

**Stigma, Violence, and Pregnancy:
Exploring Treatment of Women with Opioid Use Disorder**

by

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This paper analyzes interviews conducted with women seeking prenatal and postpartum care in a clinic focused on providing such care to women with opioid use disorder (OUD) in order to discuss factors that undermine their success in drug treatment. Among these factors are intimate partner violence, partners who also use opioids, and socioeconomic conditions. This paper shows that social attitudes toward pregnant women with OUD also contribute to their *not* seeking and/or sustaining treatment for OUD. It notes that while pregnancy is a moment of opportunity for women with OUD to seek treatment as part of prenatal care, features of healthcare and legal institutions in the United States prevent many women from taking advantage of this opportunity to treat their OUD and promote their health. This paper opens with an examination of Margaret Sanger's family planning movement, a movement that ostensibly sought to improve the reproductive and overall health of women by developing, and demanding legal access to, contraception. Sanger's movement was motivated by the goal of not only improving women's health, but also improving society through family planning, and placed the responsibility for such social improvement in large measure on women as mothers. Through her descriptions of unfit mothers and the familial and social ills resulting from their improper motherhood, Sanger articulates values of proper motherhood—both personal attributes and social conditions that would enable women to have children who contribute to society in the upper-middle class image of Sanger's own life and social contribution. This paper shows that values of proper motherhood, coupled with the stigma of illicit

drug use, inform current attitudes toward pregnant women and mothers with OUD, that these attitudes are internalized by women themselves, and that their seeking and sustaining drug treatment are negatively affected by these values and stigma.

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Preface

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1.0 Introduction

Between 1999 and 2014, the number of pregnant women with diagnosed with opioid use disorder (OUD) during delivery more than quadrupled, from 1.5 per 1,000 delivery hospitalizations in 1999 to 6.5 in 2014 (CDC, 2018). Historically, women with substance use disorder have been ill-served and even denigrated by medical, legal, and social institutions. The image of the “crack mother” that emerged during the 1980s incited a moral panic that fueled a classist and patriarchal model of the “fit” mother under the pretense of saving children from abuse and neglect (Humphries, 1999, p. 7). Social attitudes toward maternal drug use are evident in early reproductive health campaigns that ascribed deteriorating population health and social ills to irresponsible motherhood. This view of mothers as responsible for the integrity of society renders mothers who use drugs particularly vulnerable to condemnation and blame.

In some medical contexts, women who used drugs were perceived to have decreased fertility due to their substance use and were therefore considered a population unlikely to conceive (Pinkham & Malinowska-Sempruch, 2008). These assumptions were further fueled by notions of maternalism that considered motherhood to be one of women’s primary duties. Through maternalism and its integration with the early reproductive rights movement of Margaret Sanger, women’s bodies were largely considered to be vessels for future children. Thus, women with OUD are vulnerable to being labeled as bad or unworthy mothers even before they bore children and acted as mothers.

Contemporary medicine has reclassified chronic opioid use as a disorder rather than a personal choice or moral failing. This shift from *addiction* to *opioid use disorder* is part of a larger harm-reduction framework. One feature of this medicalization was to make people with OUD

more comfortable with seeking medical treatment, including replacement therapy, for their disorder. For women with OUD, this medicalization also invited them to engage in harm reduction in other aspects of their lives, such as their reproductive health. For example, compared to the 46 percent rate of unintended pregnancies in the general population, more than 86 percent of pregnancies in women with OUD are unintended (Krans, Kim, James, Kelley, & Jarlenski, 2018). The high rate of unintended pregnancy and the desire to reduce the effects of opioids on fetuses led to a prioritization of pregnant women with OUD to receive opioid treatment and its integration with prenatal care and postpartum birth control initiatives. While these interventions emerged to reduce the effect of maternal opioid use on fetuses, they failed to address the full range of women's needs. The high rate of treatment discontinuation after delivery suggests that these interventions targeting women primarily in the context of their pregnancies fail to address the health-related concerns in their various environments outside a clinic, both during and after their pregnancies.

To provide context for consideration of this conflation of women's health with their reproductive health, this paper opens in section one with an examination of Margaret Sanger's family planning movement, a movement that ostensibly sought to improve the reproductive and overall health of women by developing, and demanding legal access to, contraception. The discussion shows that Sanger's movement was motivated by the goal of not only improving women's health, but also improving society through family planning, and that she placed the responsibility for such social improvement in large measure on women as mothers. Rather than demanding that society provide conditions that would enable poor women to be mothers able of providing for the health and safety of their children, a feature of later reproductive justice movements, Sanger's movement was focused on reproductive rights—namely, the right to control the timing of one's reproduction through contraception. Through her descriptions of unfit mothers

and the familial and social ills resulting from their improper motherhood, Sanger articulates values of proper motherhood—both personal attributes and social conditions that would enable women to have children who contribute to society in the upper-middle class image of Sanger’s own life and social contribution. This first section also demonstrates that more contemporary “safe haven” laws similarly fail to provide the social support necessary for women to keep and support their children, and instead merely provide a means to prevent “unfit” mothers from having (i.e., keeping) their children.

Section two shows that values of proper motherhood were coupled with public fear of illicit drug use to portray pregnant women with substance use disorders as threats to society. From media images of crack babies and their irresponsible mothers to current concern about women with OUD, concern about women’s use of illicit drugs has focused on the impact of that use on their children. The values of proper motherhood inform current attitudes toward pregnant women and mothers with OUD. The balance of the paper shows that these attitudes are internalized by women themselves, and that their seeking and sustaining drug treatment are negatively affected by these values and internalized stigma.

Section three begins the analysis of postpartum interviews with mothers who received prenatal care while undergoing medication-assisted treatment (MAT) for their opioid use and focuses on their interaction with the healthcare system. Section four expands the discussion to include the women’s experiences with the legal system, including Child and Youth Service. Section five considers the role played by their partners and intimate partner violence in both their drug use and their seeking and sustaining drug treatment.

Together these sections explore how women with OUD are disproportionately “valued” during their pregnancies for the sake of the child they are carrying. This results in a paradox in

which women with OUD are given higher value due to their pregnancies but are simultaneously devalued through punitive policies and social expectation of their failure. These interviews with women who have OUD and received prenatal care and opioid treatment highlight how pregnant women with OUD today still face barriers when seeking long-term care and recovery. Despite the relatively newly medicalized model of substance use disorder that treats women and mothers with OUD as patients rather than criminals, this paper demonstrates that their complex needs may still be unaddressed due to a focus on their pregnancies rather than the factors that affect whether they seek treatment, remain in treatment, and are allowed to parent their children as they navigate personal and systemic obstacles. In keeping with a reproductive justice framework, which advocates for providing women the support they need to be able to care for themselves and their children (Ross and Solinger, 2017), this paper demonstrates women with OUD need care that does not just begin and end at a clinic, and that does not implicitly regard women primarily as valuable in virtue of being mothers.

2.0 Conceptualization of Proper Motherhood within 20th Century Public Health Movements

Preparation for motherhood through preconception care became a large part of public health initiatives in the last century. Miranda Waggoner (2012) coins the term “anticipatory motherhood” to frame how recent advances in women’s health and healthcare policy are focused on improving preconception care as a gateway to better motherhood. This conflation of women’s and maternal health results in women’s health being considered relevant primarily in terms of their potential motherhood. This conflation is bolstered by embrace of maternalism, the concept that has historically established women’s natural duty to be motherhood. Through this, women are considered “prepregnant” from the moment they begin puberty, and their lifestyle choices are judged in the context of their future pregnancies (Waggoner, 2012).

