Journal of Substance Abuse Treatment, Vol. 2, pp. 27-34, 1985
Printed in the USA.

0740-5472/85 $3.00 + .00

ORIGINAL CONTRIBUTION

When the Client is Pregnant: Information for Counselors

ANN WILLIAMS, RN-C, MSN

Yale University School of Nursing

Abstract— *This article explores the issues raised by methadone maintenance during pregnancy with a focus on intervention techniques for the drug counselor. Establishing and maintaining the appropriate dose of methadone is discussed. Prenatal care issues are reviewed and the counselor is suggested as a liaison with traditional sources of prenatal care and education. Postpartum experiences in the intensive care nursery are presented and recommendations about breast feeding offered. Specific activities are suggested for the drug program.*

Keywords— Pregnancy, methadone, prenatal, postpartum

INTRODUCTION

THE ATTRACTIVE WOMAN slumps over the armless chair. Her long black hair falls across her face as she leans heavily over her swollen belly. The hands resting on her knees are pock-marked and swollen as she tugs nervously at the sleeves of her blouse, pulling the cuffs over her wrists. She is 8 months pregnant.

"Why did you decide to come on the program now, Gloria?"

"I'm tired; just so tired. I can't make it out there on the street anymore."

A chubby-faced, bright-eyed young woman sits on the exam table in the medical unit and beams at the nurse. She looks no more than 15 but is actually 23 years old. She's been on methadone maintenance for 2 years and hasn't used heroin for 18 months although she takes an occasional Valium. She is married to another methadone client and is battered by him.

"Oh no, I don't want to talk about birth control. We *want* another baby. Methadone babies are so beautiful!"

Approximately one third of the estimated half million persons using heroin regularly in the United States are women. The great majority of these women are of childbearing age and do not practice contraception (Eldred & Washington, 1975; Williams, 1981). The scenes above are therefore painfully familiar.

An overused stereotype suggests that "women are hard to work with" and "women addicts are sicker than men." In fact, personality differences between male and female addicts appear to be slight (Deren & Koslowsky, 1977) and only negligible differences have been found between successful treatment outcomes for male and female drug abusers (Rosenthal, Savoy, Greene & Spillane, 1979). Two studies comparing female and male addicts at the Lexington U.S. Public Health Service Hospital suggested that the characteristics of female addicts are similar to those of male addicts (Ellinwood, Smith, & Vaillant, 1956; Williams & Bates, 1970).

It is essential, therefore, that service providers recognize that chemically dependent females are not any "sicker" than their male counterparts. They come from similar socioeconomic backgrounds and they have a similar potential for successful treatment outcomes. The social or biological differences that *do* exist between males and females are most obvious when the client is pregnant. The pregnancy, a visible and inescapable reminder of the client's femininity, triggers feelings and responses as painful and threatening to the clinician as to the client. These reactions may indeed foster an outlook that these women are "hard to work with."

METHADONE AND PREGNANCY

Prior to the advent of methadone maintenance as a treatment for heroin addiction and the development of sophisticated neonatal technology, the neonatal morbidity and mortality associated with maternal narcotic dependence were extremely high. By 1979, straightforward, effective, safe protocols for the medical management of drug dependence in preg-

Requests for reprints should be sent to Ann Williams, Assistant Professor, Yale University School of Nursing, 855 Howard Avenue, P.O. Box 3333, New Haven, CT 06510.

nancy and the neonatal period had been developed (Finnegan, 1979). For most patients, methadone maintenance is recognized as the outpatient treatment of choice in narcotic dependent pregnancy, in conjunction with an intensive program of prenatal care and social supports. Pregnant clients on a methadone maintenance program commonly fall into one of two groups: those who joined the program after they became pregnant and the women who became pregnant while on a maintenance program. Although the literature generally treats pregnant narcotic dependent women as a homogenous group, these are two distinct populations with different needs.

Entering Treatment While Pregnant

Women who enter drug treatment during pregnancy do so for a variety of reasons. Often, like Gloria, they come late in the pregnancy when they have simply exhausted their resources for survival in the very rough world that is the heroin subculture. They come for care in the second or third trimester and most often present to the drug treatment facility before seeing a prenatal clinician.

