“WHERE’S MOM?”
THE MEANINGS OF FETAL ALCOHOL SYNDROME

by

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ABSTRACT

Since it was first described in the medical literature in 1968, Fetal Alcohol Syndrome (FAS) has become recognized as the leading cause of preventable birth defects in Canada. As a diagnostic category, FAS refers to the teratogenic affects of alcohol which result in facial anomalies, growth deficiencies, and central nervous system dysfunction. The portrayals of FAS in the mass media, and elsewhere in the popular realm, indicate that FAS does not simply exist as a diagnostic category. Persons with FAS seem to be portrayed as tragedies and social deviants who place an economic burden on society. The mothers who give birth to children born with FAS are seen as irresponsible and in need of surveillance. Troubled by what the author perceived as oppressive representations of persons with FAS and their biological mothers, the present study set-out to investigate the portrayal of mothers in popular and professional discourse about Fetal Alcohol Syndrome. Semi-structured interviews, clinical observations, and an analysis of educational material and information in the mass media, were the tools of inquiry used to uncover what is said about FAS and mothers in the professional realms of medicine and social services, and in the popular realms of the mass media, educational material and the internet. Regarding and analyzing FAS as discourse reveals the multiple and contested meanings that are associated with that term. A number of processes and discourses interact to produce a shroud over mothers of children with FAS. Systems problems within the medical and social service sectors, the ambivalence surrounding FAS as a diagnostic category, and ideologies and values attached to the fetus, to mothers, and to alcohol all contribute to an eclipsing of mothers within the discourse of FAS.
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INTRODUCTION

Adam's mother...died of alcohol poisoning and I'd feel sorrier for her, if we didn't have Adam.

As it is, I only hope that she died before she had a chance to produce another child with his problems. I can't help but wish too, that during her pregnancy, if she couldn't be counseled or helped, she had been forced to abstain for those critical months. On some American Indian Reservations....the situation has grown so desperate [due to the lack of services], that a jail internment during pregnancy has been the only answer possible in some cases. (Erdrich in Dorris 1989).

Adam is a boy with Fetal Alcohol Syndrome (FAS) and Louise Erdrich is his adoptive mother. Her sentiments are taken from the Forward to The Broken Cord (Dorris 1989), a memoir of Adam's father Michael Dorris that chronicles the family's experiences with FAS. It is this book which initially brought FAS, as a subject and as an object, into public conscious. Without discounting the value of the book in creating public awareness, and without dismissing the lived reality that fueled Erdrich's resentment and anger, I find the attitudes expressed problematic. Erdrich and Dorris (1989) bring to light the social meaning(s) of FAS, but at the cost of stigmatizing both those who are born with FAS and the mothers who give birth to them.

Fetal Alcohol Syndrome is recognized as the leading cause of preventable birth defects in developed countries, and is considered the leading known cause of mental retardation in children (British Columbia Ministry for Children and Families 1998b: 14). Studies estimate that the incidence of FAS in Canada ranges from 1 in 3000 births to as high as 1 in 500 births in certain communities (BCMCF 1998b: 14). In British Columbia, these figures translate to as high as 96 children each year born with FAS (BCMCF 1998b: 14). As a diagnostic category, FAS refers to a set of characteristics associated with the
teratogenic affects of alcohol in utero. The diagnostic criteria for FAS run along a three axis scheme which include characteristic facial anomalies, growth deficiencies, and central nervous system dysfunction.

Diagnosis of FAS is a complex process that requires an interdisciplinary approach including an assessment of language, motor skills, growth and development progress, craniofacial features, a psychological review and a history of the biological mother’s alcohol and drug use. Regardless of the way FAS presents itself it is a life long condition. Challenges commonly associated with FAS include poor reasoning abilities and difficulties comprehending a cause and effect relationship. Consequently, persons with FAS are easily manipulated and tend to act on impulse.

Sentiments like those of Louise Erdrich hint that FAS does not simply exist as, or because of, a diagnostic category. It is a social concept and category that derives its meaning through the interaction of the ‘objective’ and subjective (Mehan et al. 1986). As Dorothy Smith argues, categories are expressions of actual social relations of which widespread courses of action including the contexts of speech, text, or acts are a part (1990: 162, 221). The category of FAS, and the category of women who are at risk for giving birth to babies with FAS, exist in a discursive of social and cultural discourses. It is this discursive which breathes meaning into categories like “the FAS child”, or “the alcoholic mother”, and gives them life.

To those of us aspiring to comprehend the people and society in which we live, Dorothy Smith offers sound advice: “begin with what you find puzzling in your everyday/everynight world” (2000). As a personal assistant and advocate of social change for persons labeled ‘mentally handicapped’, I view critically the images and representations associated with that category. It is from this perspective that I find puzzling the images and texts associated with Fetal Alcohol Syndrome. In common parlance persons with FAS seem to be referred to as “tragedies” and "social deviants" who place an economic burden on society. The mothers who give birth to these ‘tragedies’ are, as Erdrich illustrates, presented as irresponsible and in need of surveillance. It would appear that within the discourse of Fetal Alcohol Syndrome women have been reduced to bodies that house babies. This scenario is particularly puzzling given the apparent gains women have made over the past century in terms of our social status and reproductive choices.

Troubled by what I perceived as stigmatizing representations of women and the children they bear, I set-out to investigate more thoroughly the portrayal of mothers in popular and professional discourse about Fetal Alcohol Syndrome. In order to fulfill this objective a qualitative inquiry was made into the
following areas: the historical context within which Fetal Alcohol Syndrome was defined as a medical syndrome, the ways in which mothers in relation to FAS are portrayed in the mass media and in the medical literature, and how the images of mothers are employed in clinical practice and by social service representatives. Where do the discourses originate? What and who drive and refigure the discourses? What are the responses to and actions made on behalf of the discourses?

Mehan et al.'s (1986) ethnography of childhood disabilities in an educational context offers a helpful model from which to consider the relationship between popular and professional discourse. Mehan et al. (1986) observe that teachers claim to categorize students as “learning disabled” and “educationally handicapped” according to an objective model not unlike that of the medical model (69-70). However, the researchers also observe that teachers draw-upon, and make their observations according to, both subjective interpretations and bureaucratic codes of classification. Physicians who participated in the present study similarly draw upon both objective diagnostic categories as well as subjective assumptions about which women are at risk for giving birth to babies with FAS. The present study, like that of Mehan et al. (1986), reveals that categories like FAS and mothers are constructed objects that derive meaning from their participation in a cultural meaning system (85).

In analyzing the assemblage of meanings that the physicians draw upon, Emily Martin (1992) is particularly informative. Martin’s (1992) critique of medical metaphors that refer to female reproduction, menstruation and menopause reveals that the so-called fact based medical system of knowledge is laden with cultural stereotypes. The ambivalence associated with the category of FAS and with the category of mothers of children born with FAS pose a diagnostic dilemma for practitioners. Physicians attempt to identify a ‘mother at risk’ in the absence of a phenotype, and subsequently rely upon stereotypical characteristics. This phenomena is similar to what Dorothy Smith (1990) refers to as discourse mediated practices. Whereas Smith (1990) considers “Femininity as Discourse”, the present inquiry considers Fetal Alcohol Syndrome as discourse, and argues, as Smith does, that discourse and ideology can be investigated as actual social relations that organize and are organized by activities of actual people (1990: 159-160).

A sizable body of work discussing the social construction of motherhood offers insight into the ideologies within which the category of mother is entrenched. Adrienne Rich (1976), for example, observes that on the one hand, motherhood refers to the potential relationship of women to their reproductive
capacity and to their children. On the other hand, motherhood refers to the patriarchal institution which molds and controls the views and expectations about pregnancy and reproduction. My own observations resonate with Rich (1976) as well as with Faye Ginsburg (1987) who observe that nurturance as a cherished characteristic of motherhood is salient. The few images of mothers associated with FAS often depict the quintessential nurturing mother, an image that is also seen in other contexts. Sarah Blaffer Hrdy (1999) and others (O'Connor 1993; Rich 1976) view this portrayal of mothers as problematic and document the actual experience of motherhood as variable. In contrast to the selfless nurturing expectation of motherhood, women in the mother role can suffer depression, exhaustion and ambivalence.

Recent inquiries in the area of anthropology of reproduction are particularly instrumental in examining the prominent images of the fetus associated with educational material about FAS. Rapp (1997) and others (see Petchesky 1987; Ginsburg and Rapp 1995) consider the influence of medical technology on the meaning of the fetus and the mother. The separation of fetal and mother images within the context of FAS resonate with Rapp’s (1997) observation that imaging technologies have contributed to the personhood of the fetus as well as the separation of fetuses from the women who carry them. Cris Shore (1992) considers the problems New Reproductive Technologies (NRTs) present in terms of the relationship between parenthood and biological procreation. When embryos are selected, frozen, thawed, and implanted, a baby is conceived in a petri dish, virgins are giving birth and women’s bodies are for hire to sterile couples, the categories of mother, father, parent, baby and fetus shift.

Shore (1992), as well as Foucault (1977), offer a framework within which the history of prenatal care can be examined. Discourses surrounding prenatal care can be viewed as technologies of discipline (Foucault 1977) that operate to control the prenatal body and the postnatal outcome. This disciplining project is tied to dominant institutions which, as Shore (1992) observes, have a vested interest in controlling reproduction and are engaged in a continuous contest to control discourses about conception. Mary Douglas (1970) pointed out long ago that things falling outside of a cultural system of classification are considered an abomination or dangerous (in Shore 1992: 295). The link Douglas (1970) makes between cultural practices associated with who enters the social body (i.e. society) and cultural practices around bodily orifices and secretions is applicable in analyzing the prenatal ‘don’t’ of consuming alcohol.