This maternalism informs how women are valued in the healthcare system, and suggests why women with OUD are vulnerable to being dismissed except insofar as they are viewed mothers. The preconception state of women with OUD is considered undesirable, both socially and medically. Social notions of proper motherhood are rooted in valuing mothers whose circumstances are desirable prior to their conceiving. What constitutes desirable circumstances of motherhood has varied historically, but 20th century reproductive rights movements provide context about what values shaped contemporary reproductive policies and social attitudes.

2.1 Maternalism, proper motherhood, and the reproductive right to limit childbearing

Maternalism and values reflected in the conception of appropriate motherhood animated the early reproductive rights movement of Margaret Sanger, a movement to grant women the right and means to control the timing of their pregnancies. These values of appropriate motherhood sprang, in part, from Margaret Sanger's own experience as a mother. Sanger had three children: the first two spaced over five years and the last one coming less than two years later. For Sanger, motherhood was a central part of her life: "My activities and interests and work outside seemed only for the purpose of completing and perfecting their lives. As Sanger became increasingly involved in the fight for birth control, she used her domestic life as a standard, an example of what motherhood could be if properly timed, under the proper conditions, and with proper resources. A self-proclaimed happy "joyous, loving, happy" mother, Sanger wanted to "share these joys with other women," something that she felt would be made possible through family planning and proper child-spacing (p. 46).

Since the birth of my first child I had realized the importance of spacing babies, but only a few months before had I fully grasped the significant fact that a powerful law denied and prevented mothers from obtaining knowledge to properly space their families. (Sanger, 1932, p. 46)

In contrast, Sanger witnessed as a nurse unintended pregnancies that led to what she considered to be unfit mothers, alienated fathers, and doomed children.

As I stood at the window and looked out, the miseries and problems of that sleeping city arose before me in a clear vision like a panorama: crowded homes, too many children; babies dying in infancy; mothers overworked; baby nurseries; children neglected and hungry—mothers so nervously wrought they could not give the little things comfort nor care they needed; mothers half sick most of their lives... women made into drudges; children working in cellars; children aged six and seven pushed into the labor market to help earn a living; another baby on the way; still another; yet another; a baby born dead—great relief; an older child dies—sorrow but nevertheless relief—insurance helps; a mother's death—children scattered into institutions; the father, desperate, drunken; he slinks away to become an outcast in a society which has trapped him... (Sanger, 1932, p. 56)

Sanger's case for family planning was predicated on what was evident to her: unplanned pregnancies in impoverished circumstances led to crumbling families and, by extension, a crumbling society.

Sanger portrayed poor families as significantly contributing to overpopulation and as undeserving and undesiring of sympathy. She frequently pointed to overpopulation and families having too many children as causes of widespread poverty. She focused on women who had neither the resources nor health to bear children and live to raise them, too. She wrote:

Constantly I saw the ill effects of child-bearing on women of the poor. Mothers whose physical condition was inadequate to combat disease were made pregnant, through ignorance and love, and died. Children were left motherless, fathers were left hopeless and desperate, often feeling like criminals, blaming themselves for the wife's death—all because these mothers were denied by law knowledge to prevent conception. (Sanger, 1932, p. 46)

Sanger's focus on mothers placed responsibility on women for their health, the health of their children, and the economic health of their households, and by extension, the health of society.

Although Sanger asserts that her work as a nurse exposed her to troubling situations in families of "rich and poor alike," she almost exclusively limits her criticisms to poor women (p. 48). Sanger's view of motherhood under less privileged circumstances was almost always bleak. She used descriptions of poor mothers and families as proof that population control is necessary. Sanger makes broad generalizations about poor women and their families that are harsh and fear mongering.

The way they live is almost beyond belief...The women slink in and out of their homes on the way to market like rats from their holes. The men beat their wives sometimes black and blue, but no one interferes. The children are cuffed, kicked and chased about, but woe to the child who dares to tell tales out of the home! (Sanger, 1932, p. 49)

By comparing women to rats and their homes to holes, Sanger dehumanizes them immediately. She extends this treatment to their husbands, suggesting they are all abusive as if it is a natural part

of a poor husband's existence. She further stigmatizes and devalues poverty by associating poverty with crime:

Crime or drink is often the source of this secret aloofness...The men are sullen, unskilled workers, picking up odd jobs now and then, unemployed usually, sauntering in and out of the house at all hours of the day and night...The women keep apart from other women in the neighbourhood. Often they are suspected of picking a pocket or 'lifting' an article when occasion arises. (Sanger, 1932, p. 49)

Although she often claimed she was fighting for joyful motherhood, Sanger seemed to consider pregnancy a disease or illness when it presented in poor populations. This discrepancy demonstrates that although Sanger's fight for birth control may have been borne out of a desire for more meaningful motherhood, it was also founded on classist assumptions about who is prone to being an unfit or unworthy mother.

Sanger devalues poor mothers and their families to support the family planning movement as one that will benefit society as a whole. Speaking with a tone of saviorship, Sanger relies on this negative depiction of poor women as a call for change.

It is among the mothers here that the most difficult problems arise—the outcasts of society with theft, filth, perjury, cruelty, brutality oozing from beneath. Ignorance and neglect go on day by day; children born to breathe but a few hours and pass out of life; pregnant women toiling early and late to give food to four or five children, always hungry; boarders taken into homes where there is not sufficient room for the family; little girls eight and ten years of age sleeping in the same room with dirty, foul-smelling, loathsome men; women whose weary, pregnant, shapeless bodies refuse to accommodate themselves to the husbands' desires find husbands looking with lustful eyes upon other women, sometimes upon their own little daughters, six and seven years of age. (Sanger, 1932, p. 50)

Sanger blames uncontrolled births as the reason for infant mortality, hunger, the ruined innocence of children, infidelity, and incest.

These passages demonstrate Sanger's attitude toward less-privileged families and motherhood. Far from a simple fight for material conditions to provide better motherhood, Sanger's family planning movement is one that is rooted in denouncing motherhood in lower

classes. For those in the “untouched classes” on which Sanger often relies for examples of degeneracy, birth control also presents an opportunity for society to limit improper or even immoral motherhood among those in poverty. However, her campaign to develop and provide access to birth control was not just for the benefit of overworked, sick women and mothers, but also for the benefit of women who were positioned to find motherhood and family life joyous—women whom society considered to have a duty to be mothers—but for whom contraception would provide a benefit more in terms of lifestyle enhancement than sheer necessity of avoiding children who could not be supported. For privileged women like Sanger, birth control represented a potential mode of personal freedom, one that allows for child spacing and proper familial development.

2.2 Proper and improper motherhood and the “right” to not have children

Often masked as movements to save children from abuse and to protect women’s health, but actually rooted in judgements about who deserves to be a mother, during the last century, public health and reproductive rights movements emerged to discourage women from having and keeping children, unless the women aligned with very specific values of proper motherhood, such as economic stability or legally-recognized partnership with an appropriate, economically and socially or emotionally stable partner (Eyer, 1996). Sanger’s campaign to legalize contraception to enable planning of pregnancy was one such movement. The reproductive right promoted by this family planning movement was the right not to have children, or given maternalism, the right to limit the number and time the having of children. Her family planning movement was significant

because it was the foundation for reproductive rights movements that intertwine maternalism and public health.