When asked why they came for treatment, these women generally say, "for the sake of my baby." Program staff must carefully interpret this statement; clients do not generally mean "I knew that methadone was the best thing for my baby." For example, these expectant mothers usually have little understanding of the concept of maintenance therapy and have tried self-withdrawal before coming to the program. They may have been intermittently dependent on narcotics for years and be proud of the fact that "I never had a drug baby. I always was clean before the baby came." They will see methadone as a major problem for their baby and their dependence on methadone as failure—if they were really good mothers, they would have "cleaned up" without it.

To counteract such a negative self-evaluation, program staff can educate and orient these clients to the fact that (a) they have acted in their baby's best interest by joining the methadone program, and (b) no matter how disorganized, chaotic or incompetent the woman may seem, she has demonstrated her concern for her child by coming for help. Staff can recognize, respect and reinforce this concern by acknowledging the woman's help-seeking behavior.

No longer faced with the daily hussle for drug money and drugs, the client is faced now with daily clinic visits, program demands and prenatal needs. On one hand, she must comply with a somewhat arbitrary and initially infantilizing system and on the other she must prepare to accept responsibility for the well being of another human being. These developmental tasks usually occur at different points in the life cycle and therefore may be in conflict when the counselor first comes in contact with the pregnant client.

Induction Onto Methadone

Establishing the dose of methadone during pregnancy is difficult. The usual questions and feelings around low versus high dose maintenance become entangled with clinician and client concern about the fetus. The goal should be to maintain pregnant women on the lowest possible dose of methadone necessary to forestall illicit opiate use and the advent of withdrawal symptoms.

The mother-to-be sees daily methadone as more of a problem and threat to her baby than occasional heroin use. She is much less likely to ask for an increase in dosage spontaneously when she is pregnant. It is extremely important to give permission for needed methadone increases before the woman self-medicates with street drugs or alcohol. Encouraging the client to state how she feels and whether or not she is tempted to return to drug use gives the client and counselor further opportunity to explore this area.

Pregnant women should receive increases in their daily dose of methadone when they report that they are considering or tempted to use opiates and whenever the results of urine screening indicate active drug use. Dosage increases should be offered in a positive, nonjudgmental manner. It is far safer for an expectant mother to take a higher dose of methadone than to be exposed to the myriad of medical and social complications of street drug use, even when the exposure is only intermittent. If the counselor is secure in this knowledge, it will be easier for the client to accept her need for medication.

Pregnancy During Maintenance Therapy

The woman who becomes pregnant while she is in treatment for drug dependence has both emotional and physiological needs. She has been through the initial period of program adjustment and has a treatment relationship already established with a counselor and/or peer group. She is also more likely to come for confirmation of the pregnancy in the first trimester and thus can be referred to prenatal care earlier.

In this case, the pharmacological question is not induction onto methadone but whether or not, and how much, to decrease an already stabilized daily dose of methadone. The initial impulse of both the client and her obstetrician/midwife is often to attempt to decrease, or eliminate the methadone as soon as possible "for the baby's sake." Women become angry and confused when they are caught between demands from family and professionals that they "get off the methadone," and the drug program's reluctance to withdraw the client. It is essential to explain the risks

of spontaneous abortion associated with detoxification in the first trimester and the increased risks of fetal distress and premature labor during the third trimester (Cannaugton, Reeser, Schut, & Finnegan, 1977; Zuspan et al., 1975).

Even in the best of circumstances, pregnancy is a time of psychological and physiological stress. The year following childbirth is also inherently stressful. During this period of time, clients are at great risk for returning to illicit drug use or alcohol abuse. Most clients will benefit from the support and structure offered by the drug treatment program. The support of a sensitive counselor, sharing of experiences with peers, and a very gradual detoxification program during the first postpartum year constitute a better plan than immediate detoxification for the stable client.

Withdrawal

Following a thorough medical evaluation, it is possible to cautiously withdraw a pregnant woman from methadone during the second trimester. For some women, overwhelmed by guilt or intensely pressured by their spouse or family, the psychological benefit of a decrease in methadone dose justifies the risk. In these cases, a decrease of 5 mg every other week between the 14th and 28th week of gestation is considered safe (Finnegan, 1979). The woman should be reminded that she can stop the withdrawal process or even request an increase any time she feels increased anxiety, feels tempted to use drugs, or resumes drinking.

