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EXPERIENCES OF WOMEN WITH SUBSTANCE USE DISORDER REGARDING THE PREGNANCY PROCESS

MADDE KULLANIM BOZUKLUĞU OLAN KADINLARIN GEBELİK SÜRECİNE İLİŞKİN DENEYİMLERİ

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ABSTRACT

Objective: Substance use in pregnancy is a critical public health problem that is associated with several harmful maternal and fetal outcomes. This study was conducted to investigate the pregnancy, delivery experiences of women with substance use disorder (SUD) and the problems they encounter while using healthcare services.

Method: In the study, the qualitative research design of case study was used. This study was conducted between February 2019 and 2020 at a SUD clinic. The method of purposive sampling was used in the study. The population of the study consisted of the files of female patients who visited the clinic in the period of 01.01.2010-2018, and these files were retrospectively analyzed. The patients who turned out to be Beta HCG-positive in these files constituted the population of the study. The study was completed with 8 patients. The data of the study were collected between 01.02.2019 and 2020. The data collection instrument consisted of two parts including a "Participant Information Form" on the descriptive information of the women and a "Semi-Structured Interview Form". The interviews were audio-recorded and transcribed by removing all identifying information. Afterwards, the interview data were coded, interpreted and reported.

Results: The pregnant women with substance use stated that their pregnancy was unplanned and found out late, most stated they were afraid when they learned about their pregnancy due to some reasons, most said they sought help from healthcare personnel, half stated they could not receive help from healthcare personnel, and some said they were exposed to the stigmatizing behaviors of healthcare personnel.

Conclusion: Pregnant women using substances encounter many obstacles in receiving and continuing treatment during their pregnancy and after delivery.

Keywords: Healthcare Services, Pregnancy, Stigma, Substance Use.

ÖZET

Amaç: Gebelikte madde kullanımı, birçok zararlı maternal ve fetal sonuçlarla bağlantılı kritik bir halk sağlığı sorunudur. Bu çalışma, MKB olan kadınların, gebelik, doğum deneyimleri ve sağlık hizmetlerini kullanırken karşılaştıkları problemleri incelemek amacıyla yapılmıştır.

Yöntem: Araştırmada nitel araştırma desenlerinden durum çalışması deseni kullanılmıştır. Bu çalışma Şubat 2019-2020 tarihleri arasında Madde kullanım bozukluğu kliniğinde yapılmıştır. Araştırmada, amaçlı örnekleme yöntemi kullanılmıştır. Çalışmanın evrenini kliniğe 01.01.2010-2018 tarihleri arasında başvurmuş kadın hasta dosyaları oluşmuştur ve bu dosyalar retrospektif olarak değerlendirilmiştir. Bu dosyalarda Beta HCG pozitif çıkan hastalar çalışmanın evrenini oluşturmuştur. Çalışma 8 hasta ile tamamlanmıştır. Araştırma verileri 01.02.2019-2020 tarihleri arasında toplanmıştır. Veri toplama aracı kadınlara ait tanıtıcı bilgilerin olduğu bir "Katılımcı Bilgi Formu", yarı yapılandırılmış "Görüşme Formu" olarak iki bölümden oluşmaktadır. Yapılan görüşmeler, tüm tanımlayıcıları kaldırarak ses kaydı ve transkripsiyon yapılmıştır. Ardından tüm görüşme verileri kodlandırılarak ve yorumlanarak rapor haline getirilmiştir.

Bulgular: Madde kullanımı olan gebeler, gebeliklerinin plansız olduğunu ve geç tespit edildiğini, gebeliklerini öğrendiklerinde bazı nedenlerle çoğu korktuğunu, birçoğu sağlık personelinden yardım istediğini, yarısı sağlık personelinden yardım alamadığını, bir kısmı ise sağlık personelinin damgalayıcı davranışlarına maruz kaldığını ifade etmişlerdir.

Sonuç: Madde kullanan gebeler gebelikleri sırasında ve doğum sonrasında, tedavi olmak ve sürdürmek için birçok engelle karşılaşmaktadır.

Anahtar Kelimeler: Gebelik, Madde Kullanımı, Sağlık Hizmetleri, Stigma.

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INTRODUCTION

Substance use in pregnancy is a critical public health problem that is associated with several harmful maternal and fetal outcomes. The most frequently used substance in pregnancy is tobacco, followed by alcohol, marijuana and other illegal substances (Forray et al., 2015). Substance use disorders (SUD) during pregnancy are a difficult health problem for healthcare professionals in the entire world. The SUD problem in pregnant women is broad-scoped. Approximately a third of women with SUD are those of reproductive age (Metz et al., 2012). It is known that an estimated 60,000 pregnant women use drugs every year in Europe, and half of these women are opioid users (Gyarmathy et al., 2009). Substance use in pregnancy may bring about various harmful outcomes for both the mother and the infant. Concerns about the effects of substances on the developing fetus may be motivating for some women to reduce their drug and alcohol use during pregnancy (Forray et al., 2015).