The promise of the perfect baby that the disciplining technologies of prenatal care and NRTs
insinuate contribute to what Cohen (1995) refers to as stratified reproduction. Viewed from Cohen’s (1995) perspective, the value of FAS and the mothers of babies affected with FAS can be seen as located along a continuum where some reproductive futures are valued and others rejected. The construction of this continuum has implications for both those who assign people to devalued categories, and for those who receive the stigmatized label. People who associate themselves with a stigmatizing condition, Goffman (1963) argues, go to great pains to “pass” as someone who is not associated with a ‘dangerous’ category. Preserving the social self by avoiding embarrassing encounters and stigmatizing labels is a process Goffman (1959) sees as mitigating social interactions. Both those who are in a position to impart a stigmatizing label and those who are in a position to concede stigmatized parts of themselves interact in a dance of saving face.

The section that immediately follows provides an account of an urban anthropologist’s methods of inquiry. The interviews, observations, and sources of data collected to uncover what is said about mothers in popular and professional discourse about Fetal Alcohol Syndrome are explained, as is the form of discourse analysis used to interpret the findings. The discoveries made through this process are presented in the next section revealing the multiple and contested meanings that are associated with the term Fetal Alcohol Syndrome. The discussion that ensues will argue that a number of processes and discourses intersect to render mothers of children with FAS absent. Systems problems within the medical and social service sectors, the lack of medical category within which to place mothers, and the ideologies and values attached to the fetus, to mothers, and to alcohol all contribute, both individually and collectively, to avoid, shroud, shame, oppress, evict, and eclipse mothers of children with FAS. The implications of seeing FAS as an ideological code is considered in the concluding remarks.

**AN URBAN ANTHROPOLOGIST AND HER TOOLS OF INQUIRY: METHODS**

The field work for the present study was conducted in hospitals, clinics, offices, over the telephone, in basements, at social service agencies, while surfing the internet, watching videos, and while commuting within the city of Vancouver. The investigation began by asking what is being said about mothers in relation to Fetal Alcohol Syndrome in the professional realms of medicine and social services, and in the popular realm of newspapers, television, educational material, and the internet? The data were primarily collected from within British Columbia with a particular focus on the city of Vancouver. Two
social service agencies from the United States, one in Washington and one in Arizona, are also included
because I discovered that both agencies have web sites that are read “world wide”, and both receive
requests for information from people in Vancouver. For similar reasons, I visited a clinic at the University
of Washington where FAS was first recognized and named, and where a number of clinicians from
Vancouver receive specialized training in FAS. A communications officer from the Yukon Government
was also consulted about a commercial that aired in Vancouver but was produced in the Yukon.

In order to understand the historical context within which Fetal Alcohol Syndrome was defined as
a medical syndrome journal articles related to the diagnosis, cause, treatment and prevention of FAS were
reviewed. The genealogy of FAS within medicine was mapped from the time that it first appeared as a
syndrome until the present. How mothers are referred to in the medical literature was also identified using
the same set of articles, as well as articles more specifically related to alcohol addiction and pregnancy.

A call for volunteers was sent to a random sample of each of the three medical specialties:
obeatrics, family practitioners, and pediatrics listed in the Directory of Physicians and Surgeons (British
Columbia College of Physicians and Surgeons 2000). Ten physicians (four pediatricians, five obstetricians,
and one family practitioner) volunteered to be interviewed about their clinical experiences with alcohol and
pregnancy, and with Fetal Alcohol Syndrome. Three of the pediatricians and two of the obstetricians
practice in clinics located within a hospital (tertiary care), three obstetricians and one pediatrician operate
referral practices (secondary care), and the family practitioner was currently providing locums for a number
of family practices (primary care). One full day was spent at the Fetal Alcohol Syndrome Clinic at the
Centre on Human Development and Disability (University of Washington) observing clinical encounters
with FAS. The practices of an occupational therapist, educational psychologist, child psychologist and
pediatrician were observed doing assessments, conducting tests, gathering information from the patients
and their caregivers, arriving at diagnoses and recommending a course of treatment.

A call for volunteers was sent to all Ministry for Children and Families regional offices (child
protection and adoption/permanency planning) in the lower mainland, and to social work departments of all
hospital obstetrical wards (six hospitals). Three social workers: one from child protection services, one who
facilitates adoption, and one from a special care nursery volunteered to be interviewed about the ways in
which they respond to children with FAS and to their actual and potential biological mothers. The same
inquiry was included in the interviews with representatives from three of the agencies that provide educational material (FAS/E Support Network, YWCA FAS/NAS Prevention Project, and the FAS Program (VAFCS)) as they are also mandated to provide a social service function.

To glean a sense of how mothers are portrayed in the mass media the images and texts that refer to FAS, as well as pregnancy and alcohol, were collected from newspaper articles available to readers in BC. A total of 86 articles spanning 13 years (1987 - July 2000) from four newspapers (Vancouver Sun, Province, Globe and Mail, and National Post) were reviewed for common themes and distinctive images. Educational materials were requested from the FAS/E Support Network, Surrey, B.C.; the YWCA, FAS/NAS Prevention Project, Vancouver, B.C.; the FAS Program, Vancouver Aboriginal Friendship Centre Society (VAFCS), the social responsibility departments of the British Columbia Liquor Distribution Branch (BCLDB) and Molson Brewery, FAS Community Resource Center in Tucson, Arizona; and the FAS Family Resource Institute, Washington. Interviews with representatives from each of these agencies, as well as the communications officer of the Yukon Government, provided valuable information regarding the purpose of the material, where the material is distributed, for what audience, and the type of feedback they receive about the material. A consultant who offers information seminars about FAS not only clarified the content and goal of her seminars, but she also shared the sorts of attitudes that seminar participants have about mothers who drink.

A total of twenty-two semi-structured personal interviews were conducted. The interviews of the physicians and social workers can not be considered representative of a given profession or cohort. Rather, the interviews help to illuminate the relationship between the professional literature and clinical practice, as well as the relationship between popular and professional discourse.

A call for volunteers was sent to health nurses at all health units in the lower mainland but failed to elicit any participants. Practitioners at Sheway, a Vancouver clinic that specializes in addictions and pregnancy, regretted that they were unable to participate as they were currently operating the clinic without a project coordinator. In hindsight, the inclusion of midwives may have proved beneficial. This cohort was initially forgotten, but when consulted as to whether they would be appropriate participants for the study, a representative of the Midwifery College felt that FAS and alcohol during pregnancy were issues midwives rarely deal with. The lack of interest from general practitioners can similarly be explained. Of the few
responses all but one of the physicians declined as they felt that FAS was not a concern among their patient case load. This assumption alludes to who doctors, midwives, and others, feel a woman at risk is and who she isn’t. This is a finding in itself and will be elaborated in the sections that follow.

The perspectives from additional social workers, particularly those working in child protection, would have been helpful. The case supervisors of several offices expressed interest in the study but regretfully declined due to the overwhelming workload and lack of staff. This was again an interesting finding in and of itself and will be given more attention later.

The transcripts of interviews, the education and awareness material, the images and texts in the mass media and in the medical literature make-up the sets of data for analysis. The sets of data are interrogated for the ways in which the concepts Fetal Alcohol Syndrome and mothers are used. In what context do these concepts appear? What other concepts, slogans and images are the concepts tied to? The concept of mother here refers specifically to the category of biological mothers of children born with FAS. The term Fetal Alcohol Syndrome and its many derivatives have been variously employed, (a topic that will be explored further). In this study, Fetal Alcohol Syndrome will refer to all alcohol related birth defects.

The constituents of these categories are also dissected and similarly analyzed. How is the fetus portrayed in different contexts and across time? What meanings are attached to alcohol in the laboratory, in the clinic and in public discourse? How do these meanings change when the use of alcohol is associated with different people and at different historical junctures? What exactly is a syndrome? How did the phenomena that is now referred to as Fetal Alcohol Syndrome come to be described in that way?

The method of analysis borrows from Gee’s (1999) model of discourse analysis. This form of analysis pays special attention to the use of language, and in particular how language, in a given time and place, is used to define a situation or network of situated meanings, and how those networks simultaneously give language meaning (Gee 1999: 92). This is similar to Dorothy Smith’s (1990) "method of substructuring” which begins with the terms and concepts and then examines the social relations which they express (1990: 93). To do this, the different sets of data are considered together as a whole, as individual segments of that whole, and as interacting entities. There is a semiotic aspect to this analysis in that sign systems are identified and the relevance of an image, like the fetus, in signifying certain meaning(s) is questioned.
Assuming that all meaning is situated, the values and meanings attached to places (like the clinic), to bodies (like that of the pregnant woman), and objects (like that of the martini glass with a fetus floating inside), in a given situation are dissected. This is a form of discourse analysis that reaches beyond attention to language-in-use, that is, beyond an analysis of how language is used "on-site", to a broader examination of the activities and situations that give concepts meaning (Gee 1999: 7). Activities and identities are brought to life not through language alone, but through bodies, gestures, clothes, interactions with tools, symbols, technologies, attitudes, values, beliefs and emotions. These are the things that make-up discourse (Gee 1999: 7).