She need not be completely withdrawn in order to experience relief of anxiety and guilt. Often a decrease of 10 to 20 mg is adequate to demonstrate to the client and her significant others that she has made an effort for the sake of her child. If the client can be maintained on a low dose, she continues to have access to the resources and support of the program and the counselor can accordingly monitor her progress for the remainder of the pregnancy.

In addition, some women may require an increase in methadone dose during the third trimester of pregnancy due to increased tissue binding and metabolism of the drug (Kreek, 1983). Women should be forewarned about this possibility and their situation assessed in the third trimester.

Case History. Valerie, the 32-year-old mother of two small children, had been on a methadone program for 3 years. She and her husband were detoxing slowly and looking forward to completing the program and leaving the state. She then discovered she was pregnant.

Her detox was halted at 35 milligrams a day. Six months later, when her husband was drug free, Valerie's counselor noticed alcohol on her breath when she came for appointments. When questioned, Valerie said she had been feeling "shakey" but didn't want to ask for an increase because her husband was angry with her for still "being on the program."

The counselor had a joint session with Valerie and her husband to discuss the rationale for continuing maintenance therapy during pregnancy and to provide gentle information about the risks of alcohol to the baby.

Once she felt that her husband had provided "permission" to continue maintenance, Valerie was then able to request a 5 milligram increase in her methadone dose and subsequently stopped drinking. After the birth she was encouraged to wait 6 months before resuming her slow detox, which was finally completed when her child was 1 year old.

PRENATAL CARE

Previous research has provided clarification and documentation that the key to reducing the incidence of low birth weight, prematurity, and morbidity in the offspring of drug dependent women is the amount and quality of prenatal care obtained by the mother. Methadone therapy alone will not significantly improve neonatal outcomes in a drug dependent pregnancy. But when methadone maintenance is combined with an average of eight prenatal visits, the incidence of low birth weight, prematurity and morbidity is significantly reduced (Finnegan, 1978).

Therefore, our most important task is to ensure that pregnant clients obtain the needed prenatal care. The ideal situations are those model programs that combine prenatal, perinatal and postpartum services with a program for treatment of drug dependence. More often, clinicians in community-based drug programs must refer pregnant clients to local hospitals and clinics.

Unfortunately, the pregnant addict often has a tumultuous relationship with health care providers and systems. The tensions and negative experience engendered by prior drug seeking behavior are complicated during pregnancy by feelings of guilt, anxiety, and fear. Busy clinicians in inner city prenatal clinics may be easily frustrated by a mother's inability to modify her behavior and experience personal and professional distress as they anticipate the newborn's psychosocial environment. The dynamics of addiction and the philosophy of drug treatment programs are often unfamiliar to prenatal clinic staff. Tension between clients and staff combines with the addict's anxiety and guilt to keep her away from traditional sources of prenatal care and education. Therefore, this group of women, in desperate need of childbirth information, nutritional monitoring and teaching, counseling and support, receives minimal prenatal care and little postpartum follow-up.

RECOMMENDATIONS

Health Care Institutions

Short of actually providing these services, how can drug treatment programs and clinicians intervene to improve care for the pregnant and addicted client? The crucial role is that of liaison between the client and the prenatal clinic or hospital service. In addition to providing the needed referral note, the liaison service must operate actively in two directions: providing information and interpreting for both the prenatal clinicians and the pregnant client.

Case History. Linda was a soft-spoken, gentle appearing woman who was admitted to a community methadone program on a priority basis because she was pregnant. She lived with her mother and one school-aged child. Another child had died in infancy of crib death. Her spouse was not part of the family system. Linda was referred to the local hospital's prenatal clinic and reported back regularly to her counselor that her check ups were going well, she liked the clinic, and the baby was fine.

Four months later the staff nurse from the program had a concern about adjusting Linda's methadone dose; when she called the hospital to discuss it, she discovered that after the first visit Linda had not returned to the prenatal clinic. Confronted with this information, Linda said she had been too "upset and shy" to go to prenatal clinic, but that she hadn't wanted to "cause trouble" at the program or worry her counselor.

Linda's counselor took two steps. Although her caseload was very full and would not permit it on a regular basis, she accompanied Linda to her next check-up and while there made it a point to introduce her to the head nurse. The counselor also arranged to have the prenatal clinic notify her whenever Linda missed or kept an appointment with them.

