Pregnancy & Addiction

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Learning Objectives
- Review the specific problems of women with addiction
- Review strategies to identify the pregnant addict/alcoholic
- Review the effects of drugs and alcohol on the developing fetus
- Review the treatment needs of the pregnant woman and her newborn

How Prevalent is drug and alcohol use in pregnancy?
- 12-24% of women use drugs and alcohol during pregnancy
- 1 of every 3-4 women expose fetus to alcohol
- Alcohol and tobacco > illicit drugs and prescription drugs
- Prevalence in public clinic=private practice
- Caucasians > African Americans > Hispanic
- No significant variation by socioeconomic status

Risk Factor:
Family History and Social Situation
- Often have a family history of addiction
  - Exposed to parental violence as children
  - Experienced emotional, physical, sexual abuse as children
- More likely to have a family history of mental illness, particularly in their mothers
- More likely to live with a violent, addicted partner

Clues in the medical history
- No prenatal care –
  - May be because of fear of discovery of addiction
  - May be secondary to general chaos in her life
- Tattoos or self scarring
  - Secondary to IVDU or skin popping
- Burns on hands and clothing
- Nicotine abuse

Screening
- All pregnant women should be screened for drug and alcohol use
  - T-ACE
  - TWEAK
- A positive screen indicates the need for a further evaluation
- Elements of the history and physical may indicate need for a urine drug screen
### Treatment Barriers

- Fear, shame, and guilt about use
  - Will she lose other children if in treatment?
  - Does she have family support?
  - Attitudes of medical providers
- Lack of comprehensive clinical care services for all the problems of pregnancy AND addiction
  - Can she get to treatment? Transportation problems?
  - Lack of childcare while in treatment
- Co-morbid diagnosis impacting ability to access services
  - Difficulty addressing many issues simultaneously
  - Depression, anxiety
  - Personality Disorder
  - Immaturity/lack of coping skills

### Alcohol

- Alcohol is a known teratogen
  - There is NO safe level of drinking in pregnancy
  - 25-30% of pregnant women expose the fetus to alcohol; fewer consume quantities known to be dangerous
- Alcohol exposure in pregnancy is the leading preventable cause of neurobehavioral problems and mental retardation
- Alcohol crosses the placental barrier and is poorly metabolized by the fetal liver
- Levels of alcohol are found in amniotic fluid after only one drink – double that of maternal serum

### Alcohol - Fetal Alcohol Syndrome

- Pre and post natal growth problems
- Neurodevelopmental problems
- Characteristic facial features
- History of maternal drinking

### Alcohol - FAS – Facial Features

- Flattened midface
- Shortened palpebral fissure
- Elongated flat philtrum
- Thin upper lip
- Microcephaly

### Medical Complications: of Drug Abuse in Pregnancy

- Intravenous Drug Use
  - Bacteremia; Endocarditis
  - Sexually Transmitted Diseases:
    - Hepatitis (acute, chronic)
    - HIV
  - Malnutrition
  - Pneumonia
  - Tetanus
  - Tuberculosis
  - Urinary Tract Infections
  - Endocrine Abnormalities (ACTH and adrenal function, ovulation)

### Obstetrical Complications Opiate Abuse

- Remember the poly substance abuse is the norm.....
  - Spontaneous Abortion, especially first trimester
  - Amnionitis
  - Intrauterine Growth Retardation
  - Placental Insufficiency
  - Postpartum Hemorrhage
  - Pre-edampsia and Eclampsia
  - Premature labor/premature rupture of membranes
  - Septic thrombophlebitis
MMT in Perinatal Addiction – Major Points

- MMT is but a single element in the variety of services needed for optimal care of the pregnant opioid dependent patient.
- Comprehensive MMT with adequate prenatal care can reduce the incidence of obstetrical and fetal complications, intrauterine growth retardation, and neonatal morbidity and mortality (Finnegan, 1991).