UNCOVERING THE MEANING OF FETAL ALCOHOL SYNDROME

FAS as a Diagnostic Category

Fetal Alcohol Syndrome was first described in the medical literature in 1968 by Lemoine et al. in France (Neugut 1981). Lemoine et al. described the “highly distinctive appearance” of 127 children born to alcoholic parents (in Neugut 1981: 414). The children were considered remarkable in terms of four characteristics: distinctive facial features, retarded growth, psychomotor disorders, and a number of physical malformations. In 1973, The Lancet published similar findings from a team of researchers in Seattle (Jones et al. 1973a). Eight unrelated children ranging in age from 11 weeks to four years, born to alcoholic mothers, were all developmentally delayed, showed signs of pre and postnatal growth deficiency, and were observed to have unique craniofacial characteristics (Jones et al. 1973a: 1267 - 1271). The Seattle team was unaware of the French study until after their own research was published, and consequently took Lemoine et al.’s observations as an affirmation of their own (Neugut 1981: 414). Later that same year Jones et al. described three more infants with similar anomalies associated with maternal alcoholism (Jones et al. 1973b: 999 - 1001). These additional cases, together with two historical reports of a similar association, constituted an observable pattern that the authors labeled Fetal Alcohol Syndrome. The syndrome’s diagnostic criteria consisted of characteristic facial anomalies, growth deficiencies, and central nervous system dysfunction.

In contrast to FAS, the term Fetal Alcohol Effects (FAE) was devised in the late 1970’s to refer to cases that were compatible with FAS but did not meet all the diagnostic criteria. Unfortunately, the term FAE has been applied indiscriminately and imprecisely to children and adults displaying a wide range of
behavioral and cognitive difficulties (Asse et al. 1995). As a result, frustrated clinicians and researchers have suggested that FAE no longer be used as a diagnostic category and that a diagnosis for FAS be deferred unless all three criteria are met (Asse et al. 1995).

The various ways in which FAS is reportedly used by clinicians is indicative of the complexities associated with FAS as a diagnostic category. Currently there is no biological marker for FAS, so diagnosis relies on clinical presentation and history taking. Since it’s discovery, the characteristic facial anomalies of FAS have been considered the most clinically unique. The distinctive features of “the FAS face” (Stratton et al. 1996: 72) are difficult to reduce to verbal descriptors and the features change as the patient ages (Rosett 1980; Stratton et al. 1996). At the neonatal stage the craniofacial anomalies are not as pronounced, then become more evident during early infancy and childhood, and often diminish during adolescence and adulthood (Stratton et al. 1996: 70). The actual affect of the syndrome is also variable. A person with FAS may be severely impaired cognitively, possess an IQ within normal range, or function somewhere in between. A consensus has yet to be reached regarding which behaviour and cognitive features are the most significant in terms of diagnosis.

The boundaries of the diagnosis and the markers used to determine those boundaries remain fuzzy. Consequently, the diagnostic categorizing of Fetal Alcohol Syndrome continues to evolve in an effort to “increase clarity, rigor and consistency” (Stratton et al. 1996: 80). In 1996, the Institute of Medicine (IOM) devised five separate categories: 1) FAS with confirmed maternal alcohol exposure, 2) FAS without confirmed alcohol exposure, 3) Partial FAS (only some of the criteria are present) with confirmed maternal exposure, 4) Alcohol-related birth defects (ARBD), and 5) Alcohol-related neurodevelopmental disorder (ARND). Both ARBD and ARND refer to a history of maternal alcohol exposure and where clinical or animal research has linked maternal alcohol consumption to birth defects (neurodevelopment defects in the case of ARND). In 1998, Dr. Christine Loock adapted the IOM’s classification scheme to three categories: Fetal Alcohol Syndrome, Partial Fetal Alcohol Syndrome, and Alcohol-Related Neurodevelopmental Disorder (BCMCF 1998: 10-11). Most recently Astley and Clarren (1999) have developed the 4-Digit Diagnostic Code which ranks each of four key features (growth deficiency, the FAS facial phenotype, brain dysfunction, and gestational alcohol exposure) on a four point Likert scale (3). A total of 256 diagnostic codes can be achieved through the matrix. Astley and Clarren (1999) have further grouped these into 22
diagnostic categories (39). This complex scheme is meant to result in a definitive description and classification of a patient's presenting symptoms and complaints.

I witnessed the practice of the latter diagnostic scheme while visiting the FAS Clinic in Washington. The clinic director draws the four-by-four matrix on the blackboard and as testing is completed for each domain a ranking is assigned. Alcohol exposure is ranked from high risk (4), some risk (3), unknown risk (2) and no risk (1) (Astley and Clarren 1999: 35). These scores are based upon the confirmation and amount of maternal alcohol consumption. Brain function is ranked from "definite" to "absent". A patient with static encephalopathy is considered to have "definite brain dysfunction" and is given a ranking of four. A ranking of three is given to those with static encephalopathy, or "probable brain dysfunction", two to "possible brain dysfunction" or neuro behavioral disorder, and one where signs of brain dysfunction are absent. Growth deficiency is measured according to standards for age and ranked in terms of deficiency: significant, moderate, mild, or none. The FAS Facial features are also measured according to a standard. A ruler is used to measure the patient's palpebral fissures (length of the slits of the eye openings) according to standard deviations from the norm. Palperable fissures that are short in length are the most abnormal and given a rating of four out of four. The philtrum (area between the nose and upper lip) is measured for flatness, and the most flat assigned a ranking of five out of five. Both the thinness and circularity of the upper lip are also measured according to a five point scale with an upper lip that is most thin and flat considered the most abnormal (5) (Astley and Clarren 1999: 25-27). The Likert scores for the palpebral fissures, philtrum, and upper lip are then converted into ABC scores with C being the most typical and A the least. The various ABC combinations are further ranked according to a predetermined Diagnostic Code ranging from 1 to 4 (Astley and Clarren 1999: 28-29). This code is the score given to rank the overall FAS facial features.

By quantifying the presenting features of FAS and the history of maternal alcohol consumption, the 4-Digit Diagnostic Code does add clarity to criteria that are difficult to measure. Still, the design incorporates less than objective practices. The lip and philtrum are 'measured' according to how well the diagnostician feels the patient's features match those of a set of photographs. These sorts of 'best judgments' were also observed when clinicians attempted to determine the patient's level of brain dysfunction. The educational psychologist and child psychologist "hummed" and "hawed", while the head
clinician prodded “Well, which is it - two or three?” The standards upon which the facial type is based are equally imperfect as ethnicity is not accounted for. While diagnosing a patient of Malado descent, the pediatrician aligned a ruler to the patient’s eyes, scrutinized the philtrum and upper lip according to a set of photos, commented that “her race is a factor”, and then considered all the measurements against what she referred to as “the standard that we use for everyone.”

The Syndrome

In addition to the ambivalence surrounding the diagnoses of FAS much ambiguity remains in terms of what exactly FAS is. Despite being labeled a syndrome, which implies an unknown etiology, maternal alcohol consumption has been the presumed cause of FAS since its inception. Jones et al. (1973a) first identified “severe chronic alcoholic women” based upon the criteria set forth by the National Council on Alcoholism, and then made their assessments of the children “with full knowledge of the history of maternal alcoholism” (Jones and Smith 1974: 349). The researcher’s observations were not made blind, rather the mother’s behaviour was judged in terms of the teratogenic effects of her alcohol use.

The exact amount of consumed alcohol that will result in a baby with FAS is not yet known. However, most professionals have come to accept FAS as primarily a problem of addiction. Research suggests that excessive chronic and/or binge drinking is strongly associated with babies born with FAS (Abel 1998, 1999a, 1999b; Dufour 1994; Koren 1996; Stratton et al. 1996). Despite the strength of the association ambiguities persist in terms of mitigating factors such as nutrition, gestational age, the influence of other drug use, and the duration and timing of alcohol consumption. These ambiguities have erupted in a clash between medical specialties in terms of the information and counsel presented to women.

In 1996, Health Canada drafted the Joint Statement: Prevention of Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effects (FAE) in Canada. Not listed among the eighteen co-signatories is the Society of Obstetricians and Gynecologists of Canada (SOGC). In fact, the SOGC refused to sign the document because of one word. The Statement takes the stance that “there is no definitive information that can be conveyed to women regarding a safe quantity of alcohol use during pregnancy. Consequently, the prudent choice for women who are or may become pregnant is to abstain from alcohol.” (emphasis in original) (Health Canada 1996: 3). The SOGC felt that abstaining from alcohol should be “a prudent choice” and not “the prudent choice" for women. The Canadian Pediatric Society coordinated the project and it is their
perspective that came through in the final draft.

A similar debate was published in the journal *Teratology* in 1999. Earnest Abel (1999a), an obstetrician and leading researcher in the area of FAS, offers a critique of the studies conducted to date on the dose-response effect of alcohol in utero. He concludes that the statistical associations found between relatively low dose levels of alcohol and perinatal outcome is weak (Abel 1999: 4). He illustrates that the practice of averaging the number of drinks per day distorts the reality that “all the drinking entering into the average occurs on 1 or 2 days of the week, so the consumption per drinking day is far greater than what is implied by the average” (emphasis in original) (Abel 1999a). Abel’s interpretation of the data suggests that it is “chronic alcoholism” which is the true etiology of FAS (Abel 1999: 6). He further suggests that the name of the syndrome be changed to “fetal alcohol abuse syndrome”, to better reflect its etiology (see also Abel 1998).