Determination of substance use risk before and during pregnancy is a critical first step in preventing use through treatments and services and reducing harm. Pregnant women with SUD not only encounter psychological issues such as a sense of guilt towards their unborn child and fears towards future motherhood, but they are also stigmatized by usually the society and frequently caregivers when they start treatment (Anstice et al., 2009). Moreover, in addition to physiological problems due to pregnancy and SUD, they may be challenged with socioeconomic difficulties such as unemployment, homelessness, or legal problems. Substance abusing women frequently have relationships with substance abusing men (Tuten, & Jones, 2003), and this may make treatment problems such as somatic and psychiatric comorbidities that are highly prevalent especially in sensitive patient populations difficult.

It is important to be able to understand the problems experienced by women with SUD in the risky pregnancy group in their care in the pregnancy, delivery and postpartum periods and their access to professional healthcare services. Studies with these women are rare in the literature. In-depth studies are needed to solve the problems of women with SUD and understand them better. This study was conducted for the purpose of investigating the problems experienced by women with SUD during their pregnancy and delivery experiences and usage of healthcare services. Accordingly, answers were sought for the following research questions:

✓ What are the experiences of women with SUD regarding their way of learning about their pregnancy?

✓ What does their pregnancy mean for women with SUD?

✓ What are the interpretations of women with SUD regarding the social support systems they perceive during the pregnancy process?

✓ What is the effect of the way the pregnancy results on the mother with SUD?

✓ What are the thoughts and experiences of pregnant women with SUD regarding the attitudes and behaviors of healthcare professionals?

METHOD

As the study, which was carried out with a qualitative research method, investigated the pregnancy experiences of women with SUD in the context of the effects of the pregnancy process and its outcomes on the women and views regarding the attitudes of healthcare personnel in this process, in-depth description and analysis were employed on multiple cases in the study (Aydın, 2016). In this context, the study used the qualitative research design of case study. Permissions were obtained from the board of ethics and the institution (Approval number:318/03.04.2019/2012-KAEK-20). This study was conducted between February 2019 and 2020 at an addiction treatment center. The method of purposive sampling was used in the study. The population of the study consisted of the files of female patients who visited the clinic in the period of 01.01.2010-2018, and these files were retrospectively analyzed. The patients who turned out to be Beta HCG (Human Chorionic Gonadotropin)-positive in these files constituted the population of the study. The study included women who turned out to be Beta HCG-positive, were diagnosed with SUD, aged 18 or older and consented to participate in the study. As a result of screening the files, 20 patients turned out to be Beta HCG-positive. The positive patients were called, 6 could not be reached, 4 did not agree to participate as they were not using substances at the time, and 2 had changed cities. The study included women with a history of pregnancy in the last 5 years. The fact that the pregnancy histories of those who did not want to participate in the study or could not be reached went beyond 5 years ago also necessitated the

exclusion of these individuals. The study was completed with 8 patients. The data of the study were collected between 01.02.2019 and 01.02.2020. The data collection instrument consisted of two parts including a "Participant Information Form" on the descriptive information of the women and a "Semi-Structured Interview Form". The interview questions were assessed by relevant experts. To achieve the validity and reliability of the interview form, pilot interviews were held by speaking to three women, and after the pilot study, the necessary revisions were made on the interview form. The interview form included 10 questions examining the issues experienced by the women in pregnancy, delivery and the postpartum process (e.g., How do you think your pregnancy was? Why?). Before the study, the participants were informed that privacy principles would be complied with, written consent was obtained, and the study was carried out in line with privacy principles. Face-to-face interviews were held by the researchers using the in-depth interview method. The guidelines of the interview started with the following statement: "Could you tell me about your pregnancy story starting at the beginning?" Afterwards, the researchers continued to ask questions about the women's experiences. The responses of the women are included in the findings section exactly as they were stated. The interviews with the women lasted for about 20-30 minutes based on the responses of the women. The interviews were audio-recorded and transcribed by removing all identifying information. While interpreting the eight transcripts, content analysis was used. Three independent experts analyzed the data, and each expert formed codes that could be derived from each word and sentence. Afterwards, these experts gathered together and created a common code list. After the codes were created, thematic coding started, the codes were categorized by the researcher, and appropriate themes were derived. All interview data were then coded, interpreted and reported.

RESULTS

This section includes the demographic findings of the pregnant women with SUD and findings obtained as a result of the study on their experiences during and after pregnancy and the effects of their experiences on them.