Given this increased support and structure, Linda was able to maintain a good level of prenatal care until delivery.

Care Providers

Obstetricians, midwives, nurses, and social workers are among the care providers who will come in contact with addicted clients when they are referred. These professionals will ideally understand methadone treatment, particularly the difference between maintenance and detoxification. There should be an awareness of the treatment philosophy of the referring program and how interagency cooperation can be achieved for the maximum care of the client. Every woman coming to a clinic from a methadone maintenance program should have a counselor involved in her care, and the prenatal clinic should know who that counselor is.

This fact is especially critical when one considers that prenatal clinicians are often overwhelmed by the sheer volume of needs with which the pregnant addict presents—needs for financial services, medical services, housing, parenting support and violent partners, just to name a few. The resulting countertransferential feeling may be that of helpless frustration, annoyance, or anger. Learning that another health care professional has been consistently involved in the client's treatment will relieve a significant amount of anxiety about providing medical/clinic services for these women. In turn, having program and clinic staff working cooperatively may significantly transform the client's reception in prenatal clinic into a positive experience.

When the program counselor makes herself known to the prenatal clinician, a major avenue of communication is opened. The counselor can be a reliable source of information concerning methadone dose, current drug use, and sources of psychosocial stress for the client. The counselor can assist in interpreting angry, hostile or noncompliant behavior on the part of the client, which might otherwise be inexplicable to clinic staff.

The actual services provided by the methadone program counselor will vary tremendously as a function of program resources and the prenatal clinic. Some counselors will have only brief telephone or written contact with the prenatal clinic while others will accompany clients to the prenatal check up appointments. Whatever the pattern, it is important for the counselor to join with the prenatal clinic in a comprehensive and caring approach and not simply be utilized as a watchdog around issues like missed appointments and dirty urines. Prenatal clinic staff will follow the lead of the drug program staff, and methadone counselors may serve as role models to teach other professionals how to treat our patients.

Clients. Pregnant clients need a tremendous amount of support as they approach traditional sources of prenatal care. They may have already been in contact with the particular system, often during earlier pregnancies or visits to the emergency room. In addition to their own past experiences, rumors abound on the street, tales of denied pain medication and infants "taken" by the state. Clients expect to be treated badly, and expect they will have to defend themselves.

In addition to these anticipatory concerns, pregnant, drug dependent women begin prenatal care with feelings of anxiety about the health of their baby, including guilt about having "caused" their baby's anticipated addiction and shame for their past or present life style. In contrast to the reality of their lives, most drug dependent women hold very conservative views of women as wives and mothers (Williams, 1981). The

contrast between what they believe a "good woman" is and what they are able to do makes these women extremely vulnerable to feelings of low self-esteem and shame. Vulnerability in this area is increased during pregnancy.

Painful feelings are masked by a presentation that is angry, aggressive, challenging and sometimes actively hostile. This approach is almost guaranteed to elicit the anticipated negative and punitive responses from the prenatal clinic staff.

There are two specific interventions the counselor can use when working with the client to defuse the potential explosion. First, by giving the client detailed information about what to expect from the clinic in terms of waiting time, schedules, procedures and care, some of the anxiety stemming from the unknown can be relieved.

Second, the counselor can present some of the feelings and dynamics behind the behavior of the prenatal staff. This is most useful when presented not as excusing another profession but simply as information—"Some people at the hospital may respond to you in this manner for this reason. This may or may not be a nice thing for them to do, but it is something you will face." Going on to discuss the client's feelings and responses is a logical next step and role playing is helpful here.

One hospital affiliated prenatal clinic always scheduled patient visits at 8 a.m. The visit was usually lengthy and involved a lot of waiting. Women referred to this clinic (the only one available) from the methadone program frequently missed the 8 a.m. appointments altogether or arrived late and were upset and angry when they were not seen but given another 8 a.m. appointment.

The prenatal staff were approached about afternoon appointments but were inflexible; hospital procedure was set.

Realizing that there was little they could do to change the situation at the hospital, the counselors for the Pregnant Women's Group initiated discussion of the problem in group sessions. The women vented their anger and frustration at some length in this setting and then were able to develop a partial solution: They decided to make their appointments all on the same day so that they would have company during the long waits. One woman who often got up early offered to call the others on the mornings of appointments so they would have a better chance of getting there on time.