A hostile response from pediatricians Kenneth Jones and Christina Chambers, also leading FAS researchers, insists that the verdict is still out in terms of which women are truly at risk (1999: 249). They argue that several issues have yet to be thoroughly studied regarding the mitigating factors in the dose-response association of maternal alcohol consumption. Jones and Chambers conclude that “given our present level of knowledge, we should continue to advise “alcoholic” and “nonalcoholic” women alike that there is no known “safe” amount of alcohol to drink during pregnancy” (Jones and Chambers 1999: 249).

Abel’s rebuttal chastises Jones and Chambers (1999) for being “paternalistic” and overlooking the data that has been gathered for over thirty years (Abel 1999b: 250). The data clearly suggests, argues Abel, that “every mother of an FAS child drinks abusively” (Abel 1999b). He points out that the mitigating factors Jones and Chambers (1999) identify influence whether abusive drinking alone will result in FAS, and not whether one or two drinks will do so. Abel holds that “we should convey what we know, not what we believe is in the best interests of others” (Abel 1999b).

The obstetric-pediatric discrepancies noted in the journal articles and in the drafting of the *Joint Statement* (Health Canada 1996) were similarly noted in the responses from participants in this study. The obstetricians report that they provide patients with information and hint “why take the risk?”, but ultimately leave the decision up to the patient. Although the mother and fetus are considered as a unit, it is the mother as patient who seems to be foremost with the obstetrician when the topic of whether to drink or not is
broached. The following sentiment is indicative of the empathy obstetricians have for the mother.

Sometimes a woman will come in and they'll say that they feel like public property because everyone feels it's OK to touch their stomach. Everyone feels it's OK to say "oh, you're so small", or "oh, you're so big", and, you know, commenting on their physical appearance. I mean, she's still her individual person and this is her baby and her partner's baby and, you know, I think people sort of go "why am I suddenly this public property just because I'm pregnant?" So, when you're screening a woman in that kind of context, you know, it's like you shouldn't be smoking during your pregnancy, but how many people smoke? No you shouldn't be drinking, but... uh, it's not like we're telling people it's fine to go out and drink. [Obstetrician (OB) 1]

Maintaining the patient-doctor rapport and not appearing didactic while providing accurate information is a balancing act all of the physicians referred to. The pediatricians, however, appeared more emphatic in telling their patients, whether currently pregnant or in hindsight, that women should just not drink during pregnancy: "I advocate no use of alcohol at all!" (Pediatrician (P) 1) and "I tell them you'd be safest not to drink anything at all" (P3). Here again, the child and mother are both considered patients, and maintaining a positive rapport with the parent or caregiver is important in the diagnosing and treatment of the child. Still, the primary patient's concerns - the child's - take precedent.

When asked what they know about Fetal Alcohol Syndrome and what they tell their patients about it, all the physicians included in this study referred to the teratogenic effects of alcohol which result in "a whole syndrome of problems". The three prong diagnostic criteria are always covered: "an unusual shape of the face", "some degree of mental deficit and limitations of intelligence", and "growth retardation". With all of the doctors' descriptions pathology and current science acted to legitimate the physician's narrative. A certain anomaly related to the physician's area of specialty was sometimes elaborated. A physician who specializes in orthopedic surgery commented: "Well, the fusions, uhm, in the neck, that takes place at around, somewhere between the 25th and 30th day of pregnancy. So, I say that during that time, the fetus was exposed to blood alcohol that disturbed the formation of the spine". By contrast, a physician who has a background in genetics said: "People talk about two ounces of alcohol, and those sorts of things. The reality is that it's not quite that pure. There's going to be a lot of genetic aspects as far as the person themselves."
The Mother at Risk

The objectivity and scientific reasoning used to describe the syndrome itself was not as apparent in other depictions - namely who the physicians saw as at risk for producing an FAS affected baby. The physicians reported that the subject of alcohol use during pregnancy was usually broached by way of the regular history taking, or to address concerns that the patient herself had raised. The latter scenario was typically a woman who had consumed alcohol prior to knowledge of being pregnant. The ensuing discussion was primarily one of reassuring the patient that “if it was only the one time” (OB1) or “if very little was consumed” (OB3) that she was not at great risk. Most of the physicians felt that the knowledge of alcohol and pregnancy was “pretty much out there” (OB1), and that patients were generally aware of FAS. More than half of the physicians felt that their patient case load consisted primarily of this group. This patient type was also associated with “middle-upper class..., well educated” (OB3), and “yuppie ..., a blessed group of women” (OB2).

Since this patient type was more apt to be informed about alcohol and pregnancy, the physicians were not concerned about informing the patient about FAS or alcohol use during pregnancy. A caveat was usually added like: “obviously anyone can get these things” (OB2) revealing the doctor’s recognition that in reality alcohol dependency or abuse crosses all socio-economic classes and backgrounds (Goldberg 1995). Yet, when asked what they know about women who drink while pregnant, a stereotype that did not fit their patient population was constructed. A pregnant woman who drinks is “not well educated”, “uses other drugs along with alcohol”, is “on welfare”, of “Aboriginal” descent, and living “on the street”. It was to this patient type whom the physicians would make a special effort to talk to about FAS and in particular, the effects of alcohol in pregnancy - although they claimed not to see such patients in their practice.

The narrative of an obstetrician who has practiced in the downtown area for the past twenty-five years illustrates the ways in which women at risk are seen, and not seen. She initially states:

Uhm, I have a pretty yuppie population, to put it mildly. I don’t see a lot of patients that are substance abusers in general, you know. ...I don’t see a large population of people that are very in trouble with alcohol or drugs. Due to the nature of my practice I tend to see pretty ordinary people. [OB2]

Given the nature of her practice this doctor felt that she likely didn’t have enough experience with pregnancy and alcohol to inform this study. By contrast, when this same physician was asked if she had...
ever attended a birth where she felt a baby may be at risk for FAS she replied:

Oh sure! But then again, I'm spoiled - I work at St. Paul's [an inner city hospital]. Say I'm on-call and a patient comes in whom I don't know who, and we get lots of patients at St. Paul's who are addicted to a variety of substances and alcohol, the whole shebang, a combination. And of course St. Paul's being the Mecca [serves] patients like that. ...You know, we have lots, we get lots of FAS babies and substance abuse babies in our nursery at St. Paul's. [OB2]

Although this physician sees "lots of patients" who deliver babies affected with FAS, she doesn't consider those patients hers: "a patient ...whom I don't know". These are the 'other' ("on-call") patients who better fit the stereotype of 'the woman at risk', and whom she does not include in her conception of 'her patients'.

Other physicians also claimed to not see women at risk in their practice. A general practitioner in New Westminster does not see "those kinds of patients" and qualified this by adding that her practice is "fairly clean". Similarly, an obstetrician explained, "I don't have a lot of patients in my practice who are really at serious risk" (OB3). She felt that patients who were at risk were not part of her practice due to the geographic location of her office ("If I had a downtown practice that may be more of concern"), and because she sees patients who are primarily "of middle class and up, reasonably well educated" (OB3).

Until recently, little was known about the characteristics of women who give birth to babies with Fetal Alcohol Syndrome. One recent study reveals that biological mothers of children diagnosed with FAS are likely to have an undiagnosed mental illness, have a history of serious sexual, physical and/or emotional abuse, live with a partner who also drinks, possess fears that prevent them from asking for help, come from families with alcohol problems, have few social supports, and utilize health care at some point during their pregnancy (Clarren 2000). Alcohol use during pregnancy (where the birth outcome appears 'normal' or is not known), has been associated with women who have a college education, are employed or in school, unmarried, smoke, and have an annual income of $50,000, (US) (Ebrahim, et al. 1998). More than one study suggests that Caucasian women are as likely or more likely than other ethnic groups to drink alcohol during pregnancy (Abel 1982; Gladstone 1997; Goldberg 1995). It would appear that most of what is known about women who drink during pregnancy does not reflect the patient type whom doctors presumed to be at risk or in need of counsel.

The stereotypes that the physicians referred to are not completely divorced from reality
(stereotypes are, after all, drawn from something). People with low incomes, street youth, and Aboriginal persons tend to have more problems associated with drinking which makes them more visible than other alcohol users and abusers (Canadian Centre on Substance Abuse 1999: 26, 169). Still, the low income group includes students and those looking for work, who are not necessarily uneducated or collecting social assistance. The presumption that many women are aware of the dangers of alcohol during pregnancy is supported by the literature (May and Himbaugh 1989; Russell 1994). However, knowledge of the problem does not discount that someone may still struggle with an alcohol addiction.

Aboriginal peoples in British Columbia have intentionally associated themselves with Fetal Alcohol Syndrome. They have recognized FAS as a problem within their own communities and now take a leadership role in its prevention both within their own communities and elsewhere. It is for this same reason that epidemiological studies about FAS are focused predominantly on Aboriginal communities revealing high prevalence rates (Burd 1994; Neugut 1981; Square 1997; Van Bibber 1997). The majority of these studies are geographic and population specific because they have been commissioned by community leaders who recognized a problem. No comparable studies have been conducted in areas with populations predominantly non-Aboriginal and middle to upper class - such as the British Properties in West Vancouver where alcohol sales reached over $23,000,000 for the 1998-99 fiscal year (British Columbia Liquor Distribution Branch (BCLDB) 1999: 28). Undertaking such a study may provide insight into what several participants referred to as an unsupported but commonly voiced adage: Children who display difficulties and who come from aboriginal families of a lower socioeconomic status are quick to be identified and diagnosed with FAS. By contrast, children from middle to upper class Caucasian families displaying similar characteristics tend to get (mis)diagnosed with Attention Deficit Disorder.