The mean age of the participants was 25.3. 75% of the women were primary school graduates, 25% were high school graduates, 62.5% were single, 37.5% were married, 75.2% were not working, 50% grew up in a fragmented family, 37.5% had a nuclear family, and the families of 12.5% had died. Regarding the participants' SUD-related characteristics, 75% had an addicted relative in their families, alcohol abuse was usually seen, all used cigarettes and opioids, opioid usage was in the range of 0-1 gr per day, every day with the tinfoil method, and additionally, 25% used cocaine, and 62.5% used marijuana at some point in their lives.

It was aimed to reveal the participants' pregnancy experiences by asking them questions on how they learned about their pregnancy, what pregnancy meant for them, at what stage of pregnancy they learned about their pregnancy and what kinds of support they received. Accordingly, four themes were determined to include their experiences regarding the way of learning about their pregnancy, experiences regarding the stage of learning about their pregnancy, views on what pregnancy meant for them and views on the social support system they utilized.

As a result of the interviews, half of the participants stated that they learned about their pregnancy when they felt their breast growing, fewer than half said they learned about it when they felt nauseous, and a part of the participants stated they learned about it when they missed their period or miscarried.

Examples of the participants who stated that they got tested due to their breasts growing and learned that they were pregnant were as follows:

"I was first suspicious. …because of changes in my body, my breasts swelling, my uneasiness. I learned by taking a test from the pharmacy. Afterwards, I went to a doctor, and the doctor told me I was 5-weeks pregnant." (P4)

"I was suspicious of my breast getting tense. There was tenderness in my breasts, and it was aching. Afterwards, I went to a doctor, and the doctor told me I was 5-weeks pregnant." (P8)

Based on the statements above, it was determined that the participants learned about their pregnancies as a result of tests they had done upon noticing previously unexperienced changes in their bodies.

A part of the participants stated that they learned about their pregnancy by feeling nauseous. Examples of the statements of such participants are given below:

"As I was using a substance back then, you know the substance makes you vomit, I vomited for a couple of days and thought that it was making me vomit. I then noticed that it was not going away, it thought of getting a test, I went to the hospital and learned about it then." (P1)

"I tried to consume alcohol but couldn't, I got very nauseous. Then I went to get a test, and the test result was positive there." (P5)

As it may be seen in the example statements above, these participants learned about their pregnancy by firstly thinking that their nausea was a result of the substance they were using and then getting a test done as a result of their nausea lasting longer and not going away or preventing them from using the substance.

Two participants stated that they had tests done due to delays in their periods by statements like: "*I thought I was pregnant at the first delay of my period."* (P8) *"…I then did not have my period and learned about it after getting a test from the pharmacy."* (P4), but it was seen that some participants did not consider this as an indicator of pregnancy as they were experiencing irregular periods due to substance use. Another participant said, *"I learned about it when I had a miscarriage. That is, when I experienced the miscarriage, I was drinking then. I had been feeling a change in myself for a time, and I was not aware that I was pregnant as I had never experienced it before."* (P3).

When the responses of the participants to the question asked to understand at which week of their pregnancy, they learned about it were examined, it was found that none had planned pregnancies, half learned about their pregnancy in the first 2-3 months of pregnancy, a part of them learned about it within a month, and one participant learned about it in longer than four months. Examples of the statements of the participants are given below:

"I think it was two months old. It was eight weeks old." (P5)

"…went to the doctor, it was 2 months old. It was exactly 2 months old, because it was not possible to abort it when it became 3 months old, it was illegal." (P7)

Two participants stated that they learned about their pregnancy in the first month by saying, (P1) *"It was close to one month. Sorry, sorry, the heart sounds of the baby were not formed yet. They did not get me to listen to it. …because when the mother is going to abort, she bonds with it and experiences difficulty, that's why they did not let me listen"* and (P6) "*It was new then, about one month old."*

Only one participant stated that she learned about her pregnancy when it was 4 months old as *"I guess it was 16 weeks old, 3.5 months old, about to become 4 months."* (P2)

When the participants' views on what pregnancy meant for them were examined, if we interpret their responses to the question on what they felt when they learned about their pregnancy in general, the vast majority were afraid due to different reasons when they learned about their pregnancy, a part of the participants did not feel a thing, one participant experienced pain as she learned about it during miscarriage, while another stated that she was happy about this unexpected pregnancy as she had wanted it for a time but could not succeed in getting pregnant. Examples of the statements of the participants who stated they was afraid about their pregnancy were as follows:

"After I learned about my pregnancy, I did not get it aborted willingly. I could give birth to it if I thought my spouse would get better. I went and got it aborted hesitatingly. I made such a decision because I thought I would have difficulty taking care of it. I was afraid. I cried for a couple of days and experienced much regret, after all, the sin about the baby was mine." (P1)

"I was pregnant without marriage, which was another problem, if the men I loved learned about it, he would maybe say it wasn't his. I also thought about my family, my uncle(s), I was also using a substance. Thus, I was afraid." (P2)

