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.”

References:

MotherToBaby Blog: “Dear Opioid-Addicted Moms-To-Be, We are Here for You”

Centers for Disease Control and Prevention. (2022). ***About opioid use during pregnancy***.

Centers for Disease Control and Prevention. (2022). ***Treatment for opioid use disorder before, during, and after pregnancy***.

Gerdts-Andresen, T. (2021). Circle of security-parenting: a systematic review of effectiveness when using the parent training Programme with multi-problem families. ***Nordic Journal of Social Research***, ***12***(1), 1-26.

Henry, M. C., Sanjuan, P. M., Stone, L. C., Cairo, G. F., Lohr-Valdez, A., & Leeman, L. M. (2021). Alcohol and other substance use disorder recovery during pregnancy among patients with posttraumatic stress disorder symptoms: A qualitative study. ***Drug and Alcohol Dependence Reports***, 1, 100013.

Horton, E., & Murray, C. (2015). A quantitative exploratory evaluation of the circle of security-parenting program with mothers in residential substance-abuse treatment. ***Infant mental health journal***, ***36***(3), 320-336.

Substance Abuse and Mental Health Services Administration. (2018). Clinical guidance for treating pregnant and parenting women with opioid use disorder and their infants. ***Vol HHS Publication No.(SMA) 18-5054***.

Substance Abuse and Mental Health Services Administration. (2024). Evidence-based, whole-person care for pregnant women who have opioid use disorder. SAMHSA Advisory. https://store.samhsa.gov/sites/default/files/whole-person-care-pregnant-people-oud-pep23-02-01-002.pdf

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

The holiday season was in full swing when Katie found out she was pregnant. She called me and wanted to know if she could continue to take Zoloft (or sertraline), the medication she was prescribed to treat her depression. The idea of coming off of the medication scared Katie, just as much as the idea of taking something that could affect her baby did. Katie also had been feeling a bit more exhausted and down than usual, possibly due to both her pregnancy and to a case of the holiday blues. 'Tis may be the season to be jolly – but it is also a time when emotions (and stress levels) can run high.

Reasons for the Holiday Blues

Some of the most common reasons that people feel extra stress during the holidays include money, family, traveling, over-committing to attending events, and for some, the inability to spend time with their loved ones. Being pregnant can add another layer of anxiety to an already hectic time. Though the season is always presented as a time filled with joy, it can certainly take a toll on people's mental health. It is important to note that when depression is left untreated during pregnancy, there may be increased risks for miscarriage, preeclampsia, preterm delivery, low birth weight, and a number of other harmful effects on mom and baby. See our fact sheet on depression and pregnancy. It's also important during pregnancy to not stop (or start) taking any medications without first talking with your health provider. Whether or not a woman continues to take a medication throughout her pregnancy will depend on the benefits of taking the medication versus any possible risks associated with the medication. For that reason, I suggested to Katie that she should speak with her healthcare provider about whether or not continuing to take sertraline is in her best interest given her particular health history and pregnancy.

Mental Health & SSRIs

I then reviewed with Katie everything that we know about sertraline use during pregnancy. Sertraline has been one of our most viewed fact sheets on MotherToBaby.org in recent months, and is in a class of medications called SSRI's, or selective serotonin reuptake inhibitors. A small number of studies have found associations between sertraline use during pregnancy and particular birth defects, such as heart defects. However, the majority of the studies looking at over 10,000 pregnant women, have found that women taking sertraline during pregnancy are not more likely to have a baby with a birth defect than women not taking the medication. Overall, the available information does not suggest that sertraline increases the chance for birth defects above the 3-5% background risk that is there for every pregnancy. We have a wonderful fact sheet on this medication that you can view here. We also have a mental health web page where you can see links to fact sheets on other SSRI's and commonly prescribed medications for people

dealing with depression and anxiety, as well as Baby Blogs on related topics. All of our fact sheets also address breastfeeding, so if you are in the postpartum period please also take a look or reach out to us with questions.

If you're feeling blue this holiday season, remember that it is just as important to take care of yourself as it is to care for those around you. The holidays can also be a wonderful time of year to take stock of what it is in life that you're thankful for. If you do find that you are feeling down or depressed and have been feeling this way for quite some time, seeing your healthcare provider may be a good step to take. If you are pregnant and dealing with feelings of sadness and depression, do not assume you cannot take a medication to help with your symptoms. If you are pregnant and already taking a medication for depression, don't stop taking it without talking to your healthcare provider. Always check with your health care provider before starting or stopping any medication.

The experts at MotherToBaby are always here to offer the latest information on medications in order to help you and your healthcare provider make the best care plan possible for you and baby. If you're feeling blue, make sure to reach out to a friend or family member that can remind you you're not alone, and that you are cared for. To all women and their families, here's to a healthy, happy holiday season!

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

By Patricia Markland Cole, MPH, MotherToBaby Massachusetts

During my work at MotherToBaby, I have received calls from pregnant woman who want to know what can they safely take to sleep? Usually they are looking at natural remedies like melatonin for information. For some who have been on medications like Ambien before they were pregnant, they now wonder if they can use it because they are having a hard time catching those Zzzz's. Even though I am not pregnant, I am sure all of us can relate to a night where we

wake up and cannot fall back to sleep. We slowly see the time ticking by 10 min, 30 min, 1 hr, 2hrs. It can be so frustrating, especially if you look over at your partner in a state of blissful slumber as you toss back and forth on the bed.