The position that Aboriginal peoples take on FAS is relayed in the Foreword of the booklet Fetal Alcohol Syndrome. What you should know about Alcohol and Pregnancy:

Although this booklet contains Aboriginal illustrations, it is not meant to imply that FAS is only an Aboriginal issue, rather we are taking a leadership role in the prevention of FAS. By doing so, it is our hope others will decide to address FAS in their communities as well. [VAFCS]

Educational material developed by Aboriginal groups often include illustrations of ethnic dress and rituals and make reference to the teachings of the elders: “Our elders tell us that drinking alcohol during
pregnancy may harm the unborn baby” (VAFCS; see also Appendix A).

**Screening the Mother**

Given that alcohol addiction can cross all socio-economic and racial categories screening for alcohol use is suppose to be a regular part of every prenatal history taking. A standard prenatal form designed by the British Columbia Reproductive Care Program (BCRCP) is used as a guide for all physicians practicing in BC. Just how to best screen a patient about her use of alcohol is deliberated in a significant body of literature (Handmaker 1999; Loock and Poole 1998; Masis and May 1991; Russell 1994). The BCRCP has adopted the T-ACE questionnaire which is considered an effective tool in eliciting a disclosure for prenatal alcohol consumption (Sokol 1989). A checklist on the front of the prenatal form acts as a prompt to ask about alcohol use, and the T-ACE is printed on the reverse as a reference. The questionnaire consists of four questions: Tolerance - How many drinks does it take to make you feel high? Annoyance - have people annoyed you by criticizing your drinking? Cut down - Have you felt that you ought to cut-down on your drinking? Eye opener - Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? The first question receives a score of two for more than two drinks, and the remaining questions receive a score of one for each ‘yes’ answer. A high risk score consists of two or more points.

Despite the BCRCP’s attempt to standardize prenatal history taking and ensure that all pregnant women are screened for alcohol use, the physicians in this study reported that they rely more on their own judgment. The following transcript illuminates what physicians reported as common practice:

T: So, what do you tell your patients about FAS?

Dr. (OB4): Well, when I first see them I talk about how much alcohol intake they’ve had, and we go through a T-ACE score.

T: OK, so you use the T-ACE?

Dr. (OB4): Well, in an indirect way, because what you do is, you never ask them directly all the questions. On the first meeting you want to ask the questions in an indirect way, and eventually you’ll get what you want, instead of asking them directly and making them feel uncomfortable.

T: OK. So, how do you do that? Can you give me an example of the sort of questions that you probe?

Dr. (OB4): Well uh, we talk about social circumstances, you know, “do you drink alcohol?” You
know, “how much?” And then maybe I’ll come back later and say, you know, “do you go out on the
town? When you go out on the town, do you drink?” I mean you have to sort of ask them several
different ways. I don’t know how to explain it. You have to know the patient. You have to figure-out
how the patient ticks, and then you try to angle your questions that way.

T: Build a rapport?

Dr. (OB4): Yeah, you look for opportunities. I mean, the other thing might be “Have you ever been in
a hospital?” and then I say “Have you ever been admitted to Emergency?” and with that maybe
they’ll say “I was being detoxed”, or “I was inebriated while I was doing something.” You use those
sorts of hallmarks to try to find out where they’ve presented.

Maintaining a good rapport and developing a trusting relationship with the patient was a primary
concern of all the physicians. For this reason, the physicians explained, they often do not use the T-ACE
and instead rely on their own style. Although they all claimed to screen for alcohol use, as one obstetrician
explained, how exactly they do this is flexible.

Actually I don’t use a protocol, I actually tailor it more to the person. I mean there are people who are
obviously reticent and they don’t want to volunteer anything and you can’t force anyone to say, but
hopefully.... I guess that I would just hope with time that there’s a rapport and you can get to a point
where she can confide. [OB1]

For the same reason some obstetricians choose not to broach the subject at all. They felt that it was more
important to create an environment in which the patient might “confess”, rather than “make her feel
uncomfortable.”

Despite attempts to decrease the ambiguities around identifying a mother at risk for producing a
baby with FAS, it appears that only certain women and at certain times are considered. This phenomena is
similar to the way parts of the mother are seen and given priority by different medical specialists. For very
different reasons, social service representatives reported that they also see only certain mothers and usually
very briefly. A participant who has worked in the area of child protection for the past twenty-five years
relayed the changes she has encountered in the span of her career.

In the mid-1970s more families would, you know, self-initiate [their involvement]. There was time to
build a rapport, we had time to work with family members, to work with them and offer support.
Now, most cases are investigative and there’s a real stress on intervention - early and fast! [Worker 1]

The type of intervention involved in investigative cases often involves the apprehension of a child deemed to be “at risk.” Under sections 13 of the Child Family and Community Services Act (CFCS Act) if a parent is unable to adequately care for the child (provide basic necessities of food, clothing and shelter), or the parent is likely to harm the child, alternate arrangements will be made in “the best interest of the child” (BCMCF 1997). Although both the parent(s) and child come under the Ministry’s gaze, the CFCS Act dictates that it is the child who is ultimately ‘the client’. Thus, the child is placed into temporary foster care and in some cases relinquished for adoption. The mother, on the other hand, is given a list of areas that she needs to correct or improve in order to regain custody of the child(ren).

At this point in the trajectory the mother moves out of view of the Ministry’s gaze. The child is provided support and monitored by the Ministry, the mother is given instructions and then left to her own devices. A mother who is addicted to alcohol must be motivated and resourceful in order to find and access the necessary programs that the Ministry has recommended to her. Once she has located an appropriate parenting class or drug and alcohol treatment program, there may not be space available. Currently, there remains a 50 person waiting list to access a drug and alcohol treatment program in B.C.. If a woman is pregnant she is automatically placed at the top of the list. As with all others on the list she must wait and call daily to secure her spot. If she does manage to get admitted, she had better hope she doesn’t relapse lest she be asked to leave. This policy is in response to the lengthy wait lists and is supposed to assist participants to stay focused. Most addictions, however, are not overcome in a linear uphill climb. To the contrary, there is much stumbling and relapsing along the way.

Almost all of the participants working within the social service sector (MCF and agencies) were emphatic that there needs to be a “new way of doing things.” One worker referred to a model of care that has been adopted in Inuvik.

In Inuvik they said they don’t apprehend kids there. I said, “wow, how do you do that?” They said, “we bring the services into the home.” They said, “We do real social work here.” And I said “Well, tell me about that.” They said that if they go into a home and the parent is a product of a residential school and they didn’t learn about parenting and they didn’t learn about cleanliness and house standards, and due to alcoholism and drug abuse and sexual abuse, and chaotic home environment.
They go into the home and they say “you know, you look like you need help washing the floor today”, and they go in, role-up their sleeves and wash the floor. So they say “Wow, can you see the difference? How would it be if, it took me 15 minutes, do you think you could do that? Well, then next week we’ll try that together.” [W2]

Through modeling, teaching and drawing upon community supports, social workers assist in keeping the family intact. The needs of the family, as a unit, can be viewed and assessed accordingly.

Similar to the inability, or perhaps reticence, in the professional realms of medicine and social services to see the addicted mother as a mother, an intolerance towards addicted mothers was noted elsewhere. A consultant who provides training about FAS to social workers, probation officers, corrections personnel, drug and alcohol counselors, and other professionals, noted that "people are tolerant up to the point where a woman is pregnant".

So what I say is “we’re not going to be politically correct...” Well, they’re right there, right! So, it’s usually that they are dirty, that they are, you know a woman drinking period is sleazy, dirty a whore, asking for it. And then OK, if she’s visibly pregnant, uhm, OK then she’s irresponsible, she’s a bad mom, she’s a terrible person, you know, it moves into that.

By the end of the session, participants possess more empathy along with insight into the complexities of alcohol addiction. Still, these opinions indicate that the addicted mother is a taboo image.

In the public realm images of mothers associated with FAS are rare. Parts of mom can occasionally be found - usually her swollen stomach (Powel 1981; Buxton 2000a). When the mother does come into view, she is often depicted as the quintessential nurturing mom cuddling her baby. The image of the nurturing mom is presented in educational material about FAS (BC LDB 1999; see also Appendix B), in pre-natal educational material, as well as in much of the pro-life propaganda (SOGC 1998: cover and 91; BCMCF 1998a: 42, 88, 104 and 105; Lifesite Canada 2000; Save the Baby Humans Foundation 2000; Vancouver Right to Life Society 2000 in Appendix B). When those who had input into the creation of the FAS educational materials explained their choice of imagery, the nurturing theme was again present: “It’s a tender loving caring mom, and a beautiful baby. What everyone would aspire to” (representative from LDB; see Appendix B). Even when the message did not appear to directly imply the nurturing disposition it was reported as the underlying sentiment: “Uhm, we went back and forth, back and forth. We
chose the bear because it was so associated with the baby,... to show that kind of a connection between a mother and child, and to have some warmth and caring associated with it (representative from YWCA; see Appendix C).

