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**Shame to Resilience: Trauma-informed Perspectives on Maternal Substance Use**

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**Abstract**

**Objective.** The objective of this article is to discuss the multifaceted complexity of maternal substance use and trauma histories. **Methods.** Overview of the impact of opioid use in maternal age women is provided, as well as its impact on families. Two case examples are presented to highlight the major barriers these women encounter in entering treatment. **Results.** The use of two theories, shame-resilience (SRT) and self-determination (SDT) is also discussed as a possible framework to engage pregnant women and promote recovery and healing from trauma histories. **Conclusion.** Providing trauma-informed, gender-specific treatment using these theoretical frameworks has the potential for transformational growth and recovery for this multifarious population. **Implications.** To provide the necessary comprehensive, coordinated, and compassionate care from multiple disciplines, continued training on trauma-informed, gender-specific treatment is recommended.

*Keywords:* Resilience, substance Use, opioid, maternal.

Shame to Resilience: Trauma-informed Perspectives on Maternal Substance Use

The purpose of this article is to discuss the intersection of opioid use and pregnancy, treatment recommendations for opioid use disorder, and complex issues those pregnant women with opioid use disorder encounter. To elucidate the multifaceted issues, two case examples are provided. Following the cases, treatment recommendations are presented, utilizing theoretical frameworks. The misuse of and addiction to heroin and prescription opioids is a serious national problem that has become a public health epidemic with a dramatic increase in fatal overdoses impacting the social and economic welfare systems. Opioid use during pregnancy has resulted in a rising incidence of newborns diagnosed with neonatal abstinence syndrome associated with increased risk of poor intrauterine growth, prematurity, seizures, and birth defects (American Academy of Pediatrics, 1998; Patrick et al., 2012). Increased prevalence of nonmedical prescription opioid use nationally throughout the last decade (Jones, Finnegan, & Kaltenbach, 2012; Minnes, Lang, & Singer, 2011) has contributed to increased incidence rates among pregnant women (Substance Abuse and Mental Health Services Administration [SAMHSA], 2012). According to the National Survey on Drug Use and Health (2015), approximately 21,000 pregnant women between the ages of 15 and 45 reported that they misused opioids within the month prior to taking the survey (SAMHSA, 2015).

Between 1999 and 2015, the rate of deaths from prescription opioid overdoses and heroin use doubled with women, a greater increase than with men (National Institute on Drug Abuse [NIDA], 2014). A 2015 Centers for Diseases Control and Prevention (CDC) *Morbidity and Mortality Weekly Report* (MMWR) found that between 2008 and 2012, more than 25% of privately insured women ages 18-44 and more than 33% of female Medicaid recipients in the same age range filled a prescription for an opioid medication (Guy et al., 2015). A 2013 CDC *Vital Signs*

report noted that “every 3 minutes a woman goes to the emergency room for prescription painkiller misuse.” The estimated prevalence of substance use among pregnant women in the US, ages 15-44, was 5.4% for illicit drugs and 9.4% for alcohol (SAMHSA, 2015). NIDA (2014) conducted a survey on substance use disorders and reported a 40-60% relapse rate among opioid users.

Opioid use disorder is defined by the standard DSM-5 diagnosis as a problematic pattern of opioid use leading to clinically significant impairment or distress, occurring within a 12-month period (American Psychiatric Association, 2013). Women of childbearing age can be introduced to opioids in several ways. Legally, they might be prescribed opioid medication for acute or chronic pain or prescribed buprenorphine or methadone to treat an opioid use disorder. Alternatively, they might gain access to prescription opioids illicitly, or they might be using the opioid heroin. For the purpose of this article, we acknowledge the multiple channels through which women of childbearing age obtain opioids, including the various methods by which they ingest or inject opioids.

### **Treatment in Pregnancy: Methadone, Buprenorphine, and Detoxification**

The American College of Obstetricians and Gynecologists (ACOG) suggests that untreated heroin addiction is associated with lack of prenatal care, growth restriction, abruptio placentae, fetal death, preterm labor, and intrauterine passage of meconium. Although the Food and Drug Administration (FDA) has not formally approved methadone for treatment of pregnant women with opioid use disorder (PWOUD), it has been the standard of care for these women since the early 1970s, regardless of the type of opioid exposure (National Institutes of Health Consensus Development Panel, 1998; Center for Substance Abuse Treatment [CSAT], 2005). There has been no formal re-evaluation of this standard of care despite the increased misuse of prescription opioids in pregnant women. Research on treatment of opioid dependence in pregnant

women has focused on heroin users and those receiving opioid agonist therapies, such as methadone or buprenorphine, not opioids like Oxycodone and Hydrocodone (Cleary et al., 2011; Dasche et al., 1998).