Interdisciplinary Program

- Winnie Palmer Hospital Maternity and Neonatal Care
- Opiate Treatment Program (CFDFL)
- Methadone Dosing
- Counseling
- Psychiatric Care
- Supportive Housing
- Orange County Jail
- Various Discipline See the Maternal Fetal Dyad Differently
- Obstetricians
- Therapists
- Addiction Specialists
- Psychiatrists
- Support Staff
- Pediatricians
- Corrections Officers
- "The quality of the staff-patient interaction and attitudes of staff, good management of clinic and quality of record keeping are factors which have been linked to outcomes of treatment." Bell 2000

Benefits of Maintenance with Opioid Agonist Therapy in Pregnancy

- Pregnant Patients Receive All the Same Benefits as Non-Pregnant Patients on Maintenance Therapy
  - Reduction in All Cause Mortality
    - "...the all cause mortality rate for patients receiving methadone maintenance treatment was similar to the mortality rate for the general population whereas the mortality rate of untreated individuals using heroin was more than 15 times higher." Bell 2000

Opioid Agonist Maintenance in Pregnancy

- Methadone is the only medication currently approved for the treatment of opioid addiction in pregnancy (US).
- Maintenance with methadone during pregnancy produces the same benefits as treatment in the non-pregnant patient.
- A pregnant patient CAN taper off of methadone (opioid agonist therapy) but should not be permitted to experience significant abstinence syndrome.
  - Luty, J, Nikolau V, Beam J. 2004
- But, medically supervised withdrawal is not the standard of care due to the poor outcomes (Jones H, 2008) and the potential catastrophic consequences of relapse.
- Because the goal of treatment with methadone is to prevent relapse to illicit substance use.
Pregnancy Specific Benefits of Opioid Maintenance Therapy

- Methadone Maintenance Therapy (MMT) is regarded as an established treatment with birth outcomes comparable to a general obstetrical population (Kreek MJ, 2000)
  - Fewer Pre-term Births
  - Less Intrauterine Growth Restriction
  - Fewer Low Birth Weight
  - Less Maternal Drug Use
  - Greater reduction with higher dose of methadone
- Improved Prenatal Care Compliance Burns L, 2004; Goler NC, 2008
- There appears "to be no differential effect of either treatment (methadone or buprenorphine)—it was exposure to stable treatment that was important.
  - Gibson 2008

Principles of Opioid Agonist Therapy

- Opioids bind the mu opioid receptors in the brain.
  - The mu receptor generates the effects experienced by the patient/drug user.
  - Different opioids stimulate the receptor to a greater or lesser degree.
- By occupying the mu receptor with a long acting opioid the effects of other opioids are impeded or attenuated.
- By dosing regularly and before developing symptoms of abstinence syndrome the mu receptors will be occupied when a trigger or craving is experienced.
- A higher dose occupies more receptors longer.

Principles of Pharmacotherapy with Methadone

- Methadone is the only agonist therapy approved for use in pregnancy. It is supported by 30 years of research
- Methadone is a full agonist so the effect is directly proportionate to the dose.
- It takes 24 to 36 hours for the body of a healthy person to eliminate half of the methadone ingested.
  - A person with impaired liver function or on other medications/intoxicants may require up to 50 hours to eliminate half of the methadone.
- The opioid "blocker" effect is a result of having the mu opioid receptor occupied with methadone when another opioid is introduced.

Principles of Pharmacotherapy with Buprenorphine (Subutex)

- Antagonist / High receptor affinity
  - Highest receptor affinity and receptor occupancy: 95% occupancy at 16 mg (Greenwald et al, 2003)
  - Blockade or attenuate effect of other opioids
  - Rapid onset of action and risk of acute opioid reversal
- Partial receptor agonist / Low Intrinsic Activity
  - Lower physical dependence
  - Limited development of tolerance
  - Ceiling effect on respiratory depression
- Long Acting / Slow dissociation from receptor
  - Long duration of action
  - Milder withdrawal

Getting the Prenatal Dose Right: Induction and Stabilization

- Methadone Induction for the Pregnant Patient
  - INPATIENT
    - Permits larger initial dose and more rapid escalation
    - Prenatal assessment conducted concurrently
    - More likely to isolate patient from source of other illicit substances
  - OUTPATIENT
    - Initial dose 10-20 mg
    - Twice daily assessment for object signs of withdrawal
    - "Peak" and "Trough"
    - Increase in increments of 5 or 10 mg
    - Patient to record fetal movement regularly
Safe and Effective Induction with Methadone: Outpatient

- Safe dose:
  - "Start low and go slow."
  - Respiratory depression develops later than peak effect.
  - Cross tolerance between opioids is not 100%
  - Average dose:
    - 80 to 120mg
  - Titrate to effect/individualize treatment
  - Effective dose:
    - Abolishes abstinence syndrome for at least 24 hours.
    - Does not cause over-sedation at peak effect (4 hours after dosing.)