Pregnant Women's Group

Although most hospitals and clinics offer some form of childbirth education, these classes are rarely attended by drug-dependent women for a multiplicity of reasons. Fees are often not picked up by the funding agency responsible for maternal-child health care. The client's lifestyle is rarely able to accommodate regular attendance at this sort of a group. The questions and fears uppermost in her mind—what will drugs and methadone do to my baby?—cannot be asked or answered in the traditional group at the prenatal clinic.

But pregnant clients are concerned and interested in information about their bodies, their pregnancies and their babies. They need a safe place to ask questions and to receive reliable information. By and large, in a community-based methadone program, it must be the drug program and not the prenatal clinic who provides this information.

One approach that has been found helpful is organizing a small, "special" group for pregnant women and new mothers only. The group provides a safe forum for didactic information, allows for the sharing of experiences, and development of a peer network. Furthermore, women's groups have been found to be the most appropriate intervention for women clients (Mandel et al., 1979; Wedenoja et al., 1982).

While there is no limit to the numbers of topics that may be addressed, it is usually best to combine some formal presentations of information with discussion. There is generally a positive response to didactic teaching but the group leader should be prepared to digress with the group when a subject arouses general interest or feelings.

Most clients need information about the anatomy and physiology of conception, body changes during pregnancy, nutritional needs during pregnancy, fetal development, the process of labor and delivery, postpartum physical changes, and birth control. They are also interested in the physical effects of methadone on their bodies and their babies, the process of neonatal withdrawal, and pain medication in labor.

Although clients may not feel comfortable attending a prenatal class given in a regular hospital or clinic, it is very helpful to have speakers—midwives, nurses or childbirth educators—come to the methadone group. Usually these professionals will welcome the invitation and it serves a dual purpose in providing the speaker with a more accurate impression of the program and the clients.

Many hospitals provide tours of the labor and delivery areas, postpartum rooms and nursery for expectant parents. Again, women from a methadone maintenance program may not feel comfortable on a regular tour and will need different information; for instance, they can expect that their babies will be in a special observation nursery. A tour planned just for women from the methadone clinic is of great benefit and can often be arranged.

POSTPARTUM ISSUES

The greatest challenge to the mother and her drug program clinicians is the immediate postpartum period. Following the pregnancy, labor, and delivery, all the unsolved problems of the new mother's life confront her at a time when she is feeling great guilt and anxiety about her child. Unless a supportive bond has been established and nurtured, there is an increased likelihood that the new mother will suddenly leave the methadone program.

Newborn Special Care Nursery

In most medical centers the infants of drug dependent women spend some time in an intensive nursery setting for observation and withdrawal from opiates if necessary. In many of these units there are other infants with congenital problems, extreme prematurity, and illness. To the unaware and untrained observer, the atmosphere, equipment, and staff may appear intimidating and frightening.

Drug-dependent women often mask anxiety and guilt with aggressive behavior. Due to their own low feelings of self-esteem, they are extremely sensitive to slights or negative behavior from nursery staff. They may accuse the staff of not taking care of their babies and not knowing how to help the baby in withdrawal. They may overreact to suggestions from the nursing staff about infant care. In some units, withdrawing infants are placed in isolettes that are covered with a blanket and set off from the main unit in order to decrease external stimulation to the baby. Mothers may interpret this as hiding or rejecting their babies if they have not been prepared.

In spite of numerous studies, it is not possible to predict exactly which infant will have a prolonged withdrawal and which will go home quickly. It is not realistic, useful, or supportive of the mother to attempt to relate the size of her methadone dose to her baby's withdrawal experience. The lack of clear answers can be very frustrating and upsetting to the mother. In her acutely sensitive and fragile psychological state, she finds it difficult to ask for information about her baby or to hear information when it is given.

Physicians, nurses, and social workers in the nursery are strongly identified as the infant's advocates. Liaison with these professionals is of immeasurable benefit, and they usually welcome the involvement and support of the drug program staff. Most drug-dependent mothers fear that their children will be "taken" from them. Although the process of child protection varies tremendously from state to state, removing a child from the mother's custody is not as easy or automatic as most clients believe. By working with both the mother and the caseworker, the program clinician can forestall misunderstandings and unnecessary confrontations.