"At first, I was very afraid, perhaps it could also become an addict. There was fear, but it passed in time." (P4)

One participant stated her discomfort at the point of learning about her pregnancy as *"I learned about my pregnancy when I had a miscarriage. I had much pain, and I don't want to live it again. I don't even want to remember that day." (*P3), whereas another said, *"I did not feel a thing*." (P5). Only one participant stated her feelings as *"I was very happy, joyful. …because I wanted it very much, so did my spouse. …but it hadn't been possible, that is, it was a big surprise."* (P6)

As seen in the quotes from the participants included above, it should be stated that motherhood does not only correspond to discourses such as joy, happiness and surprise, but for mothers with SUD, it is a situation that leads to feelings of "fear" due to different reasons. For these reasons, some had

concerns about the possibility of their baby becoming an addict due to continuation of their substance use, while some had concerns that they would have difficulty taking care of the baby and concerns about the reaction of family members or the spouse. Additionally, as some were not married, they had a possibility of negative encounters in society.

Considering the views of the participants regarding the social support system they utilized during the pregnancy process, it was seen that the participants mostly sought help from healthcare professionals, followed by friends and family members and spouses, while one participant did not seek any help.

Receiving support from healthcare professionals was explained as (P3)

"*I remember experiencing violence within that day. I experienced violence at night, and I was brought to the hospital in the morning. A small discussion grew and turned into a kick. I was beaten a bit. That is, anger and stress, and I remember falling. I experienced physical violence, so, I was harmed. There was bleeding in the morning. They took me to the hospital right away."* The participant who was exposed to domestic violence resorted to the hospital with bleeding to receive support.

Examples of the statements of the participants seeking support from family members were as follows:

"*I had a male friend. I started crying when I learned, I cried thinking what I would do. …because then my family did not want my husband. I was in peace with my husband, but he was problematic and going to go to prison. I went and told my friends, my sister-in-law was my friend, I told her, too. I was working as a waiter at a hotel. I had a manager, I shared it with him, and he said he could help me financially if I wanted to abort it."* (P1)

As seen in this statement, whether or not the fact that her manager offered financial support for abortion is supportive is debatable, considering that she could not tell her family and husband and did not receive any support. P5 described support as having her mother with him during abortion by saying *"I told my mother, and we went and got it aborted."*

Among the participants who sought support from their spouses, P2 considered acceptance of her baby by her husband as support by saying "*I didn't do anything. I was drinking secretly from my husband. I could manage at most for a month. Afterwards, I told my husband and said we could divorce if he wanted. He said it [the divorce] was unnecessary, he accepted,"* while P8 said, *"My husband was very happy, did not know I was using a substance. I went to the doctor with my husband. I hadn't told the doctor about my substance use. My doctor didn't know. I went to a family health center and got my vaccinations. I didn't tell my midwife either,"* stating that her spouse was happy about the pregnancy but considering her emphasis that he did not know about her substance use, this may be thought as an indicator that his reaction could change in the case that he knew. It was also determined that she hid her substance use from healthcare personnel. One participant expressed that she terminated her pregnancy without any support from anyone by saying, *"I took care of this issue by myself. …because the father of the baby got married [to someone else] later."* (P7)

As it could be understood from the expressions of the participants, most of the women who had substance use disorders and got pregnant felt helpless, did not even inform their spouses about their pregnancy, and a part of them also hid this situation from their families. The fact that the vast majority of the pregnant women (65%) were not married, that is, they got pregnant outside marriage, gave rise to situations where their partners were unwilling or unavailable in providing them with support. In this context, it may be stated that the women who felt helpless and guilty were not able to completely utilize the support of their families, spouses and healthcare personnel who could provide them with support, and they received partial support based on their own choices.

By asking the interviewees how their pregnancy ended, what the effects of the way it ended on the mother were and how the attitudes and behaviors of healthcare personnel towards the pregnant women were, it was aimed to reveal their way of ending their pregnancy and the effects of it on the mother. In this sense, three themes were determined as experiences regarding the way of ending pregnancy, views on the effects of the way pregnancy ended on the mother and views on the attitudes and behaviors of healthcare personnel towards the pregnant women with SUD.

Considering the emotions that the participants felt regarding the effects of the way their pregnancy ended on them, a large part of the participants stated that they were afraid, the remaining said they felt emotions like pain, sorrow and happiness, while one participant stated that she did not

feel anything. The participants who said they experienced fear regarding their emotional status as a consequence of the way that their pregnancy ended stated the following:

"I was afraid something would happen to the child because of me. The mother is living as a substance addict, the child's head is coming out, they say take it away by an ambulance. I am already going to give birth, and only a word of the substance could end everything." (P2)

"Let me put it like this, you are like going to an execution or sacrificing someone. I felt that way then, I felt like I was getting executed. I was afraid. I didn't know anything then; I hadn't researched anything. It was something that suddenly arrived." (P7)

"*I was afraid of labor; I was afraid that something would happen to the child. So, I was afraid.*" (P8)

Considering all these, the feeling of fear emerged out of the issue that the participants generally did not have knowledge about labor, they were uninformed about what they would encounter, and most importantly, they had concerns about the destructive outcomes that could be created by substance use.