Buprenorphine in Pregnancy

- Not FDA approved for use in pregnancy/Category C
  - Although widely used in Europe (see TIP 40)
  - Pharmacokinetics of buprenorphine not well understood in pregnancy or in the fetus
  - Recommend buprenorphine monotherapy only (Subutex)
  - Improved pregnancy outcomes seen with methadone appear to be duplicated on buprenorphine.
  - Typical dosing is 8mg to 24mg daily and generally requires few adjustments in pregnancy
  - Highly receptor bound so less affected by increased metabolic rate and larger blood/tissue volume.
  - No benefit to divided dosing

Methadone vs. Buprenorphine

- Opioid maintained patients who become pregnant should be maintained on the current agent
  - Suboxone can be changed directly to Subutex
  - Buprenorphine should only be initiated when
    - Patient cannot tolerate methadone
    - Methadone program is not accessible
    - Patient is adamant about avoiding methadone
    - Patient is capable of informed consent

Ongoing Illicit or Polysubstance Use

- Can be reduced by higher dose
  - Does not seem to directly increase the incidence of pregnancy complications but,
  - Does reverse the positive impact of opioid maintenance on birth weight.
  - Maternal tobacco use plays a role in timing and onset of Neonatal Abstinence Syndrome (NAS)
    - Choo RE, et al 2004

The Right Dose Throughout Pregnancy

- Increased Blood Volume
  - Larger Tissue Reservoir
  - Methadone Loss to Amniotic Fluid
  - Altered Maternal Metabolism
  - Metabolic Activity of Placenta
  - Metabolic Activity of Fetus

- Patient may require progressive increases throughout pregnancy.
- Split dosing is an option to maintain adequate blood levels with fewer increases.
- Kaltenbach, Jarvis '98; Jarvis '99
- Counseling is essential to address cravings, stress, and anxiety

Methadone Dose and Maternal Infant Outcomes

Outcomes Measured (Study 1):

- For methadone-exposed pregnancies, compare maternal and infant outcomes by
  - Methadone dose at delivery
    - Timing of conversion to methadone
  - Retrospective cohort study
  - De-identified data abstracted from hospital delivery records (MOMI) – 1999-2005
  - N=224 with delivery dose
  - N=215 with conversion time
Outcomes:
Maternal & Fetal

<table>
<thead>
<tr>
<th>Outcome (n=252)</th>
<th>%</th>
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<tbody>
<tr>
<td>Fewer than 7 OB visits</td>
<td>8.3</td>
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<tr>
<td>Meconium staining</td>
<td>8.7</td>
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<tr>
<td>Abnormal fetal heart rate/ten or distress</td>
<td>15.1</td>
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<tr>
<td>Chorioamnionitis</td>
<td>6.0</td>
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<tr>
<td>Stillborn</td>
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<table>
<thead>
<tr>
<th>Outcome (n=252)</th>
<th>Mean (SD)</th>
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<tr>
<td>Birth weight (g)</td>
<td>2788 (690)</td>
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<tr>
<td>Gestational age (wks)</td>
<td>37.4 (3.3)</td>
</tr>
<tr>
<td>Preterm birth, %</td>
<td>27.4</td>
</tr>
<tr>
<td>Small for gestational age, %</td>
<td>26.3</td>
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<tr>
<td>NICU admission</td>
<td>55.6</td>
</tr>
<tr>
<td>NICU admission for NAS, %</td>
<td>41.3</td>
</tr>
<tr>
<td>NICU admit other reason</td>
<td>14.3</td>
</tr>
<tr>
<td>In hospital death rate, %</td>
<td>1.6</td>
</tr>
</tbody>
</table>

Birth weight (g), mean (sd) 2788 (690)
Gestational age (wks), mean (sd) 37.4 (3.3)
Preterm birth, % 27.4
Small for gestational age, % 26.3
NICU admission 55.6
NICU admission for NAS, % 41.3
NICU admit other reason 14.3
In hospital death rate, % 1.6