Most intensive-care or observation nursery units monitor the contacts between mothers and infants. Nursery staff are appropriately concerned with the bonding between mother and child. This monitoring process may be as simple as counting the number of times the mother visits the baby. Letting the mother know that this is happening, reminding her to let staff know when she visits her baby (by signing in if the unit keeps a visitor log), and suggesting that she call the unit on days when she can't visit are all ways of ensuring that the mother gets credit for her concern and participation in her baby's care. Often clients will visit the babies during the evening or night shift at the hospital. It is important then that the day staff are aware of these visits.

Some individuals may consider drug dependence during pregnancy a form of child abuse. It is to be hoped that the mother's membership in a methadone maintenance program would be viewed as her sincere attempt to care for the unborn baby in an appropriate and healthy manner. Unfortunately, this is not always the case and professional education in this area is our task, not the client's. An informed pediatric caseworker will consult with the drug program when assessing an individual family situation. If this does not happen, then program clinicians should initiate the communication.

Breastfeeding

Data are sparse on the actual amounts of methadone present in the breast milk of nursing mothers, but it seems clear that in the first few weeks postpartum the newborn will be exposed to very small amounts of the drug. This breast milk exposure is insufficient to affect the neonatal abstinence syndrome (Blinick, 1975; Kreek, 1983).

When asked if they would like to breastfeed their babies, many pregnant clients are surprised that this is an option. They have assumed that they would not be permitted to nurse because their milk would be "bad" due to the methadone. While some clients would not choose breastfeeding for other reasons, they all should be informed that they do not have "bad" milk and be allowed to base their decisions on the same criteria as nonaddicted women.

The major obstacle to breastfeeding for the methadone-maintained mother is not the small amount of methadone in her milk, but the prolonged separation of mother and child. All mothers whose newborns must remain in the hospital have the same difficulty in establishing and maintaining a milk supply. Often successful breastfeeding in this period requires frequent hospital visits and use of a breast pump at

home. Realistically, this project is a major investment of time and energy. Too vigorous promotion of breastfeeding may develop a sense of failure and inadequacy in the mother.

But for women who are motivated, stabilized on methadone maintenance and not abusing other drugs, there are many advantages to breastfeeding and it can be safely encouraged in the first 3 months (Finnegan, 1979). In addition to the physiologic benefits to the infant, the mother's self-esteem rises with this very special something only she can provide for her child. For some women the responsibility and structure imposed by nursing a child can be very helpful in the immediate postpartum period.

All clinicians involved with the care of the mother and child have a responsibility to the child to monitor the nursing mother's concurrent drug use. If the nursery does not have the resources or inclination to collect supervised urine specimens on a frequent basis, then the drug program should do so. Most women respond positively to being told that increased urine surveillance is part of the management of breastfeeding; some are relieved, feeling that this external structure will help them maintain their intention to stay free of all drugs except methadone.

Case History. Martha was a 21-year-old single woman admitted to the methadone program when she was 2 months pregnant with her first child. The father of the baby was unknown. At the time of admission she shared a room with another woman and two children in an apartment that was frequently used as a shooting gallery.

During the pregnancy she struggled to make order from her chaotic life. She registered for public assistance and food supplements, attended the prenatal clinic and the methadone program regularly, found a small apartment and moved out of the shooting gallery. Martha wanted a natural childbirth—she got books out of the public library and attended the hospital Lamaze classes. She was the only single mother in the class.

The birth went well. Her son was large and healthy and Martha was pleased. But although his withdrawal process was smooth, it was 10 weeks before he could come home from the hospital.

Martha wanted to nurse her son. She came to the nursery several times a day and she borrowed a breast pump to use at home. But she was also a fragile, young mother and she worried a lot. She stayed up nights painting her apartment "so it would be ready for the baby." She made friends with the downstairs neighbors who "chipped" heroin and cocaine.

Clinic staff noticed that Martha was looking very drawn and pressured. Then a random urine screen was reported with quinine. When confronted, Martha admitted using heroin "once or twice" and also talked about feeling guilty and afraid. She didn't know if she would be a "good" mother; she wanted her son to come home but didn't know what to do when he did. And she was having a hard time using the breast pump. She didn't think her son was getting enough milk.