Another public health movement encouraged women who were not proper mothers not to have children in another sense. “Safe haven” campaigns sought to save babies from their unprepared mothers by encouraging mothers to surrender their children post-birth to designate safe haven locations (Oaks, 2015, p. 2). Rather than providing resources for women to care for their children, safe haven laws encouraged mothers to drop off their children at state-sanctioned safe haven sites so children could be adopted by more able parents. These campaigns to save babies from their mothers reinforce conceptions of proper motherhood and put an added psychological burden on nontraditional mothers to reconsider whether they are fit mothers or at risk of ruining their children’s lives (Oakes, 2015, p. 3). Safe haven sites are seen as a safe and legal alternative to infant abandonment, but they do not “address the problem of motherhood for the very small number of women and girls who abandon their newborns: the social injustices that compel abandonment” (Oaks, 2015, p. 2). Safe haven sites offer only a stop-gap, individualized solution that gives priority to saving babies from unfit mothers, rather than providing resources that can improve the experience of motherhood for women, benefit babies and children within their family setting, and begin to address the underlying social issues giving rise to the circumstances prompting some women to consider giving up their children.

Like Sanger’s reproductive rights movement that focused on enabling women to prevent pregnancy, rather than on affording women the conditions necessary to have safe pregnancies and childbirth, and healthy children, safe haven laws sought to prevent women who did not fit the criteria for being proper mothers from having (i.e., keeping) children. In both cases, rather than providing assistance to nontraditional mothers, a phrase in itself that implies the normative

superiority of traditional motherhood, the state rather seeks to convince mothers that they are unfit, or explicitly treats them as unfit. This threat of being deemed inadequate as a mother is manipulated often to pit “bad” mothers against “good” ones, a distinction that subsequently affects their children.

Proper motherhood, in contrast, was planned. Children were to be brought into homes that were both loving and sufficiently affluent to provide for the household’s health, wellbeing, and education. Men would not need to turn to crime for money, or to drink for entertainment, because there would be sufficient resources to provide for higher pleasures. Women would, like Sanger, enjoy the pleasures of joyous motherhood. Women were to be responsible, to find joy in having children and providing for their families’ wellbeing, and to serve as the responsible, moral touchstones of their families. Proper mothers exhibited and embodied these values of responsibility, moderation, planning, and caregiving. Moreover, they were considered to take joy in being mothers and exhibiting these values; they were to be sufficiently self-sacrificing to take their pleasure in the wellbeing of the family unit and its members.

3.0 Women's Drug Use and "Improper" Motherhood

3.1 Evolving images and persistent views of improper motherhood

From the later 20th century into the 21st, women who use drugs are a population represented as deviating from the conception of proper motherhood. Their reproduction is considered as evidence of their lack of (sexual) moderation, just as their drug use is considered immoderate and viewed as an illicit source of pleasure-seeking, long after their substance use ceases to provide them any pleasure. Their status as mothers is thus considered improper, unnatural, and undesirable.

In October 1988, for example, NBC broadcasted a segment about crack mothers, following the lives of pregnant women who apparently spent all their money on cocaine and smoked it without concern for their unborn children (Humphries, 1999, p. 1). These mothers were represented as deviant and often were blamed for deliberately having "flawed" children. News reports zoomed in on the crying faces of shaking babies and speculated both about why mothers used drugs during their pregnancies and whether they should be allowed to have children (Humphries, 1999, p. 3). Echoing comments made by Sanger earlier in the century, in the midst of the crack mother meltdown, the socioeconomic status of these women was often weaponized against them as a reflection of their own abilities rather than the result of social systems that limited their opportunities and kept them in poverty or unsafe situations.

As the opioid epidemic has grown in the first decades of the 21st century, mothers with opioid use disorder (OUD) are subject to similar surveillance and scrutiny before and during pregnancy. The moral pressure that falls on them operates on multiple levels due to the stigma surrounding their drug use even before they became pregnant. Their opioid use disorder places

them at the intersection of medical and legal interference and subjects them to social judgement. They are revealed to be another population that is at-risk, specifically for being viewed as, and internalizing the view of themselves as, inherently less likely to be effective mothers due to their drug use.

Historic notions of the nature of maternal responsibility and the self-sacrificial mother have conceptualized the mother with OUD as a failure. This view is rooted in both the moral judgment of drug use and the fear of the improper mother as a threat to public health and social resources. Growing out of Sanger's use of proper motherhood as the key to population health, public health approaches tend to view any other type of mother, such as the single mother, the poor mother, or the mother with a drug use disorder, as a strain on public resources and a threat to the entire population. Rather than offering support to mothers in various situations, this view results in supporting women's reproductive rights—including not only the right *not* to have children, but also the right *to have* children—only if the women embody the values of proper motherhood. It does not acknowledge the nuanced circumstances of motherhood and how to validate and support the reproductive choices of different women.

Until recently, drug use was seen as a choice and therefore a moral failure. Since maternalism as part of a preconception care model placed women in a constant state of pre-pregnancy, women with OUD were seen as harming their future pregnancies. Through this framework, their reproduction is considered taboo. Despite recent reclassification of opioid use as a disorder rather than a choice, mothers with OUD are still portrayed negatively in mainstream media. The image of the mother on welfare surrounded by children has been replaced with one of a woman passed out in the front seat of her car with a syringe still in her hand and her child wailing in the backseat (Hackney, 2017).

Whether or not their pregnancies were intentional, women with OUD are devalued as mothers before, during, and after their pregnancies. Prior to their pregnancy, they are discouraged from reproducing through targeted birth control initiatives, legal precedents that cause them to fear prosecution, and a lack of positive examples of mothers with OUD. During their pregnancies, they must overcome their distrust of the medical system and risk being treated poorly by providers or being punished on the grounds of prenatal child abuse. After they give birth, they must navigate a complex legal system that threatens to punish their maternal rights and custody of their children. The uphill battle of managing pregnancy and postpartum health, undergoing treatment for drug abuse, and finding the resources to support a child that may be taken away at any moment puts an inordinate amount of stress on a pregnant woman with OUD. As discussed in the following sections, this psychosocial stress has negative implications for the health of the expectant mother, the development of the fetus, and the willingness of women to seek care for their pregnancies, opioid use, and other co-occurring experiences such as intimate partner violence.

3.2 Women with opioid use disorder

In 2017 alone, more than 47,500 deaths were traced to opioid use (National Institute on Drug Abuse, 2019; CDC, 2018). The overwhelming and increasing burden of drug use has led the media and public to declare an epidemic. What is often lost in this narrative is how many people live with OUD every day. According to the CDC (2016), over 2.1 million people have diagnosed OUD. Now, doctors and public health officials are scrambling to understand drug abuse as a chronic medical condition and disentangle it from its history of moral panic.

The number of pregnant women presenting with OUD at delivery quadrupled over the course of 15 years, and four percent of pregnant women today use drugs (CDC, 2018b). Medication-assisted treatment (MAT) is the new standard of care for pregnant women, but it is severely underutilized, with only one-third of pregnant women with OUD utilizing this treatment (Martin, Longinaker, & Terplan, 2015, p. 37).