Methadone Dose Distribution

Timing of Methadone Conversion

Infant Outcome by Methadone Dose

Outcomes & Limitations
- No association with any maternal outcomes
- Methadone dose
- Timing of conversion
- No association with infant outcomes and timing of conversion
- Source of data – medical records review
- No measure of adherence to treatment
- No data on other drug use
- Observations from hospital setting - no early miscarriages or abortions

Intrapartum & Postpartum Management
Intrapartum and Postpartum Management

- Provided the prenatal opioid agonist is dosed appropriately for the individual...
- Intrapartum analgesic need and response in the methadone maintained patient is similar to non-opioid dependent patients. (Meyer M 2007)
- Post-partum pain management is comparable to the non-opioid dependent patient. (Jones H 2008)
- MMT patients may tolerate a dose reduction in the immediate or early post-partum period even in the absence of sedation. Advance preparation makes this more successful. (Jones H, 2008; Bogen D, ----)

Breastfeeding on Methadone

Alex Grey
 "Nursing"
1985
Oil on Linen

Maternal Methadone Levels Pregnancy vs. Postpartum in 12 patients

Breastfeeding on Methadone

- AAP Recommendations
  - 1994: doses >20 mg/day contraindicated
  - 2001: methadone, regardless of dose, removed from contraindicated list
- Published Data
  - 7 case series from 1974 to 2001
  - 54 breast milk samples
  - Most doses ≤ 80 mg/day; 1 series R- + S- methadone

Calculations of the methadone level in a breastfeeding infant.

Methadone doses of 25 to 180 mg/d → milk concentrations in milk from 27 to 260 ng/mL.

Based on an estimated milk intake of 500 mL/d in an infant, average daily methadone ingestion is 0.05 mg.

In an 11 pound baby, the ingested amount is thus less than 1% of the maternal weight-adjusted dose.

Methadone clearance in neonates is slower than adults, but the infant dose will not exceed 5% of the maternal weight-adjusted dose.


Conclusions

- Implications
  - Data support revised AAP recommendations to remove methadone at doses > 20 mg/day from the list of contraindicated drugs during lactation.
  - Breastfeeding shouldn’t impact dosing decisions
Neonatal Abstinence Syndrome

METHADONE AND BUPRENORPHINE: PRESENTATION AND MANAGEMENT

Neonatal Abstinence Syndrome (NAS)
- Onset typically around 72 hours but may occur from minutes after birth to 2 weeks postpartum.
- Preterm infants generally have a milder course.
- Metabolic activity of neonate impacts onset and course.
- Course may be mild and transient, incremental or biphasic in severity.
- Concurrent neonatal illness may delay onset of NAS.
- NAS can mimic hypoglycemia, sepsis, neurologic disease and these diagnoses must be considered.

NAS Buprenorphine: What We Know
- Onset 12 to 72 hours after birth.
- Peaks at 72 to 96 hours.
- Total duration usually 120 to 168 hours.
- Some reports indicate NAS can last 6 to 8 weeks.
- Breastfeeding does not relieve NAS.
  - Infant is exposed to 1/5 to 1/10 of maternal dose.
  - Buprenorphine has poor oral bioavailability (neonate).
- NAS does not occur with cessation of breastfeeding.

NAS Buprenorphine: What We Don’t Know
- Neonatal Abstinence Syndrome occurs but may be less intense.
- No studies with sufficient power have been done to validate case reports.
- Placental transfer of buprenorphine may be less than methadone leading to lower rates of NAS.
- Patients should be informed of risk of NAS as for methadone.

Initial Neonatal Work-up
- First urine—will only detect very recent substance use.
- First meconium—will detect substances used after 20 weeks gestation.
- Standardized NAS scoring should begin within 2 to 4 hours of birth and repeated every 2 hours.
- Finnegan Scores
  - Easy to learn/administer
  - Promotes standardization/consistent management
- Assess for other diagnoses as indicated particularly for persistent diarrhea.

