarder babies, what impairment would nurses identify and seek to ease? Furthermore, how do nurses come to understand themselves in terms of their efforts to correct or ameliorate that impairment? Seemingly, the "impairment" suffered by boarder babies, while undoubtedly multifaceted, is largely the combination of their abandonment and their ongoing limbo status. Easing and treating the intangible parts of this impairment requires skills which are not ordinarily part of the repertoire of the professional, acute-care nurse. Attempts to treat this nebulous impairment are likely to be by equally intangible means.

Although it is common to talk about one's professional and personal lives as if they were mutually exclusive arenas, they necessarily overlap and co-mingle at points. The way one employs that area of overlap contributes to one's sense of self as a unique individual. In interactions with boarder babies, nurses were often called upon to avail more of their personal self and less of their professional self. In the attempt to act in the capacity of one whose directive it is to relieve impairments, nurses were challenged to re-evaluate to what extent they wished to employ their personal self in the professional context.

In struggling to define that balance which would simultaneously address both the intangible and the tangible needs of boarder babies' impairment, nurses seemed to internalize and reflect the infants' limbo status. Like the infants who simultaneously belong to someone and do not belong to someone, nurses straddle the roles of nurse and mother--not fully one or the other--at once feeling the infants <u>are</u> "our babies" and are <u>not</u> "our babies". The ambiguity of who to be (what to call their role), how to be, what to feel etc. appeared throughout the interviews. They grappled with the dilemma of their availability for attachment, their condemning and empathic feelings toward the absent mothers, their ambivalent feelings about having boarders on the unit--when the census was high they felt overwhelmed and when it was low they felt insecure in their

jobs, their feelings about the effect on their nursing skills, their small skirmishes with one another around how to meet the needs of well infants, and so on.

In the process of addressing their ambivalent, often discrepant feelings, these nurses were developing a new language, establishing norms, resolving contradictions, deciding how to feel, negotiating interactions, finding ways to describe their experience, and working to define their role. The inability to accurately identify the new role of these nurses who are with boarder babies is a marker of the emergence of what may be thought of as a sub-culture within the larger culture of nursing. In this sense, they were delineating the parameters of a sub-culture. The sub-culture is founded upon meeting those contextual demands which are not exactly like any other area of nursing. Without the focus of illness or injury that is common to acute-care and chronic-care nursing, the focus necessarily turns to meeting the child's most pressing needs, that is, the absence of parental attachments within an enduring home. Resolving the problems of a newly evolving sub-culture in which the professional environment is called upon to meet the indefinite attachment needs of infants is an enormously difficult task. This task is made none the easier by the lack of psychological and emotional preparedness or specific professional training, for a unique role not officially identified as needing to even exist, and for which nurses

feel not truly appreciated. Indeed, this is a dissonance inducing situation.

Gathering Stories of Experience

When a researcher seeks to understand human experience through the investigation of personal accounts, it is easy to believe that the sum of the data consists of the recorded and transcribed tapes. During the analysis of such data, it is appropriate to strive to be aware of one's subjective interpretation of that material. Perhaps less obvious, but no less important, is the need to recognize the impact of such data on the researcher, especially as that researcher serves as the filter from the participants to the reader. In fact, whatever it is that draws one to pursue a piece of inquiry is the data's first influence on the researcher. The process is a slow moving circle in which the data act on the researcher, who acts on the data, which act on the researcher, who acts on...and so forth. Based on the manner in which the data were gathered and the use of myself as a tool in the analysis and presentation, the process of investigating the nurses' experience would not be complete without the inclusion of my experience as researcher. When I first asked the nurses who participated to share their experience with me I was eager to hear and notice as much as I was able. They were carrying--individually and collectively--an emotional, psychological, and practical

burden which they seemed to feel nobody else was noticing or helping to bear. Several were relieved to share their story in that someone else would now help to hold their burden. Others felt ambivalent in that, in the telling, they were forced to re-acknowledge those thoughts and feelings they had struggled to store away. From my perspective, I was so grateful for the information, and so touched by their willingness to share it, that I didn't realize how hard it would be to hold all of it myself. At times, the content and emotion of these stories has been so ponderous that it has been all I could do to hold it, let alone move forward with it.

A portion of the weight has been self-generated in that I originally was stymied in finding a way that would accurately and fully represent the nuances, complexity, and depth of the participants' experience. My sense was that the burden was handed to me with an equally weighty expectation that it would be handled gently and with respect. Handling their material gently, however, is not the same as handling it gingerly. During the course of the study I came to understand that striving to convey these nurses' whole experience with every nuance manifested the polar opposite approach to how others had managed nurses' experience to date. The result was that I at first felt inhibited by a great deal to tell and others were talking about too little. That is, others were ennobling nurses

without a full understanding of the complexities, ambivalence, and hardship involved.