Happiness was expressed about the process of labor by P4 as *"It is an indescribably different feeling, I felt like being a mother. My own mother is always valuable, but this brought me much more value. I was very happy,"* and by P6 as *"I was very happy, joyful. …because we had wanted it so much."*

Generally speaking, the feeling of happiness emerged because the participants included those who felt more prepared for labor, and some wanted a child as a family.

PA, who said she felt pain, expressed this as "*It is a very bad feeling. May Allah never make anyone experience it. It is a very, very bad feeling. They put that machine in you, maybe a hard object, what was it, I don't know. …but I know a piece of me was separated. Otherwise, it wouldn't hurt me that much."*

A participant expressed the sorrow she felt about the situation as *"I felt a very bad emotion. You learn that you are having a child from your legal husband. …but you have another friend next to you, a really bad feeling. One really aches, your child from your husband to whom you are legally married, and not being able to give birth to it because of your living conditions… For example, I wanted that child, and I thought I had no trust in my parents, I already had no trust in my husband, I didn't know what to do alone. It would hurt me a lot if I were not able to buy something that my child wanted. I felt like that I couldn't live with this all my life. I sometimes remember, and I am angry with everyone. Everyone can drift away, make a mistake, but the persons next to you, supporting you, are important."* (P1) As seen here, the feelings of anger and rage were rather dominant under this emotional status. While the participant stated that she was sorrowful, she was also angry with her family and husband, as well as the fact that she could not receive support.

A participant stated that she did not feel anything as "*I did not feel anything in the emotional sense. I cried when my mother cried. That's it, didn't feel much else."* (P5)

Based on the participants' views regarding the attitudes and behaviors of healthcare personnel towards pregnant women with SUD, most participants did not receive sufficient help from healthcare personnel, while some said they were exposed to the stigmatizing behaviors of healthcare personnel. Examples of the statements of the participants who expressed that they did not receive sufficient help from healthcare personnel were as follows:

"As I had no [previous] pregnancy, I did not know what to do. For example, someone comes and says there is nothing wrong, and someone comes and cuts your private area without anesthesia. Because of this, I don't want to have normal delivery if I get pregnant a second time. It would be nice if there were a clear place regarding labor, if everyone did not say something different, and clear information were provided." (P1)

"I don't know, they could inform me on the issue. They directly took me in and told me to sit. I could have been informed, but they directly took me in, and abortion started." (P7)

"There could have been at least a psychological information process, motivation and support. My parents could have also said 'you can do it' and not make me feel bad rather than saying 'you are an addict, and it will be an addict, too.' (P4)

"Indescribable, it is like getting into a meat grinder. It hurts like they put you into a meat grinder and are grinding you into pieces, with spiritual pain being greater. I was looking around, leaving the pain in my body aside… Would a person want to get support while hurting? I forgot the

pain; I was waiting for something from the people there. If only someone held my hand there, that pain wouldn't hurt me that much." (P5).

The participants, in the spiritual sense, stated that they wanted to be informed about the situation by and receive psychological support from healthcare personnel, but this was not possible. Moreover, the participants who expressed their stigmatization experience said that they were stigmatized by healthcare personnel as they were using substances, and for this reason, they could not receive appropriate support. Accordingly, their statements were as follows:

"Private or state [hospital] doesn't matter, the substance is a stigma for me. Male or female, single or married, doesn't matter. It is like a stigma for me. Ms. X, let's look at you, do you have a problem? I would also like them to sit opposite me and tell me while prescribing my drugs. When I went there during my pregnancy, I met polite people, kind people, but they didn't go into much detail, they were superficial. She's already a substance addict, let's give this and forget about it, she won't apply it anyway. They didn't go into detail, or at least I felt like that." (P3)

"Well, they could be more sincerely attentive. Not like a relative, I guess, but they could have been in my place, I could have been their daughter. Then, they would attend my treatment, look at me, examine me, but they said this wasn't necessary. They weren't interested, they said things like, if she's using a substance and is dirty, why is she still using despite her pregnancy." (P6)

"I'm taking a substance. There is a view towards a substance user. Her clothing… I would like to be treated first as a human being. …but there is a second look on that face when I directly say that I'm a substance addict, they keep looking at me. They always behaved inadequately about drugs. They wouldn't understand. Maybe, they were looking after my wellbeing, wanted me to be treated with fewer drugs, but I always expected more." (P2)

In general, almost all participants stated that healthcare personnel were inadequate in terms of providing psychological support and information, they were stigmatized due to their substance use, and therefore, they were exposed to such behaviors.