Supportive Non-Pharmacologic Therapy
- Up to 30% of patients will require only supportive management.
  - Finnegan Score < 8
- Quiet dim room.
- Swaddling/rocking.
- Frequent feeding.
- Pacifier for excessive sucking.
- Consider hypercaloric formula.
- Frequent diaper changes.
Pharmacologic Management of NAS

- Morphine Oral Solution
  - Indicated when average of 3 consecutive scores >8
  - Begin pharmacotherapy within 2 to 4 hours of meeting criteria
  - Vomiting and diarrhea with dehydration indicate need for pharmacotherapy even with scores < 8
  - Delay in initiating pharmacotherapy is associated with increased infant morbidity

Management with Oral Morphine

<table>
<thead>
<tr>
<th>Score</th>
<th>Dose q4 hours</th>
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<tr>
<td>8 – 10</td>
<td>0.8ml(0.32mg)/kg/day</td>
</tr>
<tr>
<td>11 – 13</td>
<td>1.2ml(0.48mg)/kg/day</td>
</tr>
<tr>
<td>14 – 16</td>
<td>1.6ml(0.64)/kg/day</td>
</tr>
<tr>
<td>&gt;16</td>
<td>2.0ml(0.80)/kg/day</td>
</tr>
</tbody>
</table>

- Use birth weight for all calculations
- If scores increase or inadequate response within 12 hours consider increasing morphine by 0.4mg/kg/day increments (total 0.16mg/kg/day)
- Consider phenobarbital if CNS symptoms not controlled

Stabilization and Detoxification

- Maintain control of symptoms for 24 to 48 hours
- Wean medications at the same time every day
- Use average of scores over a 12 to 24 hours
  - Scores Titration
    - 6 – 8 reduce by %10
    - 3 – 5 reduce by %15
- Discontinue when 0.1ml(0.04mg) q 4 hours for 24 hours
  - For infants with medical problems or scores persistently >4 dose interval may be increased rather than discontinuing.

Troubleshooting

- Consider medication error if score decreases to <2 within a 12 – 24 hour period
- Score every 2 hours until symptoms resolve
- Withhold dose for lethargy
- Asymptomatic infants (score persistently "zero") may be weaned by %20 daily or %10 every 12 hours

Discharge Planning

- Observe infant at least 24 hours after discontinuing medication
- All other discharge criteria must be met
- Parental Education:
  - Subclinical withdrawal for 4 – 6 months
  - Address feeding/sleeping problems
  - Proper swaddling
  - Reinforce importance of mother’s well-being
  - Close follow up
- Home Nursing

WWW Resources

- Medications in Pregnancy and Lactation:
  - TerisWeb - http://depts.washington.edu/terisweb
- Toxicology and Teratology:
  - Organization of Teratology Information Specialists - www.otispregnancy.org
- Addiction and Pregnancy:
Methadone & Pregnancy Fact Sheet

- Pregnant women on methadone need to be on doses that alleviate withdrawal symptoms. If your baby is becoming hyperactive in utero as the methadone dose wears off, you may need to go up on your dose.
- Pregnant women on methadone are candidates for split dosing. Dosing twice a day delivers more steady methadone levels to your baby. You will be returning to once a day dosing after the baby is born.
- All pregnant women must see the medical provider once a month.
- During the third trimester, you may need to go up on your methadone dose due to increased blood volume that dilutes the methadone.
- After delivery, reduction in methadone dose is often needed. If you are feeling drowsy, let the nurse know so that we can decrease your methadone dose.

- Breast feeding in methadone maintained mothers is encouraged and safe for the baby. The amount of methadone in breast milk is negligible. (Mothers who are HIV positive should not breast feed). Breast feeding decreases withdrawal symptoms in the baby due to maternal bonding, not from methadone in the breast milk.
- Most babies born to methadone maintained mother have some withdrawal symptoms. Your baby may require opiates for a few days in order to treat the withdrawal symptoms. There are no know long term negative effects from this in the baby.
- While you are in the hospital after delivery, your maintenance dose of methadone should be continued. This will be provided to you by the hospital. If you require pain medications after a C-section or vaginal delivery, you should still get your maintenance methadone dose as well as the pain medication.