As the burden of mothers or expectant mothers with OUD increases, medical and legal systems are slowly evolving to acknowledge that viewing mothers as criminals is a barrier to care (McCarthy, Leamon, Finnegan, & Fassbender, 2017). Punitive legal measures are being replaced with medical intervention to increase treatment-seeking behaviors (McCarthy, Leamon, Finnegan, & Fassbender, 2017). Much research has been done to demonstrate that applying a chronic disease model to people with opioid dependence is much more useful for ensuring treatment engagement (Gustin, Nichols, & Martin, 2015). This new medicalized model serves to redefine people with OUD as people who are managing a chronic disease rather than voluntarily partaking in a behavior. Through this, opioid use disorder begins to be untangled from the social stigma surrounding it. Rather than regarding them as a homogenous group suffering from the same moral affliction, people would be treated like patients with a disorder. The treatment plan for each person would differ based on other aspects of their lives, such as how often they have access to clinics, whether their environment increases chance of relapse, or if there are other barriers to care such as insurance coverage. This framework encourages a more individualized approach to people with OUD in hopes of fostering a more humane approach to their recovery.

Despite this shift to viewing substance use disorders, including OUD, as a medical rather than a moral problem, restoring humanity to depictions of those who continue to live with OUD every day remains difficult. Pregnant women are particularly prone to being judged, and pregnant

women with OUD are still hesitant to seek care. Screening during prenatal visits is now considered an important tool by clinicians for identifying women in need of treatment, but it is a practice that depends on self-reporting (Ecker et al, 2019). Many women are unwilling to self-report their drug use due to fear and concerns about legal sanctions that could affect their child custody and other reproductive freedoms. In order to bypass the screening system, women sometimes forgo prenatal care altogether or delay seeking care until well into their pregnancies (Ecker et al, 2019).

Avoidance of medical professionals as a result of psychosocial stressors is a known barrier to care that is exacerbated when biased providers devalue these women and their pregnancies when they do come for care (Johnson, 2019, p. 5-6). Some pregnant women with OUD report being told that a withdrawal-induced miscarriage would be the ideal outcome of their pregnancies (McCarthy, Leamon, Finnegan, & Fassbender, 2017). These glimpses into negative provider interactions demonstrate that although availability of resources is increasing, historical misinformation and stigma still influence how pregnant women with OUD are treated. The most commonly cited psychosocial stressors on pregnant women who use opioids are: stigma, social and legal consequences, food insecurity, comorbidity with chronic medical conditions or psychiatric disorders, poverty, trauma, and intimate partner violence (Patrick & Schiff, 2017; Finkelstein, 1994; Park, Meltzer-Brody, & Suzuki, 2012). These stressors are intersecting and additive, contributing to the low rate of enrollment in healthcare services and treatment.

Mothers with OUD are at the mercy of the medical and legal institutions they become a part of when they first start to seek prenatal care during their pregnancies. Currently, 24 states and Washington D.C. have mandatory reporting laws for suspected substance use during pregnancy, and 23 states and Washington D.C. classify prenatal substance use as child abuse. Three states—Minnesota, South Dakota, and Wisconsin—have policies that cite substance use during pregnancy

as grounds for civil commitment (Rosenthal & Baxter, 2019, p. 2). More policies have arisen for pregnant women with OUD specifically as a form of protection since they were previously charged with more vague charges. Nonetheless, mandatory reporting laws are being amended to account for women in treatment.

That pregnant women still fear seeking treatment is unsurprising, since their initiation into the medical model of opioid treatment still involves at least a brush with legal processes. Even if they are not initially reported for their drug use, they frequently must prove that drugs present in their systems at the time of delivery are part of drug treatment. Often, this requirement is the result of internal hospital policies. To inform future social and hospital policies, and to provide better prenatal care and drug treatment for pregnant women with OUD, it is important to pay attention to the experiences of women currently receiving such care. The balance of this paper explores the experiences of women with OUD who received prenatal care and MAT at a specialty clinic in a mid-western city between 2014 and 2017.

4.0 Disproportionately Valuing Pregnancies Over Women

4.1 A qualitative study of pregnant women with OUD

As a part of an interview-based qualitative study, women described their experiences with treatment, law enforcement, intimate partner violence, and provider interactions. A total of 41 interviews were conducted to consider intersections of social, legal, and medical considerations that affected the quality of care women received. Women were asked open-ended questions about their experiences by trained study members. Their interviews were transcribed, de-identified, and coded for factors such as mentions of violence, barriers to care, and professional interactions.

Analysis of these interviews will be used to inform a discussion about the negative interactions women had while receiving care and the deficiencies in services being offered. Using an expanded framework that draws on principles of reproductive justice, these women's narratives will be analyzed to show that a history of criminalizing pregnancies continues to negatively impact the quality of care they receive. Specifically, this paper will explore how women with OUD are disproportionately "valued" during their pregnancies for the sake of the child they are carrying. This results in a paradox in which women with OUD are valued more highly due to their pregnancies but are simultaneously devalued through punitive policies and social expectation of failure. Women themselves speak of a paradox as well: becoming pregnant during a period of active drug use may be simultaneously good and bad for them and their health. The interviews both bring to the forefront how pregnant women with OUD still face barriers when seeking long-term care and recovery, and highlight the complex relationship between their current or future

status as mothers and the circumstances of their lives, including OUD, intimate partner violence, and interaction with the healthcare system.

4.2 The expectation of transformative motherhood

Honestly I really, like I whenever I got pregnant with my son and I always say this, it couldn't have happened at a worse time. But I thank God for him every single day and it was like perfect timing because without him I honestly would be dead by now so...I was just at the time, when I found out I was pregnant, I was strung out. I was with my son's father, this was like at the end of our road for both of us. We were both really strung out. Pretty much homeless at the time and you know things were just horrible. Like it couldn't have been at a more worse time in my life. I mean nothing was stable in my life. I couldn't even take care of my own self so. How could I in my head, I was thinking how was I going to take care of a baby, but I changed my life around and by the grace of God it worked.

This woman describes a recovery journey that was catalyzed by her child. This image of a baby inspiring a mother's long road to sustained recovery reflects ideals and expectations that are set by historical notions of proper motherhood. Radcliffe (2011) explores the moral career of drug treatment and how it works alongside performance of motherhood to convince providers and society that redemption is possible (p. 986). Through this framework, women with OUD are highly valued during their pregnancies, not for their unique needs, but rather due to the opportunity for intervention. Through this intervention, there is hope not just for recovery, but for the wellbeing of the child and the possibility of a version of motherhood that is socially endorsed.

The extra value pregnant women with OUD are accorded is conditional and manifests itself most directly in the form of accelerated access to treatment. A study done to assess access to treatment for various populations found that, pregnant women had faster initiation of treatment than non-pregnant women and men (Bach et al., 2015). This is particularly salient considering that waitlists for methadone treatment can exceed four months, and there are high rates of mortality

while people await treatment (Gryczynski, Schwartz, O'Grady, & Jaffe, 2009; Peles, Schreiber, & Adelson, 2013). Women are prioritized and pushed to the front of treatment waitlists when they are pregnant. This serves to reduce harm to their pregnancies, but it also reveals the conditions under which women with OUD are able to access care.