The few articles in newspapers and journals tend to glorify nurses' and laud their care of 'pitiful newborns', whose pathetic mothers have 'wretchedly abandoned' them. The dramatic tenor of articles of this ilk does a disservice to the nurses who are in the midst of this phenomenon because it airbrushes the complexity of their total experience. These pieces diminish and trivialize the personal and professional sacrifices individual nurses make in the process of finding ways to cope with their ambiguous role and the intangible needs of the infants, and all within a larger context which devalues their contribution. Theirs is an experience of ambivalence fraught with anger, frustration, sadness, as well as pleasure, satisfaction, and joy. What these nurses do is not without a price, and they are not entirely eager to pay that price. Exalting their actions overlooks their ambivalence, rather than acknowledging and addressing it.

Perhaps our eagerness to canonize nurses provides us with a means of camouflaging our own feelings of sadness on behalf of these children and their parents. Perhaps allowing nurses to struggle alone to deal with boarder babies assuages lurking feelings of unaddressed responsibility and guilt. Boarder babies, after all, represent a social, cultural, political, economic

"impairment" in our society--something like a sore which we, fittingly, are satisfied to have nurses treat.

These nurses may indeed be heroes, but the quality that earns them that title is not a single action, an attachment, or a saintly attitude. Rather, it is their ability to experience ongoing role ambiguity and internal ambivalence, and their willingness to continue attempting to address the phenomenon of boarder babies in spite of those conditions. Based on this more complete picture, our admiration now is founded on an understanding and acceptance of the complexity of their experience.

Implications

The outcome of this study raises questions for additional research in both applied and theoretical arenas. The most common models of caring, that is, mothering, foster parenting, etc., are currently inadequate to explain the experience presented here. Thus, there is a need to develop a new theoretical model of caring which more accurately represents, and gives meaning to, the particular ambiguousness of overlapping personal and professional spheres specific to nurses with boarder babies on an acute-care unit.

On a systemic level, because the phenomenon of hospital boarding infants is expected to continue growing, there is a need for multi-disciplinary teams of researchers, educators,

and nurses to identify the changing parameters of the context, apply the aforementioned theoretical model of caring to the context, and thereby perhaps define the unique nature of nurses' role with boarder babies. Practically, it would be interesting to understand what it is about specific nursing areas--such as pediatrics--that attracts some nurses and fulfills their needs. Given the attraction, in what ways does being with boarder babies enhance or detract from the fulfillment of adults' needs? How could we use that information to diminish ambivalence within the population of nurses who are, or might be, with boarder babies?

There is an additional need for standardization not only of the particular nursing role, but in our definitions of boarder babies. Because the particular issues of length of stay, custody, date of departure, and eventual placement are critical to nurses' experience of being with these children, deriving a standard definition, and a (consistent) standard process for a child's movement through the system, would diminish nurses' dissonance by removing a modicum of ambiguity.

Perhaps most importantly, there is an urgent need for intervention before children become boarders, as well as a need to reduce their time in limbo if they do become the guests of acute-care hospitals. Legislators and social service administrators are called upon to collaborate with hospital personnel and educators in order to meet these

goals in ways which employ all sources of information--such as nursing experience--heretofore overlooked.

The nurses who participated spoke eloquently about their feelings of being unprepared for this phenomenon. Each had found ways to manage her experience by drawing on more of her personal resources than what always felt comfortable. Feelings of ambivalence, sources of dilemma, and the ambiguity of their role contribute to experienced dissonance. Efforts to reduce that dissonance should be implemented vigorously. Such efforts might include first the acknowledgement of their unusual role and the peculiar characteristics which set this role apart from others. Another way to diminish dissonance may be to set consistent--perhaps nation-wide--standards for a boarding child's progress through the system. In that process, mandate shorter stays. In addition, finding ways to involve nurses more in the process of a child's departure and placement may decrease nurses' feeling of powerlessness; institute mechanisms for follow-up, for those nurses who are desirous.

Each of these possibilities is likely to reduce the dissonance which occurs in a context of uncertainty and ambiguity, however the implementation of these ideas likely will not remove all ambiguity and associated ambivalence. The nurses in this study reported that to the extent that they had become accustomed to the comings and goings of boarder babies, they felt less emotionally vulnerable to

such environmental changes. When the impairment of the receiving child is that which is, in part, treated through the use of nurses' emotional self, the degree to which individuals can always modulate that exchange will vary. While the assorted systems of nursing administration and education, hospital administration, social services, legislators, and the like, may be able to institute those changes which will diminish ambiguity, the less concrete aspects of the situation will continue to be unpredictable.

APPENDIX A

INFORMED CONSENT FORM

I am conducting a research study looking at the experience of nurses on a hospital pediatric unit with a "boarder baby" population. While recent attention has focused on the boarders, the experience of nurses who are with these children has gone largely unaddressed. If you choose to participate, I will be asking you about your experience of being with this population.

The study involves participating in two interviews a few days apart and completing a brief Information Sheet. During the first interview you will be asked to respond to a main question. During the second interview you will be asked to respond to several follow-up questions. Each interview will take approximately 30-45 minutes. Most interviews will occur during work hours at the unit's and your convenience. Interviews will be tape recorded for subsequent transcription and research analysis by myself and transcription/analysis assistants.