- When you go to the hospital to deliver your baby, do not let the staff give you any of the following medications because these drugs will cause immediate and severe withdrawal in you and your baby:
  - Stadol (butorphanol)
  - Nubain (nalbuphine)
  - Talwin (pentazocine)
  - Buprenex (buprenorphine)

These drugs are contraindicated in the methadone maintained patient!
Thank you.
Destruction Management: Addictive Thinking & Behaving For the Impaired Healthcare Professional

THOMAS C. ANTONEK, Ph.D.
Serenity Mission
www.serenitymission.com

Utilitarian/Functional Definition
“Destruction Management” costs time, expends energy, depletes financial resources, adversely diminishes general mental health & wellbeing, and is a form of sabotaging successful recovery.

Prerequisites
• Destruction Management is caused by faulty thinking and presumptions that require expenditure of cognitive and behavioral reserves
• Destruction Management deceives one into believing that one is actually working a recovery program as manifest in the amount of time being invested in attending meetings (“Meeting Makers Make It”)
• Destruction Management cannot be sustained as the addict’s primary defense mechanism and will eventually lead to a return to substance use.

“I KNOW THAT I AM IN RECOVERY”
• Proof by blood test, urine test, hair test.
• Negative Drug Screens authenticate that I am clean and sober, so I am in recovery.
• Abstinence from alcohol and mind altering drugs means that I am in recovery.

Abstinence does not equal Recovery
You can be abstinent from involvement in substance abuse and still not be involved in an effective program of recovery that includes:
• Healing of Your Emotions
• Improved Relationships with Others
• Provide you with a life that is based upon a foundation of SERENITY & PEACE.

Sobriety does not require Spirituality
• Having a spiritual foundation for recovery is vastly different than becoming a “Religious Zealot”
• Scientific Knowledge as a hindrance to building a Spiritual Foundation
• All that can be known, proven, or experienced is through the 5 senses.
• Spirituality cannot be experienced in a sensory capacity and is not subject to the scientific method of inquiry, so it is not real.
I am Special (for the Narcissist) or Different (for the less egocentric)

- Subsequently, I do not have to employ the same principals or actions of others in order to achieve the same results.
- My program does not need to look like yours (If it works - you work it)
- I am not going to take your inventory - so don’t take mine (No Accountability)

If I do not pay attention to “IT”, then “IT” will go away

“IT” is:
- Whatever LIE we tell ourselves
- Whatever Behavior we engage in
- That Does Not Reflect Recovery
  - Healing our emotions
  - Improving relationships
  - Serenity & Peace

Emotional & Physical Pain are undesirable states to be avoided

- I am overwhelmed by feelings that are not wanted or desirable when I am sober.
- Nothing in “THE PROGRAM” is designed to anesthetize feelings.
- I do not hurt or feel pain when I am drunk

The Past is Over - So, there is no sense in reliving it through recollection or reflection

- The Serenity Prayer attests to the reality that there are things we cannot change and the past is one of them
- “Did It - Done It - Got the T Shirt
- Forgive & Forget

No One Else TRULY Understands What I am Going Through

I am genuinely all alone in my existential despair

- Sympathy does not equal Empathy
- The solution to my anguish is not found in your expression of compassion.

Depression & Anxiety are signs of weakness and have no place in a “Happy-Joyous & Free Life”

Gratitude Trumps Melancholy

- Gratefulness can coexist with Sorrow
- I am not “One of those still suffering “in and out of the rooms”. 
Recovery is **Too Complex** of a Medical & Psychological Process to Fully Understand

Addiction adversely impacts the physical, cognitive, emotional, social/relational, moral, and vocational aspects of one’s life.

- Then it is a fallacy to imply: “Keep it Simple Stupid”
- There cannot be ONE SOLUTION fits ALL.

If I relapse into mind altering substances- **THEN I AM A FAILURE**

The underlying fear here for the addict is the Belief that active relapse occurred because Genuine recovery was never achieved or experienced or one would not have relapsed

- I need to **Start All Over** from **Ground Zero**

ABSOLUTE ALL OR NOTHING AT ALL THINKING

I need an effective reprieve from the impact that my multiple life trauma’s has had on me

- I drank/used drugs because of how I was treated by...or I drank/used drugs because...happened to me
- I am a victim and deserve a “HALL PASS” which is what an altered state of consciousness provides
- A Victim/Survivor who does not perpetrate others is successfully coping with the experience of being victimized