While the importance of providing treatment for pregnant women with OUD should not be minimized, there are conceptual, social, and ethical problems with giving priority to them based on their status as pregnant. Providing substance use treatment to pregnant women is part of a necessary harm reduction model that drastically improves maternal and fetal health outcomes. Nevertheless, the disproportionate value accorded to women when they are pregnant suggests that women are at-risk of only being valued, and that their commitment to receiving drug treatment is only respected, for the sake of protecting the fetus. The likelihood of this devaluation of women themselves is demonstrated most clearly through the neglect of the multidimensional needs of women with OUD, needs that are not addressed as part of a treatment model. This focus on their pregnancy and the impact of drug use on the fetus is buttressed by an underlying expectation for redemptive motherhood that further undermines women's autonomy by reducing them to their reproductive and mothering potential.

When pregnant women with OUD approach treatment, they become part of a system that has the potential to report them to agencies that could criminalize them for their drug use. Demonstrating progress by adhering to medical treatment becomes both a form of self-improvement and an exercise in proving that they are working towards conditions that are conducive to proper motherhood. Studies have shown that pregnancy is a significant motivator for women with OUD to seek treatment, but interventions often focus on providing medical care rather

than addressing any of the psychosocial considerations that affect treatment adherence (Mitchell, Severtson, & Latimer, 2008).

Treatment for pregnant women with OUD is unsustainable and has high discontinuation rates. Women who initiated medication-assisted treatment during their pregnancies had postpartum treatment discontinuation rates ranging from 26 to 53 percent (Wilder, Lewis, & Winhusen, 2015). This is in stark contrast to the 0 to 4 percent discontinuation rate while women are pregnant (Wilder, Lewis, & Winhusen, 2015). While there is an expectation of full recovery for pregnant women with OUD entering treatment, these discontinuation rates reveal that treatment during pregnancy does not necessarily lead to a full transformation. Although this can be partially accounted for by high rates of relapse in the general population, there are other psychosocial factors that affect women's access to resources. Combined with low rates of treatment-seeking even during pregnancy, the high rate of postpartum discontinuation demonstrates that despite the availability of treatment services, other factors affect whether women seek and remain in treatment.

Failure to seek and remain in treatment could potentially arise from the nature of these interventions, particularly their focus on protecting fetal health rather than valuing the woman and her health apart from that of her fetus. Often, policies aim to encourage self-reporting and enrolling in treatment as a means to maintain custody of children alongside a chance at full recovery. However, their drug use or continued treatment could be used against them in child custody cases to prove that they are unfit mothers. Thus the model that encourages self-referral and treatment adherence may also serve as a means to craft a case for the intervention of child protective services. In this way, both women and children are not well served.

Motivated by the possibility of maintaining custody of children and parenting them more properly due to their recovery status, women with OUD who do enter the medical system are promised transformation of their lives due to their pregnancies. While there is an expectation of change on the part of the mothers, there is no similar effort from social, medical, and legal structures to facilitate change in a comprehensive way. This dissonance between expected transformation and the resources provided to support full recovery is underscored by the lack of regard for psychosocial considerations. A history of regarding drug use as a choice still affects policies and the support women with OUD receive when seeking treatment (Kennedy-Hendricks, McGinty, & Barry, 2016). Because of the stigma of substance use, women with OUD feel uncomfortable reporting their drug use and asking for proper care. Despite the apparent goal of the medical model to increase engagement with treatment, social attitudes influence whether women are willing to accurately report the extent of their drug use.

The fear of being labelled an unfit mother is a product of both history and contemporary policy. As discussed previously, the value of a woman was often tied to proper motherhood. The individual responsibility of women to be good mothers and to control their fertility for the sake of population health put a burden on women to have children under very specific circumstances. Women with OUD are offered treatment during pregnancy as a means to becoming a more able mother through changing the state of their disorder, but the social circumstances remain unaddressed. While treatment and recovery are both positive developments for women with OUD, this puts pressure on women who are unable to recover fully or enter treatment multiple times. Increased access to treatment during pregnancy may result in faster treatment initiation and better infant outcomes, but it is often a short-term solution to a woman's chronic disorder, particularly because their social circumstances are ignored.

When interventions only address the medical aspect of OUD and offer women these treatments more readily during their pregnancies, the expectation for a journey towards proper motherhood is intertwined with an expectation for sustained recovery. Given the nature of treatment programs to focus on the medical aspect of OUD, these expectations often go unfulfilled due to lack of support in other aspects of women's lives. Considerations that can affect long-term treatment and recovery include safe home environment, partner support, legal protection, and social acceptance. Until these factors are addressed in treatment programs, women with OUD will continue to have issues achieving long-term recovery for themselves rather than just for their pregnancies.

5.0 Contemporary Surveillance of Mothers with Opioid Use Disorder and Neglect of Their Environment

Participant (P): Instead of looking down on the woman who went through it, say she used drugs like I did. That don't make her a bad parent. So, everything they do is they call child protective services on you if you have drugs in your system when you have the baby. I don't feel that is right. I don't, because it scares women more and they are already got to deal with what they got to deal with at home. So it is putting more pressure on women. And they are focused on the drugs that the women are using. Like for instance, I was on Subutex with my daughter, my four-month-old, when I was pregnant. And they called CYS [Children and Youth Services] on me and they didn't ask me why or nothing. My daughter has a bedroom, she has everything she needs, she is well taken care of, and they are focused on the using part. On nothing else, the using part. And then like when I was with S, I had the cops come to my house and I told them he wasn't beating me which they knew he was. That is why they came there, because someone reported it, and they walked away. They said okay, and walked away.

Interviewer (I): I'm sorry to hear you had that experience.

P: And same with you know like children and youth, they took my daughter out of my life, my 6 year-old at the time, out of my life because I was being beaten, instead of trying to help me and my daughter both to get away, they took her. That ain't helping a mother.

I: No. I'm so sorry.

P: It ain't helping a woman either. So I mean it ain't helping the child either because it is taking, you know. Because that is all I had was my daughter. [crying] The worst thing I ever went through. Rather beating, instead of my children taken [crying]

I: Are you ok P?

P: [crying] Yeah.

I: Okay, we can, if you want, we can stop for today if you want. I don't want to upset you certainly.

P: [crying] I would have a case worker talk to women before they call child protective services. And get to know the law before they do something like that. And luckily I did get my kids back but that is beyond the point. My kids didn't know what happened. And sometimes you know my daughter says, "Well you chose drugs over me, mom." That wasn't the issue. Or she will say, "You chose S over me." No I didn't.

I: I'm so sorry to hear that. I'm sure that must be really difficult for you.

P: Yeah, it is. You have your 11-year-old daughter who will tell me those things. I have to sit her down and explain to her that ain't how it went. And she said, "Well that is what the state said when they took me." I said "Yeah, mommy had nowhere to go. But then instead of them helping us, they separated us." I told her that.

This study participant's experiences with Children and Youth Services (CYS) reveal how women with OUD are at-risk of having their parental rights terminated, or like this participant, temporarily losing custody. First, it is important to recognize that women continue to be punished for their drug use even when medication-assisted treatment (e.g., use of methadone) is part of their treatment plan. Additionally, this participant details how she lost custody of her children due to her experiences with drug use, with CYS officials disregarding her efforts to provide a safe and loving environment. This is particularly painful for her to recount considering her previous experience with CYS in which they took away her daughter but left her in an abusive situation. Although she was able to regain custody of her children, her relationship with her daughter has been damaged.