Medication-assisted treatment (MAT) is the standard medical recommendation for pregnant women with opioid use disorder (PWOUD) regardless of the type of opioid exposure (Mattocks, Clark, & Weinreb, 2017). However, substitution of buprenorphine, an alternative office-based treatment, is considered less stigmatizing for women than methadone; although buprenorphine treatment, while sanctioned by NIH guidelines, is also not FDA approved for use in pregnancy. Additionally, Medicaid may not always cover buprenorphine treatment, and the Drug Enforcement Agency has a federal cap of 100 patients per year for each individual provider prescribing this treatment. This limitation often precludes access to buprenorphine-assisted treatment by PWOUD of a lower socioeconomic status without private insurance. Compared to buprenorphine, which can be prescribed for a 2 to 3 week period, methadone requires a daily clinic visit. Differences in treatment regimes can contribute to health disparities and further distress. However, there are some cases in which methadone providers allow “take-homes” based on clear, prescribed rules set by federal standards. In addition, there is concern that not all buprenorphine providers who may be primary care physicians or general practitioners have had adequate addiction training (Dacharme, 2007). Primary care physicians’ limited knowledge of pregnancy may lead them to refer a PWOUD to an obstetrician with limited training in addiction.

Another possible treatment option for a PWOUD is medical withdrawal via taper and the introduction of a residential or outpatient opioid-free treatment program (Pritham, Troese, & Stetson, 2007; Luty, 2003). There appears to be scant research on substitution-based opioid detoxification and abstinence-based treatment as an alternative option for PWOUD (Sander &

Hays, 2005). Taper is the acute treatment of opioid dependent individuals by lowering blood levels of the drug slowly to allow the body to adapt to the absence of the drug; throughout the treatment, pharmacological and psychological support measures are used to suppress withdrawal effects (Pritham et al., 2007). The concern with medical withdrawal includes risk of relapse, renewed exposure to shared and reused needles, risk of HIV and Hepatitis C, and illegal activity when women shift from prescription opioid to heroin (although HIV and Hepatitis C are not applicable to prescription opioids) (CSAT, 2005)

### **The Effect of Stigma on Recovery**

Pregnant women who abuse drugs receive very high societal condemnation (Finkelstein, 1994). According to Covington (2002), stigma (i.e., severe social disapproval) is the main psychological issue differentiating substance abuse concerns of females from those of males. Furthermore, the author states that substance dependent women often internalize this stigma and experience guilt, shame, despair, and fear. Carter's (2002) article addressed the stigmatic and societal attitudes toward perinatal drug abuse. For example, treatment providers may assume that a pregnant woman who is also misusing prescription painkillers would be an unsuitable parent, and when referred to child welfare authorities, her drug use becomes a legal issue. This moral construction blames the mother as the responsible party, rather than assessing social resources that would enable safe parenting and recovery from addiction. This fundamental attribution error assigns problems exclusively to the disposition and behavior of the pregnant patient and ignores contextual factors (Croskerry, 2002). It does not acknowledge potential strengths that the woman may have. It is well documented that some providers' deeply held cultural beliefs and stigma commonly result in punitive responses toward prescription-opioid dependent pregnant women

(Valez & Jansson, 2008). Carter (2002) suggests that perinatal care for women who are addicted should be less a legal issue (i.e., Child Protective Service involvement), and more of a health issue.

Stigma is present for the pregnant woman even when she is on medication-assisted treatment. This construct has the potential to become a reality with no alternative perspectives possible (Urek, 2005). For example, in spite of its initial philosophy of a “temporary harm reduction” intervention, medication-assisted treatment appears to be administered for an indefinite period, and this practice can essentially label the woman throughout the pregnancy and postpartum period as an “addict.” Additionally, there is a difference of opinion concerning medication-assisted treatment and whether it is in fact an acceptable treatment choice for some, or whether it is at best a temporary treatment choice that should be ended as rapidly as possible. The ongoing status of “drug dependent” can influence and affect medical and social treatment of PWOD and their future children.