My life is not getting any better or is no better now that I have stopped using alcohol/drugs

THIS IS SELECTIVE RECALL

- “My life was not so bad when I was using. I had a lot of fun.”
- The rewards of Recovery are exceeded by the effort needed to work and maintain sobriety

The people that I know in recovery have more problems than people not in “THE PROGRAM”

- SERENITY is the program PERSONA put on as one enters “The Rooms” but the presentation is not honest or sincere
- The residual consequences from our substance abuse history continues to plague us long after the last drink or drug.
- The emotional pain experienced at “The Bottom” before the last drink or drug does not hurt as bad as climbing out of the abyss without a drink or drug

I have used before and Lived through it

- I know that I can bounce back if I use again
- Relapse is a part of the Recovery Journey
- The Program is Universal and the Recovery Community is ever present to accept back into the fold one who has a desire not to drink or drug
I have Regained & Restored & Redeemed My:

- MENTAL & PHYSICAL FACULTIES
- FINANCIAL SECURITY
- MEANINGFUL RELATIONSHIPS
- VOCATIONAL STABILITY

THEREFORE I AM RECOVERED

SOLUTION
RECOVERY IS A JOURNEY
NOT A DESTINATION

SOLUTION
RECOVERY IS COMMUNAL
THERE IS:
ACCOUNTABILITY
EXPERIENCE
STRENGTH
HOPE

SOLUTION
RECOVERY TRANCENDS THE
SELF/EGO

SOLUTION
RECOVERY HAS BEEN SUCCESSFULLY ACHIEVED BY COUNTLESS ADDICTS WHO BUILD A PROGRAM BASED ON SPIRITUAL PRINCIPALS

SOLUTION
RECOVERY IS A RELAPSE “BUZZ KILL” YOU KNOW THAT YOU HAVE BEEN IN RECOVERY WHEN GETTING HIGH IS MORE UNPLEASANT THAN ABSTINENCE
The Addictive Family: The Legacy of Trauma

Claudia Black Ph.D.
www.claudialblack.com

Each time we focus on the addict without focusing on the family, we are in denial that we are breaking the cycle of addiction.
Therese’s Family of Origin Issues

- Overlook (deny, rationalize, minimize) behavior which hurt deeply
- Appear cheerful when hurting
- Make excuses for the hurtful behavior
- Avoid conflict to minimize further anger
- Tolerate inappropriate and hurtful behavior
- Prioritize the needs of other over own
- Caretake others

- Fault self for family’s problems
- Discount own perceptions, give others benefit of the doubt
- Believe no options are available
- Believe she is at fault, it is her job to find the answers
- Not ask for help
- Accommodate
Healthy Parenting Practices

• Basic needs of safety, food, shelter
• Appropriate role modeling
• Warm and supportive relationship between the parent and child
• Parental monitoring and supervision
• Maintaining awareness of the child’s peer relationships
• Understanding the child’s individual risk level
• Establishing appropriate parent child communication

Amelia Arria, Ph.D.

Types of Stress

• Positive – associated with moderate short-lived physiological responses
• Tolerable – associated with physiological responses that can disrupt brain architecture, but relieved by supportive relationships
• Toxic – associated with strong and prolonged activation of the body’s stress management system in the absence of buffering protection

Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults:

The Adverse Childhood Experiences (ACE) Study is an ongoing collaboration between the Centers for Disease Control and Prevention and Kaiser Permanente. Led by Co-principal Investigators Robert F. Anda, MD, MS, and Vincent J. Felitti, MD

Childhood abuse, neglect, and exposure to other traumatic stressors which we term adverse childhood experiences (ACEs) are common. Almost two-thirds of our study participants reported at least one ACE, and more than one in five reported three or more ACEs. The short and long-term outcomes of these childhood exposures include a multitude of health and social problems.

The ACE score is used to assess the total amount of stress during childhood and has demonstrated that as the number of ACEs increase, the risk for the following health problems increases in a strong and graded fashion.

