

Feeling the Burn: Extreme Heat in Pregnancy

Arizona is HOT, especially in the summer. I knew this when I moved to Tucson almost a decade ago. Since then, I have had two pregnancies while living in Arizona. I was lucky not to have to spend the last weeks of pregnancy and first weeks with my newborn in the summer heat.

Of course, Arizona is not the only place experiencing hot weather. 2023 was the planet's warmest year on record, according to the National Oceanic and Atmospheric Administration. Temperature records have already been broken in 2024, and extreme heat is becoming more commonplace. It is important to understand how extreme heat can affect health in the general population, and for us at MotherToBaby, how high temperatures can specifically affect people who are pregnant. For more insight on this issue, we turned to Dr. Christina Han with our partner, the Society for Maternal-Fetal Medicine.

What is extreme heat?

Extreme heat has been defined as “a period of high heat and humidity with temperatures above 90 degrees for at least two to three days.” (Ready.gov). According to Dr. Han, “extreme heat can lead to health issues for anyone, including heat rash, sunburn, heat cramps, heat exhaustion or heat stroke. These environmental changes also increase the rates of violence and exposure to pollution. Some groups of people are more likely to be affected by extreme heat, including people who are pregnant.”

What is hyperthermia?

Hyperthermia is a rise in body temperature that happens when the body absorbs more heat than it releases. One of the most common causes of hyperthermia is heat stroke. Fever, extreme exercise, or use of hot tubs or saunas can also increase the chance of hyperthermia.

Being pregnant during extreme heat can increase the chance of developing heat stroke, heat exhaustion, or other heat-related illness. In extreme heat, the body has to work harder to keep cool for two. When the body is unable to cool itself properly, there can be an increased chance of hyperthermia.

What are the concerns with extreme heat and pregnancy?

Studies have reported a small increased chance for neural tube defects (NTDs) in babies of people who had high fevers lasting 24 hours or longer before the 6th week of pregnancy. A few studies have reported a small increased chance for other birth defects when fever or hyperthermia happen in early pregnancy, especially if the fever is untreated. Other studies have not found a higher chance for birth defects when a person experiences hyperthermia early in pregnancy.

People who are pregnant also need to drink more water to avoid dehydration. Chronic dehydration can affect pregnancy outcomes. **One study** suggests that chronic dehydration can affect newborn weight, length, and head and chest circumference. Some studies have reported associations between high temperatures during pregnancy and a higher chance of preterm birth, low birth weight, and stillbirth.

What are some signs of heat-related illness?

Heat stroke: Body temperature of 103°F or higher; hot, red, dry, or damp skin; headache; confusion, dizziness; nausea; passing out.

Heat exhaustion: Heavy sweating; cold, pale, and clammy skin; nausea/vomiting; dizziness, headache, muscle cramps; tiredness/weakness; passing out.

Heat-related illnesses can sometimes be an emergency. Anyone who thinks they are having a medical emergency should seek care right away. For more information on when to seek medical help, visit the Centers for Disease Control and Prevention (CDC) page here: <https://www.cdc.gov/niosh/topics/heatstress/heatrelillness.html>.

Dr. Han also shared some general tips for dealing with extreme heat during pregnancy:

- Stay cool as much as possible, both indoors and outdoors
- Avoid peak sun hours if you must be outside
- Avoid or minimize strenuous activities
- Wear appropriate clothing such as hats and loose lightweight clothing
- Avoid alcohol and limit caffeine
- Wear sunscreen
- Use caution when engaging in strenuous activities; be sure to take breaks, drink water, and get plenty of rest.
- Check the local news for heat warnings and health/safety tips

Find more information from CDC on preventing heat-related illness here:
<https://www.cdc.gov/extreme-heat/prevention/index.html>.

Dr. Han's final tip: Don't forget to talk with your provider! "Your healthcare provider can help you find resources and ways to protect yourself and your family. Managing exposure to extreme heat is important for everyone's health, including those who are pregnant."

MotherToBaby specialists are also **available** to talk with you about exposures before or during pregnancy. Best of luck staying cool out there!

Questions? Call 866.626.6847 | Text 855.999.3525 | Email or Chat at [MotherToBaby.org](https://www.MotherToBaby.org).