In addition, gender-specific social expectations of a woman certainly exist. If a pregnant woman is noncompliant with the recommended substance-abuse treatment and prenatal care, she may be considered an inadequate parent, an inadequate person, and eventually, an inadequate woman (Urek, 2005). The woman is stigmatized as an immoral and deficient parent, first for being opioid dependent, and then for being on medication-assisted treatment. All of this has the potential for shaping the woman’s experience of herself and her ability to make informed choices about her treatment, whether for addiction or pregnancy, as well as who she might choose to have authentic conversations with and in whom she confides. As such, the PWOD may live in secrecy or continual anxiety in order to manage the shame she perceives from medical providers.

### **Impact of the Child Welfare System on PWOUD's Recovery**

Pregnant and parenting women with substance use disorders (SUDs) risk entering the child welfare and criminal justice systems when seeking prenatal care. The legal implications and their association with mental health and substance use are understudied. In 2012, among 18 states with laws that permit child abuse charges for illicit drug use in pregnancy, MAT was used in 33.15% of treatment admissions compared with 51.33% of admissions in states without a punitive law (Angelotta, Weiss, Angelotta, & Friedman, 2016). If an infant is removed from a mother's care, this could be detrimental to the infant's mental health. Therefore, building maternal capacity should be a priority to support mothers and their infants. Attachment disorders can lead to significant emotional, social, and academic issues later in a child's life as well as the possibility of developing substance use disorders (Mirick & Steenrod, 2016). A meta-analysis on the factors associated with mothers who use substances found that mothers with negative outcomes (e.g., lost care of their children) reported less family support, more social isolation, and fewer interpersonal resources (Canfield, Radcliffe, Marlow, Boreham, & Gilchrist, 2017).

### **Impact of Trauma**

Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening resulting in lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being (SAMHSA, 2014). The comorbidity of trauma and substance use is well documented in the scientific literature. A meta-analysis conducted to estimate substance use rates found higher rates in those with trauma compared to those without trauma (Mauritz et al., 2013). Pronounced differences in childhood sexual abuse stress the importance of gender-specific treatment, with women five times more likely to report childhood sexual abuse (Cosden, Larsen,

Donahue, & Nylund-Gibson, 2015; Giordano et al., 2016; Sanford, Donahue, & Cosden, 2014; Linden, Torchalla, & Krausz, 2013). Pregnant and postpartum women with substance use disorders have the potential for re-traumatization in environments such as healthcare and family courts and necessitate a trauma-informed approach (SAMHSA, 2015).

In a qualitative health study (Howard, 2015) the two major fears PWOUD expressed were having their infants removed from their custody by Child Protective Services (CPS) and their infants having Neonatal Abstinence Syndrome. The potentially stressful perinatal and postpartum periods can impact a mother's mental health and long-term recovery. It is unknown how infant removal by CPS impacts recovery, specifically relapse and posttraumatic stress disorder. In a longitudinal study on custodial status for women with substance use, 60% of the women who received integrative treatment had longer periods of recovery from alcohol and drugs than those who did not receive integrative treatment. Furthermore, they had secure housing, support for staying sober, and retained custody at the end of the study (Grant et al., 2011). Including infants as part of a woman's recovery process and recognizing the importance of attachment to her infant is a motivation for long-term recovery (Kruk & Banga, 2011). As the number of parents with opioid use disorders has increased, the number of infants and children in foster care has increased, thereby decreasing overall resources to serve families. Consequently the need is great for continued research regarding the use of stigma reduction strategies and trauma-informed, gender-specific policy practices to support families impacted by substance use. The following case examples demonstrate the importance of trauma-informed, gender-specific treatment that reduces stigma and increases recovery in PWOUD.

## Case Vignettes

### **Case 1: Polysubstance Use and Complicated Grief**

This is a case of a 27-year-old woman, 22 weeks gestation with no prenatal care. During her initial screening assessment, she reported having 11 years of polysubstance use of heroin intravenously, anxiolytics, and cannabis. She admitted that she had 2 other children who were residing with their father while she sought treatment. She reported that she had been diagnosed in the past with Bipolar I disorder, Generalized Anxiety Disorder, and Major Depressive Disorder. She also said she had a history of unresolved grief from the loss of her grandparents who raised her and some close friends who died from opioid overdoses. In addition to her unresolved grief and loss, she had other challenges: shame, cravings, poor impulse control, homelessness, poor family support, and unemployment. She reported that she last used heroin a few hours before she was admitted to the hospital, and the medical doctor informed her that she needed to wait 24 hours before she was inducted to medication assisted treatment (buprenorphine) and required several examinations to determine the medical status of her and the fetus. She was examined, treated, and then discharged from the hospital a week later. The perinatologist at the hospital recommended that the woman continue prenatal care with her and that she begin with a substance abuse treatment facility that specializes in maternal substance use and has a comprehensive treatment team, which uses a nonjudgmental approach consisting of obstetricians, licensed mental health clinicians, case managers, medical behavioral technicians, and doulas.