• Alcoholism & alcohol abuse
• Chronic obstructive pulmonary disease (COPD)
• Depression
• Fetal death
• Health-related quality of life
• Illicit drug use
• Ischemic heart disease (IHD)
• Liver disease
• Risk for intimate partner violence
• Multiple sexual partners
• Sexually transmitted diseases (STDs)
• Smoking
• Suicide attempts
• Unintended pregnancies

In addition, the ACE Study has also demonstrated that the ACE Score has a strong and graded relationship to health-related behaviors and outcomes during childhood and adolescence including early initiation of smoking, sexual activity, illicit drug use, adolescent pregnancies, and suicide attempts.

Finally, as the number of ACEs increases the number of co-occurring or “co-morbid” conditions increases.

Children of addiction are 2 to 4 times more likely to be sexually abused. They are prime for victimization as they...

1. Are often starving for attention
2. Are less apt to speak up because of fear of not being believed.
3. Give others the benefit of the doubt.
4. Don’t trust their own perceptions.
5. Don’t know what they feel and can’t use feelings and cues as signals.
6. Are confused about appropriate boundaries.
7. Experience shame upon shame which fuels powerlessness.

American Journal of Preventive Medicine
Volume 14 - Issue 4 - Pages 245-258 (May 1998)
**Emotional Abandonment**

When you have to hide a part of who you are in order to be acceptable/to protect self.

When you have to hide:
- Your mistakes/vulnerabilities
- Your feelings
- Your needs
- Your accomplishments/success

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**How Chronic Loss is Created**

Loss event occurs and/or loss condition exists

Attended Family response to child's pain
Abandoned

Pain of loss felt by child

<table>
<thead>
<tr>
<th>Attended</th>
<th>Abandoned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Feels:</td>
<td>Child Feels:</td>
</tr>
<tr>
<td>Comforted, cared for, allowed permission to feel, reality of loss validated, pain honored</td>
<td>Betrayed, ignored, shamed, belittled, reality of loss denied, pain discounted, diminished</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pain</th>
<th>Pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>grams</td>
<td>grams</td>
</tr>
</tbody>
</table>

Child’s reaction to attended, healed pain

Emotions | Beliefs
---|---
Safe | Okay
Protected | Worthy
Loved | Lovable
Connected | Guilt-free

Behaviors
Open to being self, expressing self. Free of need for defense, controlling self.

<table>
<thead>
<tr>
<th>Attended child’s family environment</th>
<th>Abandoned child’s family environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Free to thrive</td>
<td>Struggle to survive</td>
</tr>
<tr>
<td>Sense of self developed</td>
<td>Sense of self undermined</td>
</tr>
</tbody>
</table>

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**Characteristics of Adults Abandoned as Children**

- Seek acceptance outside of self, taking care of others, forgetting own needs
- Under-regulated or over-regulated emotions/difficulty with one’s emotions
- Connecting to objects rather than people

---

**Characteristics of Adults Abandoned as Children**

- Miss social cues when relating to others
- Hypervigilant
- Don’t see a problem until it is a crisis
- When they do recognize it is a crisis, can’t ask for help
Characteristics of Adults Abandoned as Children

- Clinging while expecting rejection
- Become relationship nomads or stay in emotionally cut off relationships
- Put up barriers if people get too close – walled boundaries
- Lack of boundaries – enmeshment

Characteristics of Adults Abandoned as Children

- Difficulty trusting or flip side – give trust when unearned
- Inability to articulate needs and feelings
- Unrealistic expectations / impoverished expectations
- Cognitive distortions, faulty thinking

Characteristics of Adults Abandoned as Children

- Inability to engage in healthy self care
- Image management- making everything on outside look good to the outside world, feeling greater despair internally
- Lack of self-worth – shame responses

Be kind to me, Lord, my boat is so small and the sea is so wide.

Epigram for the National Children's Defense Fund

Shame Screens

<table>
<thead>
<tr>
<th>Power Over Pain</th>
<th>→</th>
<th>Rage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>→</td>
<td>Control</td>
</tr>
<tr>
<td></td>
<td>→</td>
<td>Perfectionism</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Succumb To Pain</th>
<th>→</th>
<th>Procrastination</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>→</td>
<td>Victim</td>
</tr>
<tr>
<td></td>
<td>→</td>
<td>Depression</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Erase The Pain</th>
<th>→</th>
<th>Addiction</th>
</tr>
</thead>
</table>
No one person's loss is to be negated by another person's losses and experiences.