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For breastfeeding people living in rural areas, it is often difficult to find appropriate breastfeeding and lactation resources as they can be few and far between. According to the Centers for Disease Control and Prevention (CDC), infants in rural areas are less likely to ever breastfeed than infants living in urban areas.

Emma, a new mother to a baby boy, lives in a rural area where the nearest town with a healthcare facility is over an hour away. Even by phone, it was difficult to reach her provider's office. She was determined to provide the best for her son, including breastfeeding; however, she was concerned about managing her post-partum **anxiety and depression**. She wasn't sure where to find out if her medications were something she could take while breastfeeding - which made her more anxious! Emma faced some common challenges living in a rural area:

- **Travel Barriers** - Emma struggled with general breastfeeding and medications concerns, all while managing the demands of a newborn; traveling long distances for an appointment was not only exhausting, but also not ideal.

- Limited Local Support – Emma’s town had no specialized breastfeeding support services. The nearest support group was a two-hour drive away, making it difficult for Emma to access help when she needed it most.
- Limited Resources – Finding reliable information about breastfeeding was another challenge. Emma felt isolated and unsure where to turn for accurate information.

One day, while searching for answers online and discovering mixed information about the medications she wanted to start, Emma discovered MotherToBaby. Intrigued by our expert support that was available remotely and promptly, she explored our fact sheets, blogs, and podcasts that cover a range of breastfeeding topics. After reviewing our website, she was delighted to see our live chat service!

During our conversation, we addressed Emma’s concerns about breastfeeding while on her medications to treat her post-partum anxiety and depression. We were also able to discuss the recommendations for vaccines while breastfeeding (like the updated **COVID-19** and **influenza vaccines**). We also answered her questions about cold medications, referring her to our **specialized blog**. She was very relieved to connect with someone so quickly and receive accurate information on the spot.

The flexibility of MotherToBaby’s online services was also a game-changer for Emma. She was now able to access information at times that suited her schedule, as she also could use our text, email, or phone service. This was particularly important for Emma, since her days were unpredictable and often included late-night feedings and other unexpected moments!

MotherToBaby referred Emma to online lactation resources and support groups. Engaging with other breastfeeding parents and experts on an online platform can provide her with emotional support and encouragement. Sharing experiences and hearing from others who faced similar challenges can also help Emma feel less alone and more empowered in her breastfeeding journey. Engaging with the online community and support can provide Emma with a sense of connection and support that was missing in her rural area, which can help her more easily navigate the ups and downs of breastfeeding.

Mental health support was also very important to Emma because she lacked this in her daily life. Resources like **Post-Partum Support International (PSI)** and the **National Maternal Mental Health Hotline** are now tools Emma has to support her along the way.

With evidence-based information about her medications and referrals to the appropriate resources, Emma felt much more reassured about treating her anxiety and depression while breastfeeding. She felt more knowledgeable and prepared to continue taking care of herself and her newborn. The convenience of online support and education alleviated much of the stress she had been feeling. She could now focus more on bonding with her baby, knowing she can turn to MotherToBaby should she have more questions or concerns about medications or exposures while breastfeeding.

References:

<https://www.ruralhealthinfo.org/toolkits/maternal-health/2/breastfeeding>

<https://www.cdc.gov/breastfeeding/data/facts.html>

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One of the most common Zika-related questions we get at MotherToBaby is, “What is the risk of Zika if I travel to Country X?” Or, a variation of the same: “We just got back from Country X. Do we **really** need to wait 3 months before we try to get pregnant?”

Back when the Zika epidemic was sweeping the western hemisphere, answering these travel-related questions was fairly straightforward. It was easier to know where there was a risk for Zika infection as governments and public health organizations around the world collaborated to identify and report cases. Since then, the number of reported Zika cases has fallen dramatically, but sporadic, low-level transmission continues to happen in some areas. Systems for detecting and reporting cases vary widely from country to country now, making it difficult to know the exact level of risk in any given area.

So, what’s a traveler to do?