Many women have come to accept a lack of sleep or quality of sleep in pregnancy. In the early part of pregnancy, sleep is interrupted by nausea, vomiting, back pain and an increased need to urinate/pee. In the middle of pregnancy, women are uncomfortable in bed because the baby is moving and kicking, and then there is heartburn, cramps or tingling in the legs.

By the latter part of pregnancy, it is reported that over 97% of pregnant women cannot get a decent night's sleep. They are waking up and staying awake for longer periods of time. I do recall how surprised I was when I sent an email to one of my colleagues at MothertoBaby in her third trimester of pregnancy, at the crack of dawn her time (I was on the East Coast, she was on the West). I was so surprised when she responded to my email and I knew it was way too early for her to be at the office. When I asked, she stated, she was up and couldn't sleep and decided to make the most of her time. While many women and clinicians have come to accept this as just a part of pregnancy, the data is starting to show that we need to pay more attention to how pregnant women are sleeping during pregnancy.

What is Insomnia?
Insomnia is one of 3 common sleep disorders during pregnancy. Insomnia includes difficulty falling asleep or staying asleep, waking up very early in the morning, waking up not feeling rested or a combination of these symptoms. Many pregnant women do not view insomnia as a disorder or a problem in their pregnancy, but when it starts to impact how you function during the day especially when it is accompanied with sleepiness, lack of energy, increased irritability, agitation and stress, it should be considered more carefully especially if insomnia starts to occur more regularly and last longer. Having a good night's rest is important for the well-being of the mother and child.

The concern with persistent insomnia is that it could increase the chance of hypertension and diabetes, which is just as concerning in people who aren't pregnant too. Another concern is that people who suffer from insomnia have higher levels of substances that increase inflammation in the body (proinflammatory cytokines). These higher levels of cytokines are also seen in women who have experienced preterm birth, postpartum depression and other pregnancy complications. While no association with insomnia and adverse pregnancy effects have been made, researchers have started to take a closer look at the effects of insomnia due to some results. For instance one report observed a higher rate of preterm birth for pregnant women that were sleeping less than 5 hours a night in the latter part of pregnancy. And there were other observations that women who were sleeping less than 5 hours a night in the last month of pregnancy had longer labors and were more likely to have C-sections.

In light of these observations, health care providers are being asked to screen their patients for sleep disorders during pregnancy. The majority of pregnant women consider their insomnia to be mild but in some cases there could be more that is going on like undiagnosed depression or anxiety that can be responsible for the insomnia.

So what's a tired mom-to-be to do?
Expectant mothers can do their part by being more proactive. It is suggested that expectant moms keep a daily sleep diary which would include your bedtime routine, how long it takes you to fall asleep, if you have difficulty falling back to sleep after waking up, how long you are awake at night and if you feel rested. Talk with your health care provider even if they have not brought it up with you. Sometimes changes in behavior can help, called 'sleep hygiene' which involves things like avoiding stimulants (caffeine), not eating late at night, getting exposure to adequate sunlight and using your bed for only sleeping (not watching TV). Other actions that pregnant women can try includes acupuncture, massage, yoga and exercise. In some cases a referral to a sleep specialist may be needed and if all else fails some women may require medications.

Sometimes moms start looking at a natural remedy like melatonin. Melatonin, a hormone that is produced by the pineal gland, is often taken as a supplement to help with sleep. Melatonin is available in two forms, either as a synthetic product or a product that is from animals, usually beef cattle. Most health care professionals recommend avoiding the melatonin from animals due to a very small chance of contamination or viral transmission. Also, melatonin is a supplement and not a medication. That means it's not regulated by the Food and Drug Administration. Some studies have suggested avoiding use of melatonin during pregnancy due to a concern that the exposure might interfere with mom's or baby's sleep cycles.

Others want to know about prescription medications, like Ambien (zolpidem). Ambien has not been shown to increase the risk for birth defects when used in the first trimester of pregnancy. Since Ambien is a sedative hypnotic type of medicine, and has some features similar to benzodiazepines, it is thought that when used near the time of delivery,

there may be temporary withdrawal-like symptoms in the baby.

Overall it is important to develop a plan with your health care provider and if a medication is needed, you can call MothertoBaby and we can provide information on medications suggested for use in pregnancy. Remember do not take sleeping lightly during your pregnancy; as one commentator put it, you are “sleeping for two.” You, your baby and even your partner will appreciate your effort.

Patricia Cole, MPH, is the Program Coordinator for* MotherToBaby Massachusetts*. She obtained her Bachelor’s degree in Biology from Simmons College in Boston and her MPH in Maternal and Child Health from Boston University School of Public Health. She has been the serving the families of New England as a teratogen counselor since 2001 and provides oversight for the day-to-day functions and outreach of the program. She has also provides education to graduate students and other professionals.

***MotherToBaby** is a service of OTIS, a suggested resource by many agencies including the Centers for Disease Control and Prevention (CDC). If you have questions about viruses, alcohol, medications, vaccines, diseases, or other exposures, 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, **email an expert** or **chat live**.*

References:
Nodine, PM. (2013). Common Sleep Disorders: Management Strategies and Pregnancy Outcomes. J of Midwifery & Women’s Health. 58:368-377.
Reichner,CA. (2015). Insomnia and sleep deficiency in pregnancy. Obstetric Medicine. 8(4):168-171
Won,CH.(2015). Sleeping for Two: The Great Paradox of Sleep in Pregnancy Commentary. J Clin Sleep Med. 11:645-654.