DISCUSSION

In this study, the pregnancy and delivery experiences of pregnant women with substance use disorders (SUD) and the problems they encountered while utilizing healthcare services were investigated. About half of the participants learned about their pregnancy due to swelling of their breasts, some learned about it due to nausea, and others learned about it due to delayed periods. The participants thought their nausea was related to their substance use, but when their nausea lasted longer or prevented them from using the substance they were abusing, they got tested and learned about their pregnancy. Substance use may alter the menstrual cycle in women. Additionally, it may lead to milder or elevated and more severe menstrual cramps. Opiate and methadone use may lead to amenorrhea in some women (CSAT, 2015). Women with SUD might not notice that they are pregnant. Sometimes, women may associate the early symptoms of pregnancy with symptoms of substance use or substance withdrawal. As pregnant women with SUD generally experience unplanned pregnancies, they do not receive preconception care until their pregnancy, and they receive inadequate prenatal care (Mclafferty, 2015). As shown in this study, the pregnant women with SUD learned about their pregnancy not by planning it but coincidentally. It was determined that the women continued to use substances in this process as they did not notice their pregnancy. Some of the most negative effects of substance use on the developing embryo may emerge in the first weeks of pregnancy (CSAT, 2015).

Considering the information provided by the participants in the study regarding at what stage they learned about their pregnancy, it was seen that half of them stated they learned about it in the second month of their pregnancy. As the women did not notice their pregnancy, it was identified very late. Preconception care and prenatal care are important in improving the outcomes for pregnant women. In these important periods, counselling may play a role in identification and reduction of risks for the mothers and their infants. While 31% to 47% of pregnancies in the USA were found to be unwanted pregnancies, this rate was seen to be higher than 85% among women with SUD (Heil et al., 2011, Finer, & Zolna, 2016). In comparison to women without SUD, women with SUD are almost two times more likely to experience an unwanted pregnancy that is undesired or unplanned (Black et al., 2012, Guttmacher Institute, 2016). Concerns about the potentially harmful effects of the substance use of the mother during pregnancy on the health and development of the fetus have stably increased in the last three decades (Ondersma et al., 2000). Due to this situation, most of the participants were

observed to state that they were afraid because of different reasons when they learned about their pregnancy. For these reasons, some had concerns about the possibility of their baby becoming an addict due to continuation of their substance use, while some had concerns that they would have difficulty taking care of the baby and concerns about the reaction of family members or the spouse. Additionally, as some were not married, they had a possibility of negative encounters in society. Moreover, the unplanned nature of their pregnancy led the women with SUD to be afraid. Stringer reported that, although women initially feel guilt, anxiety and feelings of risk while seeking help, they feel relaxation after receiving an explanation (Stringer, & Baker, 2018). Similarly, in the study, it was found that almost half of the participants mostly sought help from healthcare personnel, and some sought help from friends, family members and spouses. In the study by Goodman (2020), while some participants terminated unsupportive relationships, others agreed to receive the support of their families and friends. Support coming from peers was found to be empowering towards increasing participants' confidence in their own care and their infants' and supporting the feelings they had (Gjesfjeld et al., 2012). Healthcare workers need to overcome stigmatization and establish a therapeutic relationship based on trust with the pregnant woman with SUD. Furthermore, healthcare professionals should inform pregnant patients regarding the potential medical, social and legal outcomes of their substance use before labor for the sake of both the women and their unborn children (Silva et al., 2012). Healthcare professionals should have empathy to increase the possibility of pregnant women to receive and continue treatment.

In the examination of their emotional status regarding the effects of the way their pregnancy ended on them, almost half of the participants in this study said they were afraid, while a quarter of them said they were happy. Transition to motherhood is associated with significant changes in social responsibilities that may affect substance use (Fletcher, 2012, Staff et al., 2010). It is an emotional moment where many women experience intense fear due to insufficient information, stigmatization, legal outcomes and involvement of child protective services (Goodman et al., 2020). Half of the women stated that they could not receive help from healthcare personnel, there was especially lack of provision of information, and healthcare personnel did not provide psychological support and had stigmatizing behaviors. This led the women to be afraid. The most noticeable theme was the prevalence of the stigmatization surrounding the women with SUD. During the interviews, the participants showed how stigmatization emerged in different forms. Some women shared their experiences of exposure to blatant discrimination and stigmatization by healthcare service providers such as those that were denied care. Some participants discussing their past experiences related to receiving substance use treatment and seeking healthcare services reported that their encounters of stigmatizing behaviors were experienced without regards to the public or private nature of hospitals. This stigmatization also appeared with the unwillingness of healthcare service providers in providing the women with SUD with services. In the study by MacAfee et al. (2020) on women with SUD, similar findings were reported, and the women stated their problems in receiving services and due to ostracizing. As a result of stigmatization and unwillingness of reproductive healthcare providers in providing services to the women with SUD, it was determined that the women had to cover large distances to receive the necessary healthcare services. It was found that, in terms of their access to healthcare services, women with SUD experienced lack of transportation, lack of insurance, lack of information, fear, dealing with security forces and stigma (MacAfee et al., 2020). Studies have shown that stigmatization regarding substance use is prevalent among healthcare service providers, and this may have inadequate health outcomes for patients with SUD (van Boekel et al., 2013).