Despite the advent of clinics that provide prenatal care, MAT, and other social services to support pregnant women with OUD, rates of engagement with these services are very low. As mentioned earlier in this paper, only one-third of pregnant women with OUD utilize treatment during their pregnancies (Martin, Longinaker, & Terplan, 2015, p. 37). While this could be due to lack of resources in certain areas, fear of mandatory reporting laws significantly affects whether women report their OUD as they undergo prenatal care (Stone, 2015). Although clinicians have frequently collaborated with state legislatures to pass laws that allow women who undergo physician-aided treatment to be exempt from reporting, women can still be reported due to loopholes, hospital error, or other confounding circumstances.

According to Pennsylvania law, providers have a duty to report cases of children under one who experience withdrawal symptoms unless: "the child's mother, during the pregnancy was ... under the care of a prescribing medical professional; and ... in compliance with the directions for the administration of a prescription drug as directed by the prescribing medical professional" (The

Center for Children’s Justice, 2015). In July 2015, this law was amended to explicitly state that mandatory reporting does not apply to mothers who are in a methadone or other MAT program. In December 2018, the Pennsylvania Supreme Court ruled that drug use during pregnancy is not a form of child abuse (Stempel, 2018).

Despite all these measures, the high possibility of negative experiences weighs heavily on the minds of mothers with OUD. Immediately after the Pennsylvania Supreme Court ruling, some senators began a public campaign to overturn the ruling (Snyder, 2018). This constant threat of being labeled as abusive and the fragility of protective legal measures function as forms of surveillance for mothers with OUD. A history of valuing fetal protection over maternal wellbeing contributes to women’s fears (Stone, 2015, p. 1).

Although new policies and amendments to laws seek to regain the trust women have in the healthcare and legal systems, women with OUD still are punished through loopholes and technicalities. For example, women in Arkansas cannot be charged with fetal homicide, but they could be charged with battery or delivery of drugs to a minor (Stone, 2015, p. 2; Murphy, 2014). One woman was even prosecuted for her stillbirth despite overwhelming evidence that the complications were not drug-related; the charges were eventually dismissed but only after a seven-year legal battle (Fowler, 2014).

Paltrow and Flavin (2013) conducted research to identify cases of women’s liberty being challenged during their pregnancies. Out of 413 cases between 1973 and 2005 that punished women due to actions during their pregnancies, 84 percent of them were linked to illicit drug use, and a majority involved child abuse charges (Paltrow & Flavin, 2013, p. 321). This is a very conservative estimate that is affected by the lack of a comprehensive database, confidentiality provisions resulting in omission of certain cases, and the fact that many of the charges against

women with OUD are vague and therefore unsearchable on a large scale (Paltrow & Flavin, 2013, p. 304). Healthcare systems were often complicit in this punishment of pregnant women, searching for evidence of drug use without consent and claiming punishment would be the most effective motivator for treatment (Paltrow, 2002).

These recent examples of punishing pregnant women who sought treatment while using drugs likely influence how women approach the medical system. Despite new legal amendments, they know that their protection is not guaranteed. Much like the participant whose narrative begins this section, other women who were honest about their drug use in hopes of demonstrating their willingness to recover were still punished for their drug use. Stone (2015) conducted interviews of recently-pregnant women who reported drug use to explore how stigma affected their care-seeking behaviors. Of these women, 73.3 percent feared how their substance use would be interpreted during their pregnancies and whether it would affect their child custody (Stone, 2015). Of the other 26.7 percent who did not have this fear, a majority were using alcohol or tobacco (Stone, 2015). A majority of women, 54.5 percent, avoided medical care, either by going to appointments less frequently to space out drug use and avoid detection or by not seeking care altogether (Stone, 2015). One woman decided being honest about her drug use and adherence to treatment would help her custody case, only to have it used against her. She expressed remorse about the crucial bonding time she missed as her case was being processed.

Concerns about child custody do not arise only within the medical system but also in the homes to which women return after giving birth. One participant expressed how her own abusive partner wanted to use her past with drug use against her:

My son's dad, my son and daughter's dad actually...he kept telling me that he was going to take the baby off of me and he was going to tell the courts all this stuff because I have a past with drugs obviously.

It has been documented that women sometimes socially isolate themselves and deny their pregnancies due to fear of being reported by people close to them (Stone, 2015). That partners use the threat of calling CYS as a form of negotiation or retaliation demonstrates that CYS is well known as a source of potential punishment for a woman with OUD. In some cases, child custody becomes primarily a weapon against mothers rather than a service for children.

A history of criminalizing pregnancies of women with OUD and the more nuanced cases brought against them today are indirect but significant violations of their right to have children and to parent them under healthy circumstances. Psychosocial stress caused by stigma and fear prevents care-seeking behaviors which are essential for better maternal and infant health outcomes (Woods, Melville, Guo, Fan, & Gavin, 2010). If women do not feel secure seeking help due to the potential repercussions of doing so, medical and legal systems should be held accountable for influencing health outcomes through their past and recent offenses against women who have sought their help. In the case of women with OUD, stigma is a risk to their health that must be addressed. More sound and comprehensive maternal protection policies that allow pregnant women to seek treatment without concern that doing so will lead to separation from their children would enable women to take control of their children's safety as well as their own.

6.0 Violence and Drug Use

In my past relationships the biological father of both of my children, he is not my current partner but he is who introduced me to using and who I used with in the past. He definitely started with name calling and belittled me all the time. He whenever I had first got pregnant, I had a miscarriage that time. He picked me up and threw me on the ground and I ended up miscarrying.

Studies have shown that there are changes to intimate partner violence (IPV) patterns during pregnancy (Mezey & Bewley, 1997). These changes are often due to either jealousy or anger directed towards the unborn child, leading to increased violence toward the pregnant woman. Adding drug use to this situation creates a multidimensional issue for women who are pregnant and in an intimate relationship with someone who is violent towards them. Women's safety is compromised. Moreover, having a substance use disorder, being abused, and facing a legal system that is more willing to criminalize than protect them disempowers women and constitutes a complicated network of intersecting, mutually reinforcing oppressions that prevents women from seeking care or remaining in treatment. This section will explore how reproductive health and safety are intertwined with drug use.

6.1 Initiation of drug use

As the participant above notes, initiation of illicit drug use often happens with a romantic partner (Angulski, Armstrong, & Bouffard, 2018). Women's drug dependency soon becomes a form of control used to manipulate women to remain in unsafe situations (El-Bassel, Gilbert, Wu, Go, & Hill, 2005). Many studies cite IPV as common among women with OUD, with women in

treatment for their drug use experiencing much higher levels of IPV than other women (El-Bassel, Gilbert, Wu, Go, & Hill, 2005). The specific intersection of IPV and drug use requires more careful consideration with regard to women's ability to access and engage in services for women experiencing violence in their relationships. One participant describes that drug use contributed to her remaining in an unsafe and abusive situation:

I was in an abusive relationship but mainly because of drugs. Otherwise I probably wouldn't have stayed. Because I was addicted to drugs in the past. So that had a lot to do with why I even got involved with the relationship and why I stayed in that relationship.