### **Case 2: Polysubstance Use and Unresolved Trauma**

The second case describes a 37-year-old woman who presented at an urban hospital at 33 weeks gestation with her fifth child to be treated for her heroin use disorder. At the hospital she needed to be inducted to MAT and examined, because she had no prior prenatal care. She was

inducted to buprenorphine and examined. It was recommended that she continue with the perinatologist and also that she engage in a substance abuse treatment program with a multidisciplinary treatment team specializing with pregnant women. She admitted to having more than 20 years of substance use but no history of treatment for her addiction. She explained that her current pregnancy was important to her because she was never a mother to her other four children, due to her addiction, and wanted to be a suitable parent to this one. She shared that she had 4 children total and had her first child when she was 16 years old. Her 10-year-old son and 17-year-old daughter were adopted; her 13-year-old daughter had always lived with her father, and her 21-year-old son also never lived with her and was currently living on his own. Prior to her arrival at the hospital, she was homeless and reported living on the streets for more than 5 years; during that time, she reported being incarcerated for 3 and a half years. A big fear for this pregnant woman was that she could possibly lose the child because she would test positive for opioids due to her MAT, and then CPS would become involved. She also reported pending legal involvement from a past charge. She explained that she was diagnosed with Generalized Anxiety Disorder when she was 18 years old and voiced that she would like to be treated for that and her addiction to opioids, stimulants, and cocaine, as well as alcohol abuse. She shared that while she was in the hospital recently, her mother passed away, which was emotionally difficult because they shared a close relationship. She mentioned that her sister also passed away a year ago and voiced that she would like help for her feelings of grief and loss. She further explained that she had an extensive history of unresolved trauma after many years of physical, mental, emotional, and sexual abuse by some ex-boyfriends with whom she had relationships when she was between 12 and 29 years old. She expressed that her pregnancy was what motivated her to make a life change, maintain a life of long-term sobriety, and finally be the parent that she would like to be to her child.

### **Theory-based Practice Considerations**

Major influences to consider when treating pregnant women with opioid use disorders (PWOUD) are the impact of shame on the person and the potential involvement with the child welfare system. Shame comprises many feelings, such as embarrassment, a sense of failure, overwhelming worthlessness, and feeling less-than. Shame is often considered the core of substance use disorders. The theoretical model called the compass of shame demonstrates the four major strategies individuals use to cope with the overwhelming feeling of shame: withdrawal (isolating oneself), avoidance (abusing drugs and alcohol), attacking of self (self put-down), and attacking others (lashing out verbally or physically) (Nathanson, 1992).

The shame associated with being pregnant and using substances is often a barrier to seeking integrated treatment during pregnancy. Brown's study (2006) demonstrated that shame is correlated with a wide range of mental and public health issues, including self-esteem and self-concept issues, depression, addiction, eating disorders, bullying, suicide, family violence, and sexual assault. The woman in case 1 reported having a few of the aforementioned barriers that would prevent her from achieving long-term sobriety. Those barriers included poor impulse control, unwillingness to take positive suggestions, low self-esteem, inability to forgive herself, and fear of child welfare involvement. When a pregnant woman on substances is experiencing shame and external stigma, it can increase her feelings of worthlessness and fear. Shame contributes to feeling trapped, powerless, and isolated, which may prevent help-seeking behavior (Brown, 2006). Along with the medical treatment and follow-up care, the multidisciplinary treatment team worked with this pregnant woman to learn how to live a structured life, how to emotionally express herself, how to overcome her feelings of shame through shame resilience theory (SRT), and how to gain and utilize her sober community for the support needed to maintain

her sobriety. These goals were each challenging. However, by working with a nonjudgmental and supportive team, this woman was able to minimize the immediate stigma that a pregnant woman using substances would usually experience. Support from the multidisciplinary team afforded this woman the hope and empowerment she needed when her self-esteem and shame were too elevated for her to be resilient from shame and stigma.