Pregnant women with SUD are unwilling to seek help due to their fears of being judged negatively and the hostile reactions of care providers (Metz et al., 2013). For this reason, care providers need to have a non-judgmental and respectful attitude to create an environment that allows a reliable relationship with patients. Morton and Konrad also emphasized the importance of healthcare specialists that acquire knowledge, skills and attitudes that promote development of reliable relationships with addicted mothers which constitute the basis of beneficial outcomes (Morton, & Konrad, 2009). It is also important to accept that pregnancy may be a strong motivation for patients to start and continue treatment, and it is a good opportunity for professionals to develop this approach rather than assuming a punishing attitude. Thus, it is indispensable to design a specialized training/education program for healthcare professionals working with pregnant women with SUD regarding ethical issues that might arise during treatment (Metz et al., 2013). Although pregnancy is a

reason for receiving treatment, it is difficult or impossible to access treatment when pregnant in some regions of some countries, because there are programs for pregnant women at very few treatment facilities. There are no specialized clinics where pregnant women with SUD could receive healthcare services. Therefore, this study showed that the participating women were not adequately supported during their pregnancy and encountered problems.

Substance use during pregnancy and motherhood is a social problem with an emotional burden that requires an evidence-based solution. Consequently, this study provides a new perspective for the pregnancy experiences of women with SUD and barriers and facilitators in their access to healthcare services. This study has significant inferences in terms of perception of the barriers to the care of women during pregnancy and potential problems that may result in relation to substance use. Understanding the obstacles intervening with women's skills of seeking healthcare services is fundamental for reduction of the negative pregnancy outcomes experienced by women with SUD. More efforts should be spent to include the voices of women with SUD. This study provided a starting point for women with SUD experiencing pregnancy to be able to make their voices heard, and it is expected to be guiding for future research and policy development. With the purpose of improving the mother and infant health outcomes for women with SUD, future studies should continue in this direction.

Limitations and Directions/Recommendations for Future Research

This study had some limitations. First of all, the design only allowed investigation of the views of the women who were receiving substance use treatment. These views may not be generalized for a population with SUD and with a large heterogeneity. The sample size appeared to be insufficient. On the basis of the difficulties experienced, the fact that this is a difficult and sensitive group and the presence of problems such as unwillingness towards the interview and stigmatization lowered the size of the sample. Difficulties were experienced in reaching these women, and many women who would meet the inclusion criteria could not be reached. Additionally, as all women in our sample were receiving substance use treatment services, we missed the views of women who never apply for treatment. In future studies, it is recommended to increase the sample size and carry out more studies on pregnancy processes.

Most of the participants of this study preferred to be interviewed by a clinically familiar staff member (HYD). This may have limited the expression of negative feelings in the experiences of these women. Nevertheless, trust is accepted as a main component of qualitative research, and previous studies have shown the effectiveness of familiar clinicians as interviewers (Jack, 2008).

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Conflict of Interest

The authors declare no conflict of interest.

Author Contributions

Study conception and design: H.Y.D.; **Data collection**: H.Y.D.; **Data analysis and interpretation:** H.T., Y.B., A. E.; **Drafting of the article:** H.Y.D., Y.B., A. E.; **Critical revision of the article:** H.Y.D., Y.B., A. E.

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REFERENCES

Anstice, S., Strike, C. J., Brands, B. (2009). Supervised methadone consumption: client issues and stigma. Subst Use Misuse. 44(6),794–808.

Aydın, M. (2016). Five Qualitative Research Approaches, Qualitative Research Methods: Qualitative Research and Research Design According to Five Approaches 3. Translation from Print, M. Bütün (ed.) Selçuk Beşir Demir, Siyasal Kitabevi, Ankara.

Black, K., Stephens, C., Haber, P., Lintzeris, N. (2012). Unplanned pregnancy and contraceptive use in women attending drug treatment services. Aust N Z J Obstet Gynaecol. 52(2), 146–50.