First and foremost, all travelers should avoid mosquito bites to help prevent not only Zika, but also other diseases spread by mosquitoes. Preventing bites is important for everyone, especially those who are pregnant or planning a pregnancy and their partners. The best way to prevent mosquito bites while traveling is to use an Environmental Protection Agency (EPA)-registered **insect repellent** with one of the following active ingredients:

- DEET
- Picaridin (also known as KBR 3023 and icaridin)
- IR3535
- Oil of lemon eucalyptus (OLE)
- Para-menthane-diol (PMD)
- 2-undecanone

Other ways to help prevent bites during travel include wearing loose-fitting, long-sleeved shirts and pants, and sleeping in areas free of mosquitoes (such as accommodations with window and door screens or air conditioning, or sleeping under a **mosquito net**).

Second, consider your destination.

Check for active **Zika Travel Health Notices** from the Centers for Disease Control and Prevention (CDC). Travel Health Notices indicate areas with known current transmission of Zika.

After checking for Zika Travel Health Notices, visit the CDC **interactive Zika map**. The map uses different shades of blue to broadly classify Zika risk in countries and territories around the world:

- Dark blue areas have reported Zika transmission in the past and there could be current sporadic or low-level transmission in some areas. As in any area, there could be delays in detecting and reporting any new outbreaks.
- Medium blue areas have the kind of mosquitoes that most commonly spread Zika, but they have not reported Zika cases in the past.
- Light blue areas are not known to have the kind of mosquitoes that most commonly spread Zika, and they have not reported Zika cases in the past.

Third, learn the recommendations.

Learn the recommendations related to pregnancy based on your destination (summarized below). Depending on where you're thinking of going, CDC might advise that you avoid travel, take steps to prevent passing the virus to a partner through sex (sexual transmission), and/or delay pregnancy if you or your partner are planning to become pregnant. Preventing sexual transmission of Zika means using condoms or dental dams, not sharing sex toys, or not having sex for 2 months after travel (for biological females) or 3 months after travel (for biological males). If delaying pregnancy after travel, follow these same timeframes (2 months after travel for biological females and 3 months after travel for biological male partners).

Recommendations for areas with a Zika Travel Health Notice:

- If you are pregnant, avoid travel to these areas.
- If your partner is pregnant and you must travel to these areas, prevent mosquito bites and sexual transmission during and after travel according to the guidelines and timeframes above.
- If you or your partner are planning a pregnancy and you choose to travel to these areas, prevent mosquito bites, prevent sexual transmission, and delay pregnancy after travel according to the guidelines and timeframes above.

Recommendations for areas with current or past transmission (dark blue on the map):

- If you or your partner are pregnant and you choose to travel to these areas, be sure to prevent mosquito bites. If you are concerned about Zika, prevent sexual transmission during and after travel according to the guidelines and timeframes above.
- If you or your partner are planning a pregnancy, be sure to prevent mosquito bites. If you are concerned about Zika, prevent sexual transmission during and after travel and consider delaying pregnancy according to the guidelines and timeframes above.

For travel to all other areas with mosquitoes, take steps to prevent bites.

Lastly, talk to your healthcare provider.

Talk to your healthcare provider about any questions or concerns. They can help you consider the nature of your travel, your ability to prevent mosquito bites and sexual transmission, the risks associated with a potential **Zika infection**, your pregnancy plans, and any other factors specific to you, your partner, and your circumstances.

MotherToBaby specialists are also **available** to talk with you about Zika or other travel-related exposures before or during pregnancy. Safe and happy travels!

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“I’m worried. I can’t sleep. It’s anxiety.” The message came through from Natalie a few minutes after I had logged onto our live chat service at [MotherToBaby.org](https://www.MotherToBaby.org). “I’m 14 weeks pregnant and concerned about taking a SSRI” she continued. As a Teratogen Information Specialist, I answer questions about exposures during pregnancy and breastfeeding on a daily basis, and I was happy to chat with Natalie about this topic.

Natalie had just returned from a visit to her OB/GYN’s office where she was diagnosed with **anxiety**. She had shared with her doctor that she was having trouble eating and sleeping, and was experiencing racing thoughts and constant worry about the future. Natalie’s OB/GYN was concerned that what she was describing was more than the typical pregnancy concerns that many women have. She recommended that Natalie start on an SSRI to help manage her symptoms.

Natalie knew she needed to do something to deal with her anxiety, but she was reluctant to take any medication. “I’ve read online that SSRIs can cause the baby to experience withdrawal symptoms, and I would never want to do anything to hurt my baby!” she quickly typed. “Instead of taking this medication, would it be better for me to just suffer through

the next 26 weeks so my baby will be born ok?”

Natalie’s question was not uncommon. Here in the United States, anxiety affects about 6.8 million adults, and women are twice as likely as men to have this mood disorder. Furthermore, about 6% of women will develop anxiety at some point during their pregnancy. Non-medication approaches may be an effective first-line treatment for certain individuals. Some women benefit from daily meditation or exercise. For others, opening up to a friend or attending talk therapy sessions may help. Natalie had tried all of these options in her first trimester, and unfortunately her anxiety was getting worse.

I knew Natalie wanted a quick answer to her question about withdrawal, but I told her that first it was important for us to review just how necessary it was for her to treat her mood disorder. I applauded Natalie for recognizing the symptoms of anxiety, and having an honest conversation with her doctor about how she was feeling. Next, I let her know that many women think that suffering through these feelings during pregnancy may be the best option. However, we know that anxiety can actually cause problems on its own when left untreated. Studies have identified an increased risk for preterm birth (baby born before 37 weeks) and low birth weight when women do not properly treat their anxiety during pregnancy. Women with untreated anxiety may also have more trouble bonding with their baby both during pregnancy and after delivery. Lastly, a personal history of anxiety prior to or during pregnancy is a known risk factor for developing a serious mood disorder after giving birth.

Natalie completely understood the importance of weighing the risks vs. the benefits. Her niece had been born premature and she has seen firsthand just how scary that experience was for her sister. She agreed that treating her anxiety was important.

Natalie’s doctor had recommended that she start on **sertraline (Zoloft)**, which belongs to a class of medications known as selective serotonin reuptake inhibitors, or SSRIs. Other medications in this class include **citalopram (Celexa)**, **fluoxetine (Prozac)**, and **paroxetine (Paxil)**, to name a few. The SSRIs are well studied, which means that we have a good idea of what the effects might be when a woman takes one of these medications during pregnancy. Withdrawal (also known as neonatal adaptation syndrome) is one of those known effects.

Babies of women who are taking an SSRI at the time of delivery may have some difficulties in the first few days of life. Reported symptoms include jitteriness, increased muscle tone, irritability, constant crying, changes in sleeping patterns, tremors, difficulty eating, and problems with breathing. Not every baby will experience these symptoms. For the SSRI medications, it is estimated that 10-30% of babies will be affected.

Some babies with symptoms of withdrawal may need to spend time in the neonatal intensive care unit (NICU) to receive additional care. However, in most cases the symptoms are mild and go away within two weeks. Reassuringly, there does not seem to be a dose-response relationship, which means that women who need a higher amount of medication to manage their anxiety are not expected to have babies who are at a higher risk for withdrawal.

“I feel so much better after chatting with you, and I really feel like this withdrawal issue can be managed if I plan ahead” Natalie said. “I think it’s going to be in my baby’s best interest for me to start taking this medication as soon as possible to get my anxiety under control.” I was glad that Natalie had reached out to chat with us about this issue. It can be a complex topic, but certainly not an uncommon one. Now armed with the most current information available, Natalie can make the best choice for her and her baby

References:

- U.S. anxiety stats: <https://www.womenshealth.gov/mental-health/illnesses/generalized-anxiety-disorder.html>
- Pregnancy anxiety stats: <http://www.postpartum.net/learn-more/anxiety-during-pregnancy-postpartum/>
- Postpartum Anxiety: <https://www.anxiety.org/postpartum-anxiety-risk-factors>
- Medications used to treat anxiety: <https://adaa.org/finding-help/treatment/medication>

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By Kirstie Perrotta, MPH, MotherToBaby California

Cara and her husband Mark were contacting MotherToBaby for the first time. “Our adoption counselor just called – we have been matched with a potential birth mom this morning and she’s due next Friday!” Cara blurted out excitedly. “The counselor said you would be able to tell us about the baby’s exposure to heroin and Klonopin. I don’t know how much she used, or when she stopped. We need to make a decision today.”

As a Teratogen Information Specialist, I often receive calls from parents who are in all stages of the adoption process. The adoption journey can be an emotional rollercoaster, as Cara was experiencing. Here at MotherToBaby, we’re happy to help and it’s not uncommon for us to hear from potential parents who need to make a quick decision. We always let the prospective parents know that it’s important to learn about any exposures that may have happened during the birth mom’s pregnancy to best understand what a future with this child might look like. Bottom line: We want adoptive parents to feel as prepared and informed as possible.

So, what should a potential adoptive mom or dad ask about when making this important decision?

Alcohol

When asking about prenatal exposures, be sure to ask about **alcohol** use. Alcohol can be one of the most worrisome and scary exposures. That’s because when a woman drinks alcohol while pregnant, it has the ability to affect the baby’s brain, which is developing throughout the **entire** pregnancy.

Children exposed to alcohol during pregnancy are at risk for something called fetal alcohol spectrum disorders (FASD). FASD is a spectrum of disorders ranging from very severe effects (such as low IQ and small head) to more minor effects (such as attention issues and poor judgment). While FASD is a lifelong diagnosis, we know that early interventions have the potential to significantly improve outcomes for these children. If you notice that your child is starting to struggle in school, or having behavior issues, will you have the time and resources to get them the extra help they may need? It’s a question you want to ask yourself as you consider adopting a child that might have special needs. Finding a specialist in your community that is familiar with treating FASD is a great place to start if you find yourself in this situation.

Recreational Drugs

Heroin, cocaine, marijuana, and methamphetamine are exposures that we unfortunately hear about all too often. While some women continue to abuse drugs up until delivery, other birth moms are motivated to quit when they learn they are pregnant. The most important information you can try to gather about this type of exposure is **HOW MUCH** and **HOW OFTEN** did the birth mom use the drug. Was it a one-time occurrence early in pregnancy, or an addiction she struggled with the entire nine months? These details can help the specialist you speak with best assess the situation. Using these types of recreational drugs during pregnancy can increase the risk for birth defects, pregnancy complications, and learning problems. See MotherToBaby’s **fact sheets** for more information.

Methadone and Buprenorphine

Methadone and **buprenorphine** are two prescription medications that are commonly used to treat addiction to opioids such as heroin, codeine, and hydrocodone. Methadone works by changing how the brain and nervous system respond to pain. It also lessens the painful symptoms of opioid withdrawal and blocks the euphoric effects of opioid drugs. To get methadone, a person has to visit a clinic every day. Buprenorphine works a bit differently and is called a “partial agonist.” This means that it partially creates a feeling of euphoria, but to a lesser degree than a narcotic like heroin. Buprenorphine is available by prescription only.

For many women, there are benefits to staying on a maintenance therapy like methadone or buprenorphine during pregnancy. Most importantly, it helps prevent relapse for women who have a history of abusing opioids. We also know that the women are getting a controlled dose of the medication every day from a healthcare provider. Lastly, women who remain on methadone or buprenorphine throughout pregnancy are less likely to have some of the health issues that traditional drug users may experience, such as a risk for infectious disease (like hepatitis C or HIV) from sharing dirty needles.

While these medications are generally preferred over continued drug abuse, there are still some risks associated with their use during pregnancy. If the birth mom you are considering reports exposure to methadone or buprenorphine, please **contact us directly** to learn more.

Cigarette Smoking

Cigarette smoking often goes hand in hand with alcohol and drug use. Again, knowing how much and how often the birth mom was smoking is the most helpful information you can have. Many times when a woman finds out she is pregnant she is able to either stop smoking completely, or cut down to just a few cigarettes per day, greatly reducing any possible risks to the baby.

Many studies have associated heavy cigarette smoking during pregnancy with an increased risk for preterm birth (delivery before 37 weeks). A baby born too early has a higher chance for health problems and may need to stay in the neonatal intensive care unit (NICU). If the birth mom you are considering is a heavy cigarette smoker, it’s important to think about how you would handle a baby that may need to spend some extra time in the hospital. For some moms and dads who are matched with a baby in a different state, this may present some logistical challenges. A couple of questions to ask yourself: will you be able to temporarily relocate to the city where the baby is born, and spend some extra time there if the baby does requires a longer hospital stay of a few weeks or more?

Prescription Medication

If a birth mom is taking a prescription medication, the most important thing to try to find out is whether she is taking it as directed, or possibly abusing it. There are many medical conditions that need to be managed during pregnancy – asthma, anxiety, depression, diabetes, and nausea to name just a few. If the birth mom is taking the medication as directed, there’s a good chance we have studies looking at typical use of the medication during pregnancy, and any possible risks to the baby may be small. If a woman is abusing the medication there is likely not as much data, so we have less understanding of how the pregnancy may be affected.

Genetic Predisposition

It’s also important to consider the reason a birth mom needs to take a specific medication. If the woman is prescribed a bipolar medication, for example, her medical history should be something to think about. Many health conditions have a genetic component, meaning that the baby you may adopt has the potential to inherit this condition. If the child does develop a genetic condition like bipolar disorder or schizophrenia, is this something you think that you (and your partner) could take on?

While this question is slightly outside our area of expertise, it’s an important one to consider, and speaking with a **genetic counselor** to better understand any potential risk is a good idea.

Prenatal Care

Getting early and regular prenatal care improves the chances of a healthy pregnancy. Women who see a doctor or midwife routinely may be more motivated to stop unhealthy behaviors (such as drug use and cigarette smoking) and start healthy behaviors (like taking a daily prenatal vitamin with folic acid). Women who have access to prenatal care are also less likely to experience pregnancy complications caused by health conditions they might have (such as high blood pressure and diabetes).

While this information may not be readily available to you, there are certain situations where we know that the birth mom is more likely to be receiving prenatal care: women who are in jail or women who are in rehabilitation programs.

Ultrasounds are another aspect of prenatal care that can be helpful to know about. Typically, during a normal healthy pregnancy, women will receive what is called a fetal anatomy scan right around 20 weeks. This is a detailed ultrasound that is taking a look at all of baby's organs (heart, kidneys, bladder, sex organs, brain, etc.) to make sure they developed properly. Measurements will also be taken to make sure the baby is growing as expected. While ultrasounds are not 100% diagnostic (meaning they can't pick up every possible problem) a normal ultrasound does provide some reassurance. Ultrasounds are especially helpful if the birth mom was using a drug or medication that is associated with a higher risk for birth defects.

Has the Baby Already Been Born?

If the baby has already been born when you get the call, we have a lot more information to work with! First off, we know whether the baby was born early and we know the baby's weight. If baby was born full term (after 37 weeks) and at a healthy weight, the likelihood of them having to stay in the NICU is much lower. A physical exam can also help rule out any major birth defects.

Lastly, we can look for something called neonatal abstinence syndrome (commonly called withdrawal). Withdrawal is an issue that can occur in some babies exposed to drugs like heroin or methamphetamine, or prescription medications like antidepressants or methadone later in pregnancy. While the specifics can vary depending on the exposure, symptoms typically develop soon after birth and in some cases can last for weeks. If a baby experiences withdrawal, they may need to spend some time in the NICU getting medication and extra care.

Making an Informed Choice

Wow, that sure is a lot to think about, right? The purpose of this blog is not to overwhelm you, but to inform you! We know first-hand that many adoptive moms and dads-to-be are provided with very few details about the birth mom and her possible exposures. We want to arm you with the questions to ask! In many cases you can gather some of the information discussed above from conversations with the adoption agency or the birth mom, medical records, or once the baby is born. The more information you have to share with experts like us, the better, so ask as many questions as you can! After all, this is one of the biggest decisions you will make in life, and it's important to be as informed as possible.

After spending some time learning about the effects of heroin and Klonopin, Cara and Mark felt that they had a good understanding of the potential issues associated with these exposures, and decided to move forward with the adoption. The good news for this couple (and all adoptive parents-to-be!) is that multiple studies have shown that babies that are raised in loving and stable adoptive homes do much better than children that remain with a birth mom who is continuing to abuse drugs or alcohol. Cara called back three months later to thank us for all the information we had provided. She shared that her baby boy was home and thriving, and they were so happy to have made an informed decision.

As you move forward in the adoption process, don't forget that Teratogen Information Specialists at MotherToBaby are available to review any specific adoptive scenarios you are presented with, at no cost to you. Don't hesitate to give us a call at 866-626-6847 or **chat** with an expert today to get your questions answered!

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