In contrast to the nurturing sensibilities associated with images of mothers, an obstetrician offered a very different side to motherhood. She reported that within a career spanning 12 years, she has personally known three patients who have killed their babies. She claims that alcohol was a mitigating factor in at least two of these deaths. This doctor wonders if her experience is more common than it is presumed to be. She attends fewer deliveries than most of her colleagues and feels that either she is “very unrepresentative of what may be happening out there, ...or unlucky” in that she sees more of these cases (OB3). This doctor’s insight challenges the assumptions reported by many of the other study participants, both professional and lay - that a woman who drinks while pregnant is not intentionally trying to harm her baby.

No one starts off their pregnancy thinking “I’m going to hurt my baby. I’m going to use heroin, cocaine and alcohol throughout my pregnancy so my baby is not going to have a good chance at life”.

Nobody starts out pregnancy that way” (W2).

This attitude usually presents itself within the context of empathizing with the addicted mother, and to counter stereotypes that she must be irresponsible.

All of the physicians, including the pediatricians, said that they have counseled women, patients or others, who were concerned about their consumption of alcohol prior to knowledge of the pregnancy. With the exception of one pediatrician, all other physicians felt that terminating the pregnancy should not be a consideration if no further alcohol is consumed. The physicians were oriented toward the teratogenic effects of the consumed alcohol and the level of risk posed for the fetus. That the woman’s concerns, and even drinking behaviour, may be related to ambivalent feelings about the pregnancy was only a consideration of one physician.

When I have been referred women who are pregnant and they have had exposure, and they come to see me because they are worried that their child might be affected by FAS, we start with “is this a planned or desired pregnancy or not?” We look at that, what the feelings are around this pregnancy, and then we look at what we know from research. [P2]

I observed only one instance in popular discourse of Fetal Alcohol Syndrome where a pregnant
woman was depicted as someone with an alcohol addiction. A 60 second commercial that aired once on CBC in June 2000 showed six women ranging in age from seventeen to forty three. All the women were at various stages of a real pregnancy, and all were portrayed as having an alcohol addiction. Each woman’s testimony, given with a concerned and worried disposition, reiterated that “if you have a problem, there’s help available” (Living 2000).

Mothers in Hiding

In British Columbia images of the addicted mother remain marginal. A Communications Officer from the Yukon was surprised that the above commercial actually aired in Vancouver but admitted that it was possible. Although the commercial by CBC North was to be aired in the Yukon, CBC also has “a feed to Vancouver, so there is some cross over” (Living 2000). This investigation uncovered other, hidden, places where mom does come into view. The following four vignettes provide a glimpse into the spaces that mom does occupy.

Vignette one: After hours.

A social service agency that operates a twenty-four hour telephone help-line reported that the agency receives 25-30 percent of its calls after hours. It is during this time that a biological mother of a child with FAS is apt to call. The agency representative felt that it was safer for mothers to access their services at this time, as “we can’t call somebody else [like MCF], and as long as there is not child abuse, it doesn’t matter what they tell us [it’s confidential]” (W3).

Vignette two: Finding a niche.

The Vancouver Aboriginal Friendship Centre provides one of the few support programs available for families coping with FAS. The program is specifically mandated to support persons of First Nations ancestry. However, the coordinator often stretches that category to include families who may not otherwise get help. Most of the women who access the services at the Centre come from a lower-socioeconomic class. The few women of middle to upper class status who do access the services prefer not to visit the Centre. These women, too uncomfortable to be associated with FAS in public, meet with the worker “but of course it’s in their homes.”

Vignette three: Home by curfew.

A social worker employed in adoption services for the past eight years has noted a recent trend.
Young, often teenage, pregnant women "give birth to the baby [in the hospital] and then sneak home by curfew" (W4). These same teens continue to drink and use drugs throughout their pregnancy due to a combination of denial and lack of maturity. Fear and denial also prevent the teen from disclosing the pregnancy to her parents or anyone else. In many cases only the social worker and the teen mother know of the birth.

_Vignette four: Taking the 'mike'._

Some women have braved the public spotlight, telling their stories at conferences and seminars. One of the participants recalled a conference she attended where “two birth moms took the microphone.” One of the moms relayed her frustration at being shunned and ignored by professionals: “Why don’t you ever ask us? I can tell you what it felt like when I drank. I can tell you when I drank. I can tell you what was helpful. I can tell you what wasn’t helpful.”

Alcohol as Teratogen

The invention of Fetal Alcohol Syndrome has brought the teratogenic nature of alcohol to the forefront which may account for the shame and secrecy eluded to above. Cautionary tales about drinking alcohol during pregnancy have been referred to throughout history - in the Bible, depicted in art work, and even eluded to in the medical literature (Armstrong 1998; Neugut 1981). However, it was Fetal Alcohol Syndrome that clarified the nature of alcohol not only as a drug, but as something that adversely affects the normal development of the fetus - a teratogen. The association between alcohol and the fetus has since been incorporated into the pre-natal material available in the popular realm. _Baby’s Best Chance_, a “handbook of pregnancy” made available to expectant parents by the Provincial government, first made reference to alcohol as a teratogen in 1979:

> There is growing evidence that pregnant mothers should not drink alcoholic beverages. ...Alcohol is a drug that passes from the mother to the unborn fetus through the placenta, and thus when the mother drinks the fetus is exposed to a drug that can delay mental and physical functioning. [Ministry of Health 1979: 30]

The most recent edition of this book reiterates that “the most important thing to remember about drinking while pregnant is that when you drink, so does your baby” (BCMCF 1998a: 24-25). The obstetric proclivity is apparent in the Society of Obstetricians and Gynecologists of Canada’s 1998 inaugural publication of
Healthy Beginnings:

Less is better, none is best... Nobody knows just how much alcohol a woman can drink during pregnancy without causing harm to her baby. What we do know is that some babies will suffer serious birth defects if their mothers drink steadily or heavily during pregnancy. [SOGC 1998: 10]

Very graphic portrayals of the fetal-alcohol relationship are depicted throughout FAS educational material. The flow of alcohol from the mother’s mouth to the fetus is mapped both externally and internally in a recent publication by the VAFCS (Appendix D). In reality the affects of alcohol on the fetus can not be made visible. Current technology may be able to detect that the fetus is small for its gestational age, but this finding is non-specific and is indicative of a number of birth defects. Still, the fetus is predominant in depictions of alcohol as a teratogen within FAS educational material (Appendix E). It may be floating in a martini glass or bottle of liquor, for example, to effect a strong association between alcohol and the fetus. Free floating fetuses, both in and out of utero, are depicted alongside messages like “She’ll have what you’re having” and “Be good to me... stay alcohol free. A message to Mom from your baby” (Appendix E).

That alcohol is a known teratogen appears to also influence the depiction of FAS as something tragic to be mourned. September 09 has been proclaimed the International Fetal Alcohol Syndrome Day by a network of agencies worldwide (FAS World 2000). Observed on September 09 at 9:09 a.m., the ringing of bells at this time, followed by a minute of reflection, is meant to signify the “nine months of pregnancy when a woman should not drink alcohol” (Buxton 2000b). This is also a time to “remember those millions of individuals who will not reach their genetic potential because their mother drank in pregnancy” (Buxton 2000b).

The tragic undertones of the latter sentiment have been more the overtone in how FAS is portrayed in the media. The tragic nature of FAS is one the media also tends to associate with crime. Of the 86 newspaper articles reviewed 25 of them referred to FAS as a “tragedy”, and 32 articles associated FAS with crime (either as the cause of crime or as a mitigating factor). For example:

As Minister of National Health and Welfare, I am deeply concerned by the human tragedy of FAS. [Benoit Bouchard in response to Nicole Parton’s column which ran a series about FAS 1991: A12]

Tragic Kids of Moms who Hit the Bottle [headline of a special section on FAS in the Province; Fournier Dec. 27, 1999: A40].
John, a teenager with FAS, is a brain damaged child who can’t control his actions. At 15, he’s also a dangerous criminal who is becoming more dangerous. [Fournier Dec. 27, 1999: A 40]

More recently, the story of Serena Nicotene hit the front page: “Fetal Alcohol Syndrome turned teen into a killer” (Zareski Jan. 22, 2000: A1). At the age of 15 Serena drowned a toddler and subsequently spent one year in custody. Upon her release, she brutally murdered a 58 year old woman.

The ‘criminality of FAS’ is portrayed elsewhere in the popular realm. A poster produced by the FAS Community Resource Centre (1999) depicts FAS as “a lifelong sentence” eluding to the permanency of the condition and to the actuality that an estimated 50-80 percent of persons in the criminal justice system also have FAS (Appendix F). Although some studies have revealed an association between FAS and criminal behaviour (Fast, Conry and Loock 1999), a number of mitigating factors are often involved. Lacking a proper diagnosis a person with FAS may not be eligible for services. Consequently, a person with FAS may struggle through life without a safety-net of support and structure. This can, in some cases, lead to criminal behaviour as persons with FAS often act on impulse and are easily manipulated. Other mitigating factors that often do not reach the headlines are an unmanaged mental illness, an unstable family life, and a history of abuse. Foster parents and others who specialize in the care of persons with FAS demonstrate that with the proper guidelines and structure, a person with FAS can live a productive life (FAS/E Support Network 1997; Zacharias May 12, 2000). Such a testimony raises the question: If the environment can be changed to allow a person to reach his or her potential, where does the tragedy lie? Is the person a tragedy, or does the source of tragedy lie with the unstructured and unsupported environment that allows the person in need to be manipulated and to engage in unsafe activities?