Center for Substance Abuse Treatment (CSAT). (2015). Substance abuse treatment: Addressing the specific needs of women. Treatment Improvement Protocol (TIP) Series, No:51. HHS Publication No. (SMA) 15-4426. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Finer, L. B, & Zolna, M. R. (2016). Declines in unintended pregnancy in the United States, 2008–2011. The New England Journal of Medicine, 374(9), 843–852. Doi:10. 1056/NEJMsa1506575.

Fletcher, J. M. (2012). The effects of teenage childbearing on the short- and long-term health behaviors of mothers. Journal of Population Economics, 25, 201–218.

Forray, A., Merry, B., Lin, H., Ruger, J. P., Yoker, K. A. (2015). Perinatal substance use: a prospective evaluation of abstinence and relapse. Drug Alcohol Depend. 150, 147–155. Doi:10.1016/j.drugalcdep.2015.02.027

Gjesfjeld, C. D., Weaver, A. C., Schommer, K. (2012). Rural women's transitions to motherhood: understanding social support in a rural community. J Fam Soc Work. 15(5), 435–48.

Goodman, D. J., Saunders, E. C., Wolff, K. B. (2020). In their own words: a qualitative study of factors promoting resilience and recovery among postpartum women with opioid use disorders. BMC Pregnancy and Childbirth. 20, 178, 2-10. https://doi.org/10.1186/s12884-020-02872-5

Guttmacher Institute. (2016). Unintended pregnancy in the United States. Retrieved from https://www.guttmacher. org/fact-sheet/unintended-pregnancy-united-states.

Gyarmathy, V. A., Giraudon, I., Hedrich, D., Montanari, L., Guarita, B., Wiessing, L. (2009). Drug use and pregnancy – challenges for public health. Eur Surveill.14(9):33–36.

Heil, S. H., Jones, H. E., Arria, A., Kaltenbach, K., Coyle, M., Fischer, G., Martin, P. R. (2011). Unintended pregnancy in opioid-abusing women. Journal of Substance Abuse Treatment, 40(2), 199–202. Doi:10.1016/j. jsat.2010.08.011.

Jack, S. (2008). Guidelines to support nurse-researchers reflect on role conflict in qualitative interviewing. Open Nurs J. 2, 58–62.

MacAfee, L. K, Harfmann, R. F., Cannon, L. M., Minadeo, L., Kolenic, G., Kusunoki, Y, & Dalton, V. K. (2020). Substance Use Treatment Patient and Provider Perspectives on Accessing Sexual and Reproductive Health Services: Barriers, Facilitators, and the Need for Integration of Care, Substance Use & Misuse, 55, 1, 95-107, Doi: 10.1080/10826084.2019.1656255

Mclafferty, S. (2015). Disease cluster detection methods: recent developments and public health implications Annals of Gis. 21, 127-133. Doi: 10.1080/19475683.2015.1008572

Metz, V., Köchl, B, & Fischer G. (2012). Should pregnant women with substance use disorders be managed differently? Neuropsychiatry, 2(1), 29–41. https://doi.org/10.2217/npy.11.74.

Minozzi, S., Amato, L., Bellisario, C, et al. (2013). Maintenance agonist treatments for opiate-dependent pregnant women. Cochrane Database Syst Rev. 2013;12: CD006318. 10.1002/14651858.CD006318.pub3

Morton, J., Konrad, S. C. (2009). Introducing a caring/relational framework for building relationships with addicted mothers. J Obstet Gynecol Neonatal Nurs. 38(2), 206–213.

Ondersma, S. J., Simpson, S. M., Brestan, E. V., Ward, M. (2000). Prenatal Drug Exposure and Social Policy: The Search for an Appropriate Response. Child Maltreat. 5(2), 93-108. Doi: 10.1177/1077559500005002002.

Silva, S. A., Pires, A. P., Guerreiro, C., & Cardoso, A. (2012). Balancing motherhood and drug addiction: The transition to parenthood of addicted mothers. Journal of Health Psychology, 18(3), 359-367. Doi: 10.1177/1359105312443399.

Staff, J., Schulenberg, J. E., Maslowsky, J., Bachman, J. G., O'Malley, P. M., Maggs, J. L, & Johnston, L. D. (2010). Substance use changes and social role transitions: Proximal developmental effects on ongoing trajectories from late adolescence through early adulthood. Development and Psychopathology, 22, 917–932.

Stringer, K. L., Baker, E. H. (2018). Stigma as a barrier to substance abuse treatment among those with unmet need: an analysis of parenthood and marital status. J Fam Issues. 39(1), 3–27.

Tuten, M., Jones, H. E. (2003). A partner's drug-using status impacts women's drug treatment outcome. Drug Alcohol Depend. 70(3), 327–230.

Van Boekel, L. C., Brouwers, E. P. M., Van Weeghel, J, & Garretsen, H. F. L. (2013). Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: Systematic review. Drug and Alcohol Dependence, 131(1-2), 23–35.