In "You, Me..and Drugs—A Love Triangle," Dr. Chris Cavacuiti (2004) considers the psychosocial context that affects the relationship between people who use drugs together. Although men are more likely to become dependent on drugs, women have a much more difficult time recovering from their dependence (Becker & Hu, 2008). Research has postulated that this increased risk for dependence is due to hormonal differences that affect the reward pathway, but gender-based violence has roots in the power relations between partners that affect drug behaviors (Lynch, Roth, & Carroll, 2002).

For relationships that involve intimate partner violence, drug use becomes both a reason for remaining in relationships and a form of mental escape. Maladaptive coping is the phenomenon that some postulate drives people to remain in abusive relationships while using drugs (Cavacuiti, 2004). In couples where both people have a substance use disorder, drugs can be used by the party being abused to numb the physical and emotional pain they are experiencing, such as with this woman:

There would be points with X's dad where say for example we were trying to quit, you know, and then we would get into this big fight over money and a physical fight over money because he wanted money to go buy drugs and you know, whatever. Then he would go do it and bring them back and I would say well fuck it, if you beat the shit out of me and stole my money I might as well get high on it.

In addition to offering escape, substance use in couples leads to what Cavacuiti refers to as triangulation, in which drugs become a third member in their relationship and leads to increased difficulty in entering and sustaining recovery, since their relationship and emotions for each other are tied so closely to a substance (Cavacuiti, 2004).

6.2 Sustaining drug use, impeding recovery

In addition to partners affecting drug initiation, many participants claim their partner's drug use influenced whether they sought treatment and were able to remain in recovery. One participant recounted:

I mean there were times, not currently like recent, but with my current relationship we have been like living together and he was using and I would like find rubber bands or like empty bags on the bathroom floor or there would be like blood in weird places and stuff like that. It would really mess with me. Last time that happened I did relapse actually. I found an empty bag in the bathroom...Like I relapsed when I was pregnant.

P: I hate crack. I hate it. I hate crack cocaine. My father, my real father, he was a crack addict and ruined our family. To the point actually when I was younger I found him smoking and threw away all of his crack, flushed it down the toilet. You know what I mean? So her dad, the one night I actually caught him smoking. And he knew I hated it. That is why he would hide it from me. So I ended up trying it, and of course I liked it.

I: That was your first time of trying?

P: Yes. When I was pregnant with her, I tried it.

A common theme among these narratives is that partners often used drugs to keep women with them. This form of treatment sabotage functions to maintain control over women and is a form of violence and manipulation:

There was a few times that I wanted to get clean and whenever I was with my kid's dad I remember leaving the one time, things just got really bad and I went to rehab and I slept in there for maybe two days because I kept talking to him from there and you know he wanted

me to come back home and it just, I ended up leaving and coming back home. And just started using again and just didn't stick it out because based off of what he wanted.

We enabled each other. He was when I first started using heroin but like I wouldn't say he ever forced me to but it was definitely his way of kind of you know manipulating me and keeping me from leaving. He basically said to me I didn't have to pay for anything, he would always have it there and I know a few times whenever I would, you know I knew the relationship was doomed and unhealthy but I would talk about leaving or I'm going to start saving some of my money to buy my own place, he would you know bring gifts of drugs and of course I would be happy and high and we would...It was blatant that he knew if he could keep me high that I wouldn't leave him. And so he would definitely, he did not want me to get sober and it would also mean I wanted him to get sober too if we were going to stay together.

It wasn't like pressure but anytime I would try to get clean you know as soon as I was doing good then my son's dad would come around and say "Hey, I got this, do you want some?" And whenever he was in a program or just got out of rehab or whatever. I really feel like he wanted me to stay like he did.

I could not stay clean being with him. It wasn't possible. If he was using then I was using.

Especially due to the prevalence of reproductive coercion and sexual assault, reproductive justice advocates have always acknowledged that IPV is a threat to women and their reproductive health (Moore, 1999). In addition to these threats to sexual and reproductive autonomy, women with OUD are at risk for treatment sabotage and relapse. For pregnant women, the risk of relapse due to violence or control within their relationships poses a significant threat to their health and the health of their pregnancies and future children. Services that offer MAT only address the medical aspect of OUD. Establishing and maintaining a safe and healthy environment is necessary for MAT to be effective and to ensure prenatal and postpartum health.

To provide effective treatment to women with OUD it is necessary to evaluate whether the environments women live in are conducive to the goals they have for themselves and their children, such as physical safety and a chance at sustained recovery. It is thus critical to evaluate whether

they face intimate partner violence, and to intervene effectively in this health-threatening situation, as well as intervening in their OUD.

6.3 Stigma and tolerance of violence

I think you tolerate the abuse more because you already feel like you deserve it because your actions, you know what I mean? You are using and usually the opinion of yourself isn't high when you are using. But you feel like you deserve it. So once your mind is clear and your head is clear, you realize that it wasn't you or you really didn't deserve it.

Another risk introduced by treatment sabotage is not just relapse but the effect drug use has on women's self-esteem and the conditions in which they are willing to live. Very early studies of drug abuse and recovery noted that women are particularly prone to feeling shame and depression when undergoing treatment for drug use (O'Connor, Berry, Inaba, Weiss, & Morrison, 1994). For women with OUD who are pregnant, the stigma of drug use, the values of proper motherhood, and the history of criminalizing their pregnancies combine to add another layer of judgement that could negatively affect their perception of themselves and their value as women and mothers (Roberts, 1991, p. 1422). Services should address how women's drug use affects their self-esteem and the environment they feel they deserve. Prenatal care and substance use treatment during pregnancy provide a valuable point of contact for providers to not only address intimate partner violence and other unsafe environment factors, but also tackle internalized stigma that affects the quality of the environment women live in after they give birth.

6.4 Unequal legal treatment

It is amazing to me to see how many women out there are going through what they go through and things that happen to women and the way that the judicial system and the way that the police just how things are set up and how things go and how these men can go to jail and get in and out of jail and you know they can take a child from a woman in a heartbeat and it just – certain things with the way the system works and it just amazes me that these things need to be looked at. I feel there are just certain things that need to be changed.

This participant identified how the legal system treats men with multiple offenses and criminal records better than women with OUD during their pregnancies. This participant experienced both sexual and physical abuse by her former partner, often with his son just a few feet away from her. This same participant turned herself in when she first found out she was pregnant in order to get care for herself and her unborn child away from the abuse:

I was in a program – I got myself actually had gone to jail because I was using at the time. I was in active addiction, I actually had turned myself in and wanted to get help because I didn't want to you know hurt my daughter, I didn't want to keep using. So I put myself, turned myself in and put myself in a program, got myself court-ordered to a 6-month program.

In addition to emphasizing the unequal legal treatment of drug-using women and men, including men who are abusive, this discusses how she has friends who have almost died or had their pregnancies terminated at the hands of an abuser against whom they had a protection from abuse (PFA) order against:

I have been around friends of mine that have actually been pregnant and have had their boyfriends kick them and push them down stairs hoping that they would miscarry because they didn't want the baby anymore. And they didn't want to be with them anymore. They didn't want to have that responsibility.