All interview material will be kept strictly confidential. Your anonymity will be protected outside of the unit. Others on the unit may be aware that you are in the study, but will not know what you say during your interview. Any material you contribute may be used in writing up the results of this study, and I will disguise all identifying information about you.

Participation is voluntary. As a participant, there are no risks and you will benefit only in personal interest and in your ability to contribute to research. Withdrawal from the study at any time, and for any reason, will not affect any privileges or services to which you are entitled.

I am aware that I may be asking you questions about which you may or may not have had an opportunity to think. You will be encouraged to take your time. Please remember that I am interested in <u>your</u> experience, in whatever way you wish to talk about it. Finally, with that in mind, you are requested to avoid discussion with others about your interview until all of the interviews have been completed to minimize possible influence between participants. If you have any questions, please feel free to ask them. If you wish to participate, please sign below. Thank you.

I have read and understood all of the above.

Name (please print):_____

_____ _____

Participant Signature Date

_____ _____

Interviewer Signature Date

APPENDIX B

PERSONAL INFORMATION SHEET

The following is a Personal Information questionnaire. It will take about 5 minutes to complete. The information will enable me to describe participants in general terms. Please write your name (item #1) on this detachable sheet to help insure confidentiality during data compilation and analysis. Then continue to item #2 on the next page. Thank you.

1. Name_____

Please complete each of the following:

2. Age_____

3. Marital status_____

4. Do you have any children? yes_____ no_____

   If yes, how many?_____
   What is/are their age(s)?_____

5. How many years have you been a nurse?_____

6. What type of nursing degree do you have?_____

7. Please list your training history:

	program	length	degree	year completed
a.				
b.				
c.				

8. How long have you been on this unit?_____

9. What type(s) of unit did you work on before coming to this unit, and for how long?

	unit	length of stay
a.		
b.		
c.		
d.		

10. In the last 6 months, what is the average number of hours per week you have worked on this unit?_____hours/week

11. In the last 6 months, which shifts did you work and approximately how often in a given week?

shift	average number/week
a. days	_____
b. evenings	_____
c. nights	_____

12. What is your current job title?_____

APPENDIX C

PRINCIPLE STATEMENT FOR UNSTRUCTURED INTERVIEW

Interview I

I am looking at the experience of nurses on a unit with "boarder babies". At this point, very little is known about the experience of these nurses. Therefore, I am interested in your experience. Please tell me about your experience in whatever way you wish to talk about it. I am interested in anything you have to say about the topic.

APPENDIX D

QUESTIONNAIRE FOR SEMI-STRUCTURED INTERVIEW

Interview II

Introductory Statement:

The format for this interview will be somewhat different from the first time we met. This time I have some specific questions to ask you. You may feel you have already covered some of these questions, but I will go through all of them in case there is anything you find you want to add.

Questions:

1. Who usually gives a boarder baby its name?

2. Who decides whether or not they stay? Who do you feel is responsible for their lengthy stay?

3. How do you think of what you do with boarder babies, ie. what do you call what you do? What label do you use?

4. Are there things that are distinctive about your relationship with well babies who are boarding versus sick ones who are not? (Probe: What do you do if you are assigned to a boarder baby and sick child at the same time?)

5. What characteristics of a child, or the situation have made a baby more or less appealing to be with? For example: physical features, personality, activity level on the unit, length of stay, the child's level of functioning, etc..

6. Please describe your experience of, or relationship with one child. (A boarder baby.)

7. How would you describe your thoughts and feelings about the mothers and fathers of these boarder babies?

8. How has the presence of boarder babies on the unit affected your relationship with other nurses on the unit?

9. How has the presence of boarder babies affected you feelings about other in-house people such as social workers, nursery nurses, doctors, administrators---who may be involved with these babies?

10. What are your feelings toward visitors from outside the hospital such as the media, politicians, or others?

11. Please describe your thoughts and feelings when you learn about the admission of a new boarder baby to the unit?

12. Please describe your thoughts and feelings when you learn about a discharge, and when a baby actually leaves.

13. What kind of information do you usually get about a baby's history before he or she arrives, or what their placement will be when they leave?

14. What changes, if any, have you noticed about the unit, yourself, or your feelings about being here since three years ago when the first boarder baby arrived?

15. Is there anything about your religious beliefs or ethnic culture that affects your feelings about boarder babies?

16. As you think about it, is there anything about your growing-up family--the situation that you came from--that affects your feelings about boarders?

17. Is there anything about your current personal life or family situation that affects your feelings about boarder babies?

18. How would you describe how the presence of boarder babies has affected your perception of yourself?

19. How has being with boarder babies affected your relationships at home or in your personal life with your kids [if appropriate] or (significant other)?

20. What kind of outlets do you have for your feelings about this issue?

21. What kind of supports do you have around this issue?

22. Has being the Assistant Head Nurse/ Head Nurse had any affect on your total experience? [When appropriate.]

23. What changes would make the situation with boarder babies easier or better?

24. Is there anything else you would like to add or emphasize?

25. Do you have any questions about this or the first interview?

26. Is there anything you would like to say about the experience of these interviews?

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