As with popular stereotypes associated with mothers, the tragic and criminal associations with FAS also interact with the medical realm. A pediatrician who teaches at the University of British Columbia relayed a poignant example of how popular and professional discourse intersect. Fetal Alcohol Syndrome was the tutorial topic the same week in which the media ran a story about a man with FAS, David Trott, who was accused of murdering nine year old Jessica Russell (McMartin May 09, 2000: A3; Nuttal-Smith May 09, 2000: A7; Ouston May 09, 2000: A1 and A7). After encountering FAS in a context different from the medical one that she encountered in tutorial, one of the students returned to class extremely upset exclaiming “this is what can really happen [to people with FAS]!”
DISCUSSION

Assembled Meanings

In her cultural analysis of reproduction Emily Martin (1992) found that concepts and language used within biomedicine that refer to menstruation, reproduction, childbirth and menopause are laden with cultural stereotypes. For example, metaphors such as “waste and decay” are used in reference to menstruation and menopause, and “labor and production” models presume that women’s bodies are engaged in production. This, according to Martin (1992), indicates that although biomedicine appears to describe events independent of their context with an emphasis on facts, in reality biomedical descriptions are concrete stories rooted in social hierarchy and control.

A phenomena similar to what Martin (1992) describes appears to be at play in the present study. On the surface, physicians talk about Fetal Alcohol Syndrome in technical terms, however, cultural stereotypes enter-in, particularly when talking about women at risk for producing an FAS affected baby. Negative connotations about women’s defiled bodies as a potential vessel of contamination are indirectly indexed through opposite notions of a “clean practice”, and “educated” or “blessed” patients who just would not produce babies with FAS. Eugenics connotations are similarly indexed in reverse by associating “yuppies” and the “blessed” with those who will generate healthy babies, and the ‘degenerates’ (street people, inner-city drug addicts) with those most likely to contribute to the social and medical problem of FAS. Stereotypes of people who “go out on the town” or who “were being detoxed” are couched as “hallmarks” and places where “they’ve presented” providing a medical-objective sensibility to subjective assumptions.

That physicians have some knowledge that alcohol addiction runs across class and race yet refer to FAS as primarily a problem of lower class, uneducated and Aboriginal people is perhaps indicative of a diagnostic dilemma. In theory, the nature of arriving at a diagnostic classification relies on a carefully delineated set of criteria that are narrowly defined (Stratton et al. 1996: 64). Fetal Alcohol Syndrome as a diagnostic category has undergone multiple revisions in an effort to reduce its many ambiguities to an objective and explicit clinical entity. The 4-Digit Diagnostic Code is a paradox in this regard (Astley and Clarren 1999). Attempts to convert the fuzzy boundaries of the facial phenotype and brain dysfunction into quantifiable explicit categories draw upon subjective practices and racialized assumptions. Clinicians
operate within the same reductionist framework when trying to identify who may be at risk for giving birth to a child with FAS. What is known about women who drink during pregnancy is sensitive but not specific enough to delineate a phenotype, and knowledge about the very specific category "biological mother of a child with FAS" is just starting to be uncovered - and there lies the dilemma. In the absence of clearly defined criteria for that diagnostic category, physicians rely on the most visible - or stereotypical.

When diagnosing a woman with an alcohol addiction, or a child with Fetal Alcohol Syndrome, the physician imparts not only the medical complications associated with drinking, but through that a morally and ideologically loaded identity is also imparted upon the patient. Fear of embarrassment is something Erving Goffman (1959) sees as mitigating social interactions. Within certain social milieux, such as romantic love, religious passion, or family intimacy, people are less concerned about embarrassment and social gaffes (Schudson 1984). The clinical encounter is one milieu within which great pains are taken to avoid causing embarrassment. The clinician is expected to respect patient privacy, be sensitive to patient autonomy, and "above all else, do no harm" (Duffin 2000: 126).

The preference for a screening process that is less direct than the T-ACE questionnaire is indicative of the physician's sensitivity towards 'saving face', or "preserving the social self" as Goffman (1959) would say. As diagnostician, the physician is in a position to 'blow the patient's cover' exposing the part of the patient's self, such as a current or previous addiction, that is normally left in the background (Goffman 1959: 108). The process of uncovering what Goffman calls the "back region" of the self involves a delicate interaction between the superordinate doctor and the subordinate patient (1959: 159, 200). In order for a disclosure to occur while still saving face "a feeling-out process occurs whereby one individual admits his [sic] views and statuses a little at a time" (Goffman 1959: 192). This is a reciprocal process where the patient drops her guard "just a little, and waits for the [doctor] to show reason why it is safe for her to do this" (Goffman 1959: 192).

The power imbalance inherent in the doctor-patient, superordinate-subordinate, relationship can become blurred when class differences are minimized. This, however, may not allow for a clinical encounter that is less awkward. It has been noted elsewhere that physicians are less effective with patients who are of the same or higher socioeconomic status (Duff and Hollingshead 1968). This type of doctor-patient relationship has been found to threaten patient care as physicians tend to focus on pleasantries and
salutations, rather than solving the patient’s problem (Duff and Hollingshead 1968: 142-145). This same dynamic may be an additional mitigating factor in the emphasis physicians place on preserving patient rapport. The scope of the physician’s concern may reach beyond preserving patient integrity and the doctor-patient relationship, to encompass a concern for the integrity of the clinician’s own social class and/or profession. In addition, a physician’s own use or misuse of alcohol has been proposed to influence the clinical interaction. Physicians have an equal incidence of alcoholism compared with the rest of society (Mansky 1999: 108). Yet, research notes that doctors often avoid or ‘fail’ addiction treatment because they tend to deny in themselves symptoms of physical illness and emotional pain (Fayne and Silvan 1999: 125). A physician’s own experience with alcohol use or addiction may then impact how s/he relates to patients with the same addiction, particularly patients of the same socioeconomic class.

When referring to their clinical encounters with FAS the physicians draw upon what Gee (1999) refers to as an assemblage of meanings. A physician’s use of concepts and language is not confined to medical training and is relative to a physician’s socio-culturally-defined experience in the world (Gee 1999: 49-50). Medical ambivalence regarding the exact effect of alcohol on the fetus remains, and very little is known about the mothers who give birth to affected babies. The use of a dominant/professional discourse along with a subordinate popular discourse about FAS is a reflection of both the medical uncertainties, and the multiple contexts within which the physician encounters FAS. In the clinic or hospital the medical-professional discourse is foremost with the physician. Yet, discourse that the physician has encountered on television, from friends, in the newspaper (“this is what can really happen”), and so on, is also present but at a subordinate level and often when the professional discourse is insufficient or possibly uncomfortable. This assemblage of meanings impacts the clinical encounter producing a myopic lens through which women who may be at risk for drinking during pregnancy are viewed.

The Fetus

The meanings that influence the clinical encounter are also tied to ideologies about mothers and fetuses. The prevalence of fetal images associated with FAS can be explained in terms of the historical location of FAS, and in particular the ways in which the fetus itself has evolved as a subject. It is the late 1960s to mid-1970s that mark the advent of FAS as diagnostic category and as discourse. At this same time the abortion debate in Canada had come to a head. Pierre Elliot Trudeau’s now famous words, “the state
has no business in the bedroom of the nation" signaled the legitimate recognition of reproductive choice for women (McLaren and McLaren 1986). That abortion was now a woman's right also sparked a pro-life/anti-abortion backlash that continues to procreate even today. The pro-life discourse includes such rhetoric as "the rights of the unborn", "woman as killer of her unborn child", and a barrage of other morally loaded slogans and associated images (Rudy 1996). The fetal images associated with FAS are reminiscent of those associated with the abortion debate (see Birthright International 2000; Lifesite Canada 2000; Pro-Life Action League 2000; and Pro-Life America 2000). The various producers of the FAS related images claim no direct link to the abortion debate, but some report that the images are often misinterpreted as "talking about abortion."

The fetal images associated with FAS appear to also reflect a subject(ing) of the fetus within a different realm. The fetus was initially considered as a patient in the seventeenth century when a Swiss sow gelder performed the first successful cesarean delivery on his wife (prior to antisepsis and anesthetic) (Duffin 2000: 246). However, it wasn't until the late 1970's with the birth of the first baby resulting from in vitro fertilization that the fetus reached full status as a subject in its own right and moved beyond the laboratory and into the public realm (Kurjak 1985; Shore 1992: 297). It is ironic that the image of the fetus is so predominant within public discourse of FAS, yet the clinical reality is that with fetal technologies the fetus can not be made visible enough to be diagnosed with FAS. Diagnosis is not made at the pre-natal stage and rarely at the neonatal stage. The clinician must diagnose a presenting child or adult based upon who mom might be and what she may have done to the developing fetus vis-à-vis her body.

FAS as research subject and social concern has evolved alongside the growth of fetal technologies such as amniocentesis, ultrasound imaging, in-utero corrective fetal surgery and reproductive technologies. With the advances in fetal technology 'baby's first picture' is now often produced through ultrasound imaging. Viewing the fetus in this way drives its personification as sonographers refer to the fetus as "hidden" or "shy" if it is difficult to visualize; and an active fetus is "swimming" or "playing" (Mitchell in Rapp 1997: 40). These same technologies have given pro-life groups the images for their own propaganda where the personification of the fetus is again underscored: "These are not blobs of tissue or products of conception. They are babies" (Pro-Life America 2000).