Watching her own friends file multiple PFAs against their abusers that were not enforced, she hesitated to bring any charges against her own abusive partner. She reports that the measures taken against abusive men are too weak or are not enforced until it is far too late:

I've watched the police pick them up and not even take them to jail. Drop them off a mile away and tell them stay away from the house for the night. Not even take them to jail and of course they show back up there, you know if they were drunk or whatever the case was and no, I never did it because I thought it was such a joke. They need to really listen, they really need to listen because I think they see so much of it sometimes and they don't take it seriously. And then two days later, they are winding up going there because somebody is dead.

This participant's interview captures the flawed logic behind the intense criminalization of pregnant women with drug use: they are often treated more like criminals for their actions against an unborn fetus than are abusive men who assault women.

With a legal system that is eager to punish pregnant women for drug use but unwilling to bring violent men to justice, women's trust in law enforcement diminishes. Another participant captures this sentiment by pushing back against popular advice for women in violent situations:

They wonder why people don't call them or don't press charges. Because honestly it would have been better for her to just call my dad, have my dad go over there and beat the shit out of him, and say stay the fuck away from my kid, you know what I mean though.

Violence against women is obviously detrimental to women's reproductive health, and is noted as such within a reproductive justice framework (Solinger, 2007, p.42). For women with OUD, addressing violence in their relationships is complicated by their drug use being used against them when they try to file a report:

I feel that people that are addicts that have been addicts in the past, we have a label on our foreheads so we are automatically treated like scum.

Another participant had similar negative experiences:

Everybody looks at you like this drug addict so you know depending on, like say you are in this relationship and you are saying like oh, my boyfriend raped me. And they are like he is your boyfriend, you are a drug addict, he is some good guy that has a good job blah

blah blah, and then like you know because [of] the title they put on you as a drug addict they may not believe you.

For women with OUD, IPV increases women's physical and emotional stress, interferes with their treatment, and increases the chance of unequal protection from abuse. Therefore, reproductive initiatives should consider whether services that may be adjacent to methadone treatment, such as shelters for women experiencing abuse, are equipped to deal with the complex needs of pregnant women and mothers with OUD who must care for themselves and their children while separating themselves from abuse.

6.5 Barriers to addressing IPV

Them shelters you have to go to, they send you to these shelters, right? And then you go well I don't have any money can you help me get a bus pass or something so I can get a job. Oh no, we don't help you with that. Oh, we don't help you with food either. Well shit, you want me to move me and my kids somewhere in Oakland with no bus pass and oh wait, I don't have money for food either. Well great, that sounds awesome. Do you know what I mean? So most of the time you are going to say, I'd rather fucking stay at my house and deal with this asshole every once in a while being an asshole, because at least there is food here and I'm in my own house, and if I need to go do something, at least I'll have bus money and shit for my kids. But you want to move me to a shelter where you are just saying you can't get anything, we don't have that. Well what the fuck?

This participant details how, although she was able to leave her abusive situation, the resources provided to her made her second guess her decision to leave. As a mother, she felt that the resources she had at home for raising her children were worth enduring abuse. When providing women, especially mothers, services to address IPV, it is important to account for their children, transportation to treatment, and other needs they may have apart from a roof over their head.

An additional consideration in seeking redress for IPV, that participants mentioned, is how reporting abuse invites CYS into homes and risk losing custody of their children, at least temporarily.

Well I was afraid if I would say anything about the abuse that I would get my daughter taken off of me. So I was kind of afraid of that because she was only two and a half and I was just so afraid that you know that I would get – with everything going on and you know with him, you know, abusing me.

Since mothers with OUD already jump through many hoops to maintain custody of their children, dealing with CYS again and reigniting a debate around their custody rights serves as a barrier to reporting abuse. While technically there are systems in place to protect women and their children from abuse, drug use complicates their decisions and requires women to weigh their options and potentially to sacrifice their own health for the sake of remaining with their children. Even when children are not involved, women report their drug use as an obstacle to calling law enforcement:

It was a guy I dated for a short period of time and he put his hands on me. I called the cops right away. But I was clean at the time. I think had a lot to do with it... Because when you are using, you don't want to call the cops.

Finally, one of the largest barriers to leaving a violent relationship is the possibility of reconciliation, achieving a complete family and meeting the standards of proper motherhood.

It can get so serious – they think they are not going to hurt them but when they are putting their hands on you and when they are getting to that point, they can hurt you and they can hurt you and push you or kick you or punch you in a certain spot in your body and you can be dead instantaneously. And we don't understand that because we think they love us still because afterwards when they do the crying and I'm sorry, and I'll never do it again and I'm sorry I hurt you, we want to believe that so. It is hard especially when there is a child involved you know what I mean, you think you are going to be a family.

While their drug functions as a form of psychological and social control that keeps women with OUD in harmful relationships and that prevents them from accessing resources for treatment, the alluring possibility of somehow achieving the conditions necessary to fulfill the ideal values

of proper motherhood also functions to keep women in abusive relationships. Even if they enter drug treatment, they cannot meet the idealized notion of being proper mothers if they lack a male partner with whom to raise their children.

7.0 Conclusion

Women with OUD, and especially those who are pregnant, have needs that extend beyond treatment through medication. While pregnancy provides an important point of contact with the healthcare system for them, they are at-risk of having their complex needs reduced to those of their unborn child. These reductivist approaches—focusing solely on medical issues, and reducing women to their childbearing capacities—contributes to low treatment retention rates and ultimately only provides a very short-term solution to a chronic disorder. Although the relatively new medical model of opioid use disorder aims to reduce stigma and increase treatment-seeking behaviors, simply providing medical services to these women is not sufficient. Environmental factors affect treatment adherence. These include multiple sources of psychosocial stress, partners who also use drugs, and intimate partner violence. Further, the influence of norms of “proper motherhood” exert an influence not only on women’s decision-making, but also on the legal and medical infrastructures that could be mobilized to meet the needs of women with OUD.

As the narratives of women in the research study reveal, there are multiple intersecting factors that affect their recovery, health, and safety. Although all the women received prenatal care and replacement therapy during their pregnancies, their road to recovery and the conditions of their motherhood were complicated. One factor that affects the care women receive is notions of the individualized burden of motherhood that affect the nature of treatment and whether women are valued outside of their pregnancies. After women deliver, their right to parent their children is threatened by punitive systems that operate under the mission of child protection. While child protection agencies do provide valuable services that combat child abuse, social stigma and expectations of failure affect how women with OUD are disproportionately targeted as unfit

mothers. This surveillance that works to their detriment is remarkably similar to the negative interactions women with OUD have with law enforcement when attempting to report violence in their household, interactions that also fail to benefit them as women and mothers despite their not being the legal wrongdoer in the incidents that they report. In both contexts—both reporting IPV and receiving treatment for OUD— women with OUD are under extra scrutiny in regard to their ability to be mothers and experience dismissal of their own safety concerns.

Given the increasing number of women, including pregnant women, diagnosed with OUD, it is essential that interventions evaluate women's needs as separate from their pregnancy needs. While integrated pregnancy clinics help to address fetal health concerns, they should also be a point of contact for other services, such as long-term comprehensive therapy and shelters. This more comprehensive approach would help to ensure that women with OUD are not reduced to their pregnancies and have an opportunity to seek help for their own long-term goals.

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