After a long discussion, Martha decided to try hard to resist the temptation to use drugs again. She also chose to stop nursing her son, feeling that the pressure to "produce" was part of her stress. In addition, her counselor referred her to a local agency providing parenting support for high risk families.

Birth Control

Planning for future pregnancies is an integral part of postpartum care for all women. Unfortunately, many women do not keep the 6-week check-up appointment to explore contraceptive options. As inpatients, drug dependent mothers may be aggressively recruited for sterilization procedures, making future discussions about birth control difficult.

Contraception should be presented as a tool for empowerment and control. Studies have shown that the majority of women in drug treatment do not desire more children immediately and that they also fail to practice effective contraception (Eldred & Washington, 1975; Williams, 1981). This paradox is not limited to women who are drug-dependent, but it lends itself well to group discussion. The clinician's goal should not be that all the women in the group have tubal ligations or "get on the pill," but that each woman makes a conscious, informed decision regarding what is in her best interests.

CONCLUSION

The pregnancy is just the beginning. Women who are opiate-dependent and mothers will need guidance and support for many years to come. A strong connection between the program staff and the client, made during the early days of therapy and pregnancy is of immeasurable benefit and can significantly improve program retention rates.

Pregnant women are perhaps the most challenging and most rewarding clients to work with on a methadone maintenance program. The very crisis that has brought them to treatment—an impending new life—can be a continuing stimulus to success in treatment.

Given ample amounts of respect, support, and encouragement, major changes in life situations do occur. And if we hope to have any impact at all on future generations, then where better to begin than with the pregnancies of our own clients? There is nothing more satisfying than watching competent, proud mothers smiling into their babies' eyes.

REFERENCES

Blinick, G., Inturrisi, C.E., Jerez, E., & Wallach, R.C. (1975). Methadone assays in pregnant women and progeny. *American Journal of Obstetrics and Gynecology*, **123**, 617–621.

Connaughton, J.F., Reeser, D., Schut, J., & Finnegan, L.P. (1977). Perinatal addiction: Outcome and management. *American Journal of Obstetrics and Gynecology*, **129**, 679–685.

Deren, S., & Koslowsky, M. (1977). Personality sex differences of narcotics addicts and treatment implications. *International Journal of the Addictions*, **12**, 541–551.

Eldred, C.A., & Washington, M.N. (1975). Female heroin addicts in a city treatment program: The forgotten minority. *Psychiatry*, **38**, 75–85.

Ellinwood, E.H., Smith, W.C., & Vaillant, G.E. (1966). Narcotic addiction in males and females: A comparison. *International Journal of the Addictions*, **1**, 33–45.

Finnegan, L.P. (1978). Management of pregnant drug-dependent women. *Annals New York Academy of Sciences*, **311**, 135–146.

Finnegan, L.P. (1979). *Drug dependence in pregnancy: Clinical management of mother and child.* National Institute on Drug Abuse, Rockville, Maryland.

Kreek, M.J. (1983). Clinical perinatal and developmental effects of methadone; critique. In: *Research on the treatment of narcotic addiction, state of the art.* National Institute on Drug Abuse, Rockville, Maryland, 444–453.

Mandel, L., Schulman, J., & Monteiro, R. (1979). A feminist approach for the treatment of drug-abusing women in a coed therapeutic community. *International Journal of the Addictions*, **14**, 589–597.

Rosenthal, B.J., Savoy, M.J., Greene, B.T., & Spillane, W.H. (1979). Drug treatment outcomes: Is sex a factor? *International Journal of the Addictions*, **14**, 45–62.

Wedenoja, M., & Reed, B.G. (1982). Women's groups as a form of intervention for drug dependent women. In: *Treatment services for drug dependent women*, Vol. II, National Institute on Drug Abuse, Rockville, Maryland, 62–136.

Williams, J.E., & Bates, W.M. (1970). Some characteristics of female narcotics addicts. *International Journal of the Addictions*, **5**, 245–256.

Williams, A. (1981). *Concerns of methadone addicted women about sexuality, contraception, pregnancy and motherhood.* Unpublished master's thesis, Yale School of Nursing, New Haven, CT.

Zuspan, F.P., Gumpel, J.A., Mejia-Zelaya, A., Madden, J., & Davis, R. (1975). Fetal stress from methadone withdrawal. *American Journal of Obstetrics and Gynecology*, **122**, 43–46.