With these advances also comes the notion of "stratified reproduction" as certain categories of
people are encouraged to reproduce, while others are disempowered (Cohen 1995). At this particular social, political, historical, and cultural juncture, the fetus is a metaphor for perfect babies. It signifies who should be re-produced and who should be re-producing them. Mary Douglas (1970) has argued that where there is a concern about who enters the social body (i.e. society), there will be a concern about bodily orifices and secretions. She demonstrates that cultural activities linked to the bodily processes of defecating, urinating, passing gas, burping, sneezing, bleeding, and so on, are not simply efforts to escape disease, but are a molding and remolding of our environment towards an ideal. In the age of perfect babies, what goes in the mouth of the mother, and what the womb secretes through the birth canal, have come to be seen in terms of “purity and danger” (Douglas 1970). A woman who follows the prenatal prescription of avoiding alcohol during pregnancy not only reduces the risk of danger posed to the fetus, but also to society once the child is born. By contrast, a pregnant woman who pollutes her body and baby through alcohol - a teratogen - risks producing a teratism - a monster (as defined in Funk and Wagnalls Canadian College Dictionary, fifth edition 1989).

Whereas Douglas (1970) argues that something comes to be seen as dangerous or polluted when a moral boundary is crossed, it would appear that the boundaries themselves are shifting in terms of acceptable prenatal behaviour and post natal outcome (Bergesen 1978). Prior to the recognition of FAS and other ‘fetus as patient’ concerns, the taboo about women consuming alcohol during pregnancy had not yet crystallized. It wasn’t until Fetal Alcohol Syndrome emerged as a category, as a real object, that the drinking while pregnant taboo developed and was encompassed into the list of prenatal “don’ts”.

The Mother

The invention of prenatal care emerged in Canada out of a concern for building a strong Nation and needing a healthy pedigree. Within the wombs of women lay the potential of building and protecting a powerful Nation. The hegemonic agenda of pre-natal care is laid out in the 1923 Canadian Mother’s Book: “the mother is the first servant of the State” meaning “No baby - no Nation” (McMurchy 1923: 1,8). Overwhelmed by the high rates of maternal morbidity, the Department of Health developed literature and made provisions for services for women and children. By 1944, prenatal classes were offered in most communities, and education was sent over the radio, displayed on posters in department stores and in newspapers (Arnup 1994). Women’s pregnant bodies came to be seen as something to be disciplined
through proper diet, cleanliness, rest and exercise. These disciplining practices were, and still are, monitored through regular visits by public health nurses to ensure a positive post-natal outcome. Prenatal care in this respect is a "technology of power", to borrow a term from Foucault (1977). The normalizing judgment of these practices assists in homogenizing the pregnancy experience by bringing deviant mothers in line with the normal (Foucault 1977: 178-179).

As knowledge about birth defects expanded, and diagnostic fetal technologies advanced, monitoring and surveying the fetus itself was incorporated into the disciplinary mechanism. Thus, the relationship between society, pregnant women and the fetus shifted (Harrison 1991: 262). By shifting the moral boundaries related to prenatal behaviour, certain people and activities are placed 'on the other side' - i.e. come to be seen as deviant, dangerous or dirty. The expectant mom who does not adhere to the cultural practices of prenatal care, such as abstaining from alcohol, is herself an abomination. A woman's embodiment, particularly a pregnant woman's embodiment, is then liminal. The insights of Adrienne Rich (1976) resonate with these moral categories. On the one hand the female body is considered impure, corrupt, the site of discharges, bleedings, and the source of moral and physical contamination. By contrast, the woman as mother (with her same defiled body) is seen as beneficent, sacred, pure and nourishing (Rich 1976).

Unlike the predominant images of the fetus, images of mothers that are associated with FAS are few. The Images of the mother that are visible reflect what Marlee Kline delineates as the dominant ideology of motherhood: the natural desire of all normal women, a mother unselfishly puts the child's need before her own, and is always available to her children to support both physically and emotionally (1995: 119). The selfless nurturing mother is a normalizing project imaged in educational material about FAS (BCLDB 1999), in handbooks about pre-natal care (SOGC 1998: cover and 91; BCMCF 1998a: 42, 88, 104 and 105), and in pro-life propaganda (Lifesite Canada 2000; Save the Baby Humans Foundation 2000) (see also Appendix B). I do not mean to suggest that an intentional or unintentional link exists between the abortion debate and what is said about Fetal Alcohol Syndrome. What I am suggesting is that there is an ideology of mother as nurturer that is salient and crosses various contexts. Faye Ginsburg (1987) observed this phenomena in the narratives of abortion activists, both right-to-life and pro-choice. Both groups drew-upon the notions of nurturance in relation to biological reproduction. The pro-choice narratives embraced
nurturance as "a valued quality to all women and the basis for their cultural authority" (Ginsburg 1987: 629). Yet, they also rejected nurturance as an attribute that assigns women with care taking, the home and having children. The narratives of the pro-lifers referred to nurturance as something achievable, not inherent. Nurturance, they suggested, had become devalued at a time "when wombs can be rented and zygotes are commodities." Abortion for this group was viewed as symbolic of the "increasing commercialization of human dependency" (Ginsburg 1987: 629).

In reality, the experience of motherhood is of course variable (Hrdy 1999; O’Connor 1993; Rich 1976). Sarah Blaffer Hrdy (1999) argues that there is no such thing as maternal instinct. The flood of chemicals and hormones that build in the woman’s body during and after pregnancy do impact the “mother love” response. However, Hrdy (1999) insists that there are no guarantees that a mother will respond to the birth of her baby in a nurturing way. She cites the history of infanticide in both primate and human societies demonstrating that the practice has functional as well as biological roots. Hrdy’s (1999) research illustrates that whether or not a mother will love and nurture her baby, or any baby, is mediated by ambivalence about the pregnancy and child rearing. If a woman is prepared, both emotionally and practically (i.e. financially, socially, culturally), she will be able to love any child whether born to her or to someone else. If the prospects of her own or the infant’s future are perceived as bleak, and/or she has not developed an attachment to the baby, a mother may respond by abandoning or even killing her baby (Hrdy 1999: 311-317; see also Rich 1976).

The image of the addicted mother, and/or ambivalent mother, does not fit the predominant ideology of the quintessential nurturing mother - although in reality she may present herself in that way. Similarly, the unthinkable act of a mother killing her child challenges the commonly held assumption that a woman who drinks during pregnancy is not intentionally harming her baby. Only one physician was oriented toward the ambivalence associated with pregnancy. Within the context of Fetal Alcohol Syndrome, when all other physicians counsel a woman about terminating a pregnancy, the teratogenic affects of alcohol became the primary-focus. Given that the majority of pregnancies are unplanned, it is surprising that counseling regarding the patient’s feelings about the pregnancy were not reported as standard practice. I am not suggesting that women who drink are intentionally harming their babies. The point, rather, is that mothers are expected to fit either the ‘good’ or the ‘bad’, and that little room is allowed
for the in-between, not so certain ambivalence, particularly when pathology is foremost in the clinician’s mind.

The ideology surrounding motherhood, and in particular the prenatal activities she is expected to adhere to, can perhaps explain why, intentionally or not, Fetal Alcohol Syndrome has escaped the disability rights discourse. In an age of political correctness, it is perplexing that a disability is so openly degraded as a tragedy. Fetal Alcohol Syndrome and the disability rights movement have evolved within the same historical period, yet the two remain largely divorced from each other. Both the baby with Down Syndrome and the baby with FAS are not ‘perfect babies’, and both are preventable. Yet, the woman who discovers through amniocentesis that her baby has Downs and chooses to carry it to term and parent it, is glorified as unselfish. By contrast, the woman who produces a child with FAS is vilified and the baby considered a tragedy as the quote from Erdrich (in Dorris 1989) above, and the headlines in the newspapers insinuate.

The mother of a child with Downs has no control over the trisomy 21 that the baby carries - other than terminating the pregnancy altogether. The mother of the FAS baby, on the other hand, is doing something to her body and her baby. She is disrupting “the genetic potential of the person” to be (Buxton 2000b: 5). The drinking mother is also resisting the disciplinary technologies of prenatal care that regulate what goes in the body and what comes out. Whether intentional defiance, or overwhelmed by addiction, the mother’s behaviour can then be considered a form of resistance. This is her body, not the State’s. This is her baby, not the Nation’s.

Multiple Gazes

Until fairly recently, if a woman’s pregnancy was not complicated or at risk for complications, her family doctor (general practitioner) would likely follow her throughout the pregnancy, deliver the baby, and continue to care for both patients as necessary. If complications arise - the baby is a breech presentation for example, or the mother develops gestational diabetes, she will be referred to an obstetrician who will care for the mother through to the delivery of the baby and for a few weeks after the birth. If the mother requires even more specialized care, such as prenatal diagnosis for birth defects, or the management of multiple pregnancies, she will be referred to someone who specializes in maternal-fetal medicine. If alcohol and/or substance abuse is found to be part of the mother’s lifestyle, she may be referred further to a detoxification Centre or hospital ward where a physician who specializes in addictions and pregnancy can
assist her. Regardless of who cares for the mother and delivers the baby, after the baby is born it becomes the care of either the family physician or a pediatrician. As one obstetrician emphatically stated: “I don’t do babies!” The mother, on the other hand, will continue with the specialist for a few weeks before being referred back to her primary physician.

The ‘politics of reproduction’ also intersect with the medical system influencing who will care for the mother. Midwives are now legitimate practitioners whose services are covered by the Medical Services Plan (MSP) of B.C. (Ministry of Health and Ministry Responsible for Seniors 1998). One physician in the study explained that some General Practitioners (GPs) are no longer willