When Addiction Recovery Meets Pregnancy: Finding a Balance for Mom and Baby

“This is my first child, and I don’t know what to do!” exclaimed Lyndsay, a newly pregnant woman when I answered MotherToBaby’s free and confidential helpline. Lyndsay explained that she is taking several medications and was concerned about their potential effects on her unborn baby. She is currently very new to recovery from cocaine and opioid use disorder. She is taking buprenorphine and naloxone for the opioid use disorder, along with baclofen and n-acetylcysteine (NAC) for cocaine cravings. Her medication regimen also includes aripiprazole, escitalopram, bupropion and mirtazapine for depression, mood stabilization and insomnia.

“This combination has been working well for me,” she explained. “Having that said, I wonder if the treatments are increasing my chances for pregnancy complications or birth defects in my baby?” She wondered if she would be better off getting off the buprenorphine and naloxone now.

In preparing to answer her concerns, I reached out to Ellen Kolomeyer, PhD, PMH-C, a licensed clinical psychologist certified in perinatal mental health, who is part of the National Maternal Mental Health Hotline team to assist us in providing the best answers about recovery treatment while pregnant. The National Maternal Mental Health Hotline provides 24/7 support to pregnant and postpartum individuals experiencing challenges with mood and anxiety, as well as their support women and loved ones through its phone and text line 1-833-TLC-MAMA.

Q: How common is it for a woman in recovery and who is also pregnant to be treating an opioid use disorder with medications?

According to the Centers for Disease Control and Prevention (CDC), about 7% of pregnant women used opioids during pregnancy, with one in five of those women reporting that they misused opioids during pregnancy. But, only about half of the pregnant women who use opioids during pregnancy are in recovery, so it is wonderful that Lyndsay is reaching out to learn how to best care for herself and her baby. I hope her story shows that it is possible to get help and have a healthy pregnancy.

Q: What treatments can be used?

When a pregnant woman is dealing with opioid addiction, healthcare providers often prescribe medicines like methadone and buprenorphine. It is best if treatment starts before someone gets pregnant to help both the mother and baby stay healthy. But sometimes, people face challenges that make it hard to get treatment. These can be personal issues like having a tough time managing feelings or problems with relationships. There can also be unfair judgments from others about drug addiction that make it harder for people to seek help. Besides giving medicine, it is also important to get help for mental health. This means talking to a counselor or therapist about the things that might be causing someone to use drugs in the first place.

Q: Is discontinuing treatment while pregnant recommended? Why or why not?

It is important to know that stopping opioid use suddenly during pregnancy can be dangerous for both the pregnant woman and the baby. Managing opioid use with medication is a better way to stay healthy and reduce the risk of going back to using drugs. So, it is best to keep taking the medication rather than stopping it while pregnant. It is crucial to

talk with a healthcare provider before making any decisions about treatment.

Q: Should a pregnant woman expect her healthcare provider to start or stop medications or switch to alternatives?

Each pregnancy is different, so there is no one answer that fits everyone. Depending on the situation, a pregnant woman might start, stop, or switch medications. It is common for healthcare providers to talk about medications, like methadone https://mothertobaby.org/fact-sheets/methadone/ or buprenorphine, https://mothertobaby.org/fact-sheets/buprenorphine/ and suggest starting them if needed. Sometimes, providers might think about changing to a different medication but they will carefully consider the risks and benefits. It is best to see a healthcare provider who knows how to give the right recommendations for pregnant women.

Q: What can a pregnant woman do to advocate for herself in this scenario?

Pregnant women who are struggling with opioid use often face challenges in getting the right information and help. Even though there can be judgment from others, pregnant individuals can benefit from speaking up for themselves. One important way to do this is to understand the reasons behind the problems they are facing and to talk about their goals.

Research shows that many people turn to drugs because of past trauma, not having enough support or money, dealing with bad feelings, and having tough relationships, among other reasons. By thinking about their own situation and struggles, individuals can work to address the main issues they're facing.

I want every pregnant woman in this situation to know that they can still have a good relationship with their baby and take care of their baby's needs. It is a good idea to find a healthcare provider who knows a lot about opioid use disorder to get the right support. Building a strong support system could be the key to making a big change and getting better.

There are some great ways that pregnant women recovering from opioid use disorder can build their support system. Talking through personal hardships in support groups, with home visitors, with a counselor, or with a therapist can help build the tools and confidence you need to learn how to advocate for yourself and your baby with medical providers.

Q: What is the best way that a pregnant woman can share her questions and concerns with their Obstetric provider?

To make sure you get the best support, it is helpful to find a healthcare provider who knows about substance use issues. One great way for a pregnant woman to talk about their questions and worries with their OB is to write them down before an appointment and bring the list with them. As the pregnancy progresses, working together with the provider to plan for labor, delivery, and postpartum care can get the parent-to-be ready for what is ahead at each stage. I suggest asking your obstetric provider to be open and share information throughout the process so that there are fewer surprises when it is time for the birth, after-birth care, and taking care of the newborn.

Q: After delivery, what does a typical newborn period look like for the parent(s) and baby?

It is common for babies to experience withdrawal symptoms from medications used to treat opioid addiction (also

called neonatal abstinence syndrome), but this should not stop a healthcare provider from prescribing the medications or pregnant women from taking them. After the baby is born, parents should team up with their baby's healthcare provider to keep an eye on the newborn and get help when needed. It is important for parents to be involved in their baby's care and spend time bonding with them. If parents feel they are not getting these chances, they can speak up and ask for them.

Withdrawal symptoms in a baby are treatable, but some babies need to be monitored extra closely and around the clock. It can also be helpful to prepare ahead of time and learn if it is possible that your baby might go to the Neonatal Intensive Care Unit (NICU) instead of staying in the recovery room with you. While unexpected things can happen in any pregnancy and birth, you could ask your providers ahead of time whether they think there is a reason your baby might go to the NICU and what you might expect. For example, you might want to know how long your baby could be in the NICU and make a plan for advocating to still be able to see, touch, and care for your baby as often as possible during your baby's medical care.

Q: Can you share recommended resources?

There are widely available, free, and confidential programs, resources, and provider directories that anyone can access including the following:

- National Maternal Mental Health Hotline provides 24/7 support to pregnant and postpartum individuals experiencing challenges with mood and anxiety, as well as their support persons and loved ones. Call or text 1-833-TLC-MAMA.
- MotherToBaby provides information about exposures, like medications and diseases, during pregnancy and while breastfeeding through its free phone service 866-626-6847, text 855-999-3525, email and live chat via MotherToBaby.org.
- Substance Abuse and Mental Health Services Administration (SAMHSA) offers a directory to find medical providers who specialize in treating opioid use disorders. Locate a practitioner here. SAMHSA also provides a National Helpline that can provide treatment referral and information 24/7. Call 1-800-662-HELP.
- Postpartum Support International HelpLine provides basic information, support, and resources for pregnant, postpartum, and parenting individuals and their support persons and loved ones. This line is not 24/7 but messages are returned daily. Call or text 1-800-944-4773.
- Postpartum Support International Provider Directory lists medical and mental healthcare professionals who are specially certified to care for pregnant and postpartum individuals. Access the directory here.
- The Suicide and Crisis Lifeline is available 24/7 by calling or texting 988.
- Circle of Security is an evidence-based program that helps parents build secure parent-child relationships, effectively meet babies' needs, and help parents break cycles from their own childhoods that they do not wish to carry over to their children. Learn more here and a Circle of Security Parent Educator here.

We had just shared a lot of information with Lyndsay. She was relieved to hear that her recovery treatment was going to allow her to stay well in pregnancy and give her the best chance to have a healthy baby. “I feel like I have a better idea of what questions I need to ask my OB and pediatrician,” she told us. “I feel less alone in this now and it looks like there are places I can go to get more information too.”

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Note: This information should not take the place of medical care and advice from your healthcare providers.

When Addiction Recovery Meets Pregnancy: Finding a Balance for Mom and Baby

By Lorrie Harris-Sagaribay, MPH, Teratogen Information Specialist and Coordinator, MotherToBaby North Carolina

Back in the early 1970s, pregnant women and their health care providers didn't talk about alcohol and drugs in pregnancy. Birth defects caused by alcohol? Unheard of! Then, along came two pediatric specialists at the University of Washington who changed everything: Drs. David W. Smith and Kenneth Lyons Jones noticed that a group of babies who had been exposed to high amounts of alcohol during pregnancy were all born with a similar pattern of unusual facial features and developmental delay. Their astute observations, along with further research and collaboration, led them to coin the term Fetal Alcohol Syndrome (FAS) in 1973.

The discovery that alcohol was a teratogen (an exposure that can cause birth defects) fueled the research on other exposures and opened up a world of questions. What about other drugs? What about medications? In order to share findings from the limited but ongoing research, Dr. Jones established the first teratogen information service in 1979, housed in a small apartment in San Diego and run by a dedicated staff of three. This service was the beginning of what would later become MotherToBaby.

Fast forward to June 2017, when experts from MotherToBaby and other teratogen information services around the world gathered in Denver, Colorado for the 30th Annual Meeting of the Organization of Teratology Information Specialists (OTIS). There, dozens of experts presented the latest research on exposures during pregnancy. Speakers summarized what we've learned, pointed out what we still don't know, and suggested priorities for future research. Here are a few highlights from the meeting:

Prescription Opioids

At one time, opiates were peddled as remedies for fatigue, menstrual cramps, and even teething in children (search Mrs. Winslow's Soothing Syrup as an example). Now, more than a century later, we are in the middle of an epidemic of substance use disorders from opioid pain relievers. And according to a 2014 study, more than 14% of pregnant women in the U.S. are prescribed opioids at least once during pregnancy for reasons such as back pain and migraines. Pregnant women who develop opioid use disorders (either before or during the pregnancy) are encouraged to undergo maintenance therapy such as methadone treatment, which is less risky to the baby and more likely to result in successful recovery than sudden withdrawal would be.

Infants with ongoing exposure to opioids during pregnancy can experience withdrawal symptoms at birth, commonly called neonatal abstinence syndrome (NAS). Like Fetal Alcohol Syndrome, NAS was first described in the literature in the 1970s, by Dr. Loretta Finnegan. The syndrome has gotten renewed attention during the current opioid epidemic as providers and researchers consider the best ways to prevent and manage NAS. Studies have shown that hospitalized infants with NAS have better outcomes–less severe symptoms, less need for medication, and shorter hospital stays–when they are breastfed, even if the mothers are still on opioid maintenance therapy. But some health care providers hesitate to encourage breastfeeding in these cases out of concern about baby's ongoing exposure to the mother's medication through the milk. Continued funding can help address these concerns by developing consistent standards of care for infants with NAS. If you are using opioids for any reason, be sure to talk to your health care

provider as soon as you find out you are pregnant. Together, you can work on a plan for the best possible care for you and baby during and after the pregnancy.

Cocaine
To study the effects of cocaine in pregnancy, researchers have followed a group of young adults, now in their early 20s, since they were born. About half the group was exposed to cocaine before birth. Early on, the researchers observed that those with cocaine exposure had challenges with attention and remembering what they saw when compared to the children who had not been exposed to cocaine. In older years, exposed children had more difficulty with language skills, more behavior problems at school and at home, reported more substance use and risk-taking behavior, and had more difficulty with everyday skills such as staying organized, thinking ahead, and controlling their own behavior. Some dropped out of school. Interestingly, having a positive home environment seemed to help with some, but not all, of these challenges. For example, children in foster or adoptive homes had better language and reasoning skills than children who still lived with their birth mothers who used cocaine, but there was no difference in their behaviors. As the study continues, researchers hope to learn more about how prenatal cocaine exposure affects these individuals into adulthood.

E-cigarettes
E-cigarettes are marketed and often seen as a "safer" option to cigarettes. In fact, the most common users are current and former cigarette smokers who are using e-cigarettes to replace or reduce the number of cigarettes they smoke. In a study of over 1,300 pregnant women, those using e-cigarettes reported doing so because they felt they were less harmful than cigarettes, or to help with smoking cessation. They also preferred the sweeter flavors, and thought they were even less harmful than the tobacco-flavored liquids.

E-cigarettes don't expose users to the combustion by-products of traditional cigarettes, but even those labeled "nicotine-free" do contain nicotine, and vaporization creates its own potentially harmful by-products. Since e-cigarettes are liquid-filled and can be smoked longer, it's more difficult to monitor actual exposure to nicotine than it is with traditional cigarettes. Plus, because e-cigarettes are not regulated by the FDA, there is no way of knowing exactly what they contain and what your pregnancy is exposed to when you use them.

Past studies have observed that prenatal exposure to nicotine affects baby's brain development and increases the chance of later behavior problems and depression in adolescence. It even predicts baby's own cigarette use in his/her teen years. And recent studies have shown that those adolescents who use cigarettes are more likely to also use e-cigarettes as teens and adults than their peers who don't use cigarettes. We will learn more about the possible long-term effects of prenatal e-cigarette use as the first generation of children who were exposed to them in pregnancy gets older.

Marijuana
Marijuana is the most common "illicit" drug used in pregnancy. Some health care providers in Colorado, where marijuana is now legal, are seeing more pregnant women who believe that using it is not harmful and might even be beneficial. For example, pregnant women in one survey reported using marijuana to help manage depression or anxiety, help with pain, or ease nausea and vomiting, among other reasons. Without crucial data about exactly how marijuana might be harmful to a pregnancy, some health care providers are hesitant to talk to women about it, even if they know they are using it in pregnancy.

There is little doubt that marijuana can be harmful in pregnancy: THC crosses the placenta and, even in very early pregnancy, can affect the cells that form the baby's brain. But studies on its effects on overall brain development and pregnancy outcomes have had mixed results so far, and they face challenges such as co-exposures (women using other substances along with marijuana) and, in some cases, relying on self-reporting to know how much of the drug a pregnancy is exposed to (this can skew the data if users do not accurately reveal how much and how often they use.) As researchers forge ahead to provide better answers, the best advice is still to avoid marijuana altogether in pregnancy.

Alcohol
Since those early years, we have discovered that the facial features and developmental delay often seen with FAS are not the only possible effects of prenatal exposure to alcohol. In some children, subtle changes to the brain might not be noticed until the child is older and begins to struggle with learning and behavior problems that can follow them into adulthood. This range of possible effects has been more recently named Fetal Alcohol Spectrum Disorder (FASD). According to Dr. Jones, FASD affects about 2% of babies born in the U.S. each year–more common than autism–despite the fact that it is 100% preventable.

Looking ahead.
The decades ahead require not only continued research, but also increased awareness of what we already know. To that end, each September we observe FASD Awareness Month. MotherToBaby is happy to answer your questions about alcohol and other exposures in pregnancy—in fact, check out **our brief YouTube video here.** Together, we can continue the work towards the best possible outcomes for future generations.

Lorrie Harris-Sagaribay, MPH is the Coordinator of MotherToBaby North Carolina and a bilingual Teratogen Information Specialist. After working with midwives as a community health educator with the Peace Corps in Honduras, she earned her Master of Public Health at the University of North Carolina at Chapel Hill. She has worked in the field of maternal and child health for over 25 years.

About MotherToBaby

***MotherToBaby** is a service of the Organization of Teratology Information Specialists (OTIS), suggested resources by many agencies including the Centers for Disease Control and Prevention (CDC). If you have questions about exposures during pregnancy and breastfeeding, please call MotherToBaby toll-FREE at 866-626-6847 or try out MotherToBaby's **new text information service** by texting questions to (855) 999-3525. You can also visit **MotherToBaby.org** to browse a library of fact sheets about dozens of viruses, medications, vaccines, alcohol, diseases, or other exposures during pregnancy and breastfeeding or connect with all of our resources by downloading the new MotherToBaby free app, available on **Android** and **iOS** markets.*

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Presented at the (joint) Annual Meetings of OTIS (Organization of Teratogen Information Specialists), DNTS (Developmental Neurotoxicology Society), RSA (Research Society on Alcoholism) and the Teratology Society in Denver, Colorado on June 25-27, 2017:

- ***From the FAS to OTIS – A Long Strange Trip.*** Buzz Chernoff, California Environmental Protection Agency (Retired).
- ***The Opioid Epidemic and Impact of Prenatal Exposure on Child Development.*** Lynn Singer, Case Western Reserve University.
- ***Project Newborn: What We Have Learned from 20 Years of Research on Prenatal Cocaine Exposure.*** Sonia Minnes, Case Western Reserve University.
- ***Epigenetic Changes Induced by Prenatal Nicotine and Cocaine Exposure.*** Pradeep Bhide, Florida State University.
- ***Effects of Prenatal Nicotine Exposure on Adolescent Dopamine Systems.*** Frances Leslie, University of California at Irvine School of Medicine.
- ***Electronic Cigarette Use in Pregnancy: Patient and Provider Perspectives.*** Katrina Mark, University of Maryland School of Medicine.

- ***Pathways from Prenatal Tobacco Exposure to Electronic Cigarette Use.*** Natacha M. DeGenna, University of Pittsburgh School of Medicine.
- ***Perceptions and Use of Electronic Cigarettes during Pregnancy: Implications for Infant Outcomes.*** Laura Stroud, Brown Medical School.
- ***Pathways from Prenatal Exposures to Tobacco and Cannabis to Adult Electronic Cigarette Use.*** Natacha De Genna, University of Pittsburgh Medical School.
- ***Counseling Women about Prenatal Marijuana Use: Weeding through the Data.*** Torri D. Metz, University of Colorado-Denver.
- ***Introduction: Marijuana and Child Development Symposium.*** Diana Dow-Edwards, SUNY/Downstate Medical Center.

Questions? Call 866.626.6847 | Text 855.999.3525 | Email or Chat at MotherToBaby.org.