In addition to SRT, self-determination theory (SDT) assists treatment providers in understanding the individual's psychological needs to support her inclusion in health decision-making. SDT is an approach to human motivation and personality that encompasses three psychological needs of the individual: (a) autonomous motivation, (b) competence and capacity for change by providing information and support for efficacy with respect to autonomously selected goals, and (c) relatedness to the change agent through a relationship characterized by unconditional positive regard (Ryan & Deci, 2000; Ryan & Deci, 2008). Within SDT, the construct of autonomy concerns the self-endorsement of one's behavior and the accompanying sense of volition. The medical and clinical importance of SDT is that when individuals are more autonomously engaged in the treatment decisions, they will be more likely to integrate behavior change, resulting in more positive health outcomes (Ryan & Deci, 2008).

Specifically, SDT proposes that health behavior consists of two psychological factors: (a) the patients' perception of autonomy, and (b) competence concerning their health behavior (Williams, Niemiec, Patrick, Ryan, & Deci, 2009). SDT also focuses on the social environment and the potential obstacles that may impede the social function and well-being of the person. Research on health decision making, such as Ryan and Deci (2000), identifies that failure to provide autonomy support by the provider to the patient contributes to alienation, ill-being, and poor outcomes. Autonomy support is defined by these authors as the health care provider eliciting

and acknowledging patients' perspectives, providing a clear rationale and effective options for change to the patient, supporting patients' initiatives for change, and minimizing external pressure and control (Williams & Deci, 1996).

SDT suggests that an important factor affecting patient engagement and treatment maintenance is whether patients feel autonomous in treatment settings or controlled in treatment settings. SDT has been used as a theoretical framework for many health behaviors: greater attendance and involvement in an addiction treatment program (Ryan, Plant, & O'Malley, 1995), facilitating long-term tobacco abstinence (Williams et al., 2009), and methadone maintenance treatment (Zeldman, Ryan, & Fiscella, 2004). Given some of the populations in which this framework has been explored, it appears to be an optimal framework by which to begin understanding how pregnant women who are drug dependent experience self-determination in dialogues with their health providers. SDT illuminates the psychological and emotional requirements for the inclusion in health decision making and demonstrates the importance of professional support for autonomy in the medical care of pregnant women who have an opioid use disorder.

Many pregnant women or nonpregnant women with opioid use disorder (or any other substance use disorder) have a history of trauma. This suggests that having a history of unresolved trauma can lead to substance use and ultimately addiction. In case 2, the 37-year-old woman shared that she was seeking treatment not only for the substances she was using, but also for the trauma she experienced. Substance abuse treatment programs utilizing a multidisciplinary approach empower women to use their voices to request the care they would like during treatment. It is important that women in general and especially pregnant women using opioids or other substances receive support for various aspects of their lives while they are in treatment. These aspects include

addressing legal issues, perinatal issues and follow-up, trauma, nutrition, and housing for postpartum women and their infants. By receiving the suitable support needed while in treatment, women can express their unmet needs and can recognize they have a choice of what goals they choose to work on and from whom and where they receive their care and treatment. SDT connects one's personality, determination, and level of functioning together, thereby producing two types of motivation: intrinsic and extrinsic. Intrinsic and extrinsic motivation determine our behaviors (Ryan & Deci, 2000). Pregnant mothers have an intrinsic motivation that can help them to stop using substances, seek treatment, and learn skills to be a parent. Motivation plays a pivotal role in the initiation and maintenance of behavior change, including the cessation of addictive behaviors such as smoking (Heppner et al., 2011). A woman's motivation initiated during pregnancy can be maintained during treatment and postpartum if given adequate support by a compassionate multidisciplinary staff, trained and willing to provide each pregnant woman with encouragement when her motivation is low and the ongoing empowerment needed as she works toward obtaining her goals.

### **Conclusion**

Researchers have found that there is a lack of training for substance use counselors regarding trauma approaches, and they acknowledge there is lack of gender-specific treatment in the US (Acquavita et al., 2016; SAMHSA, 2017). Integrating trauma-informed services will increase clinical outcomes in alleviating trauma symptoms and decreasing problematic behavior associated with opioid use disorder. Acknowledging and addressing the multifaceted complexity of maternal substance use, prenatal care, nutrition, and housing, and addressing unresolved trauma and complicated grief is essential in the treatment of maternal substance use. It requires comprehensive, coordinated, and compassionate care from multiple disciplines. The potential for

transformational growth with women of childbearing age using a trauma-informed and SRT/SDT framework is conceivable in alleviating the profound effect the opioid epidemic has on individuals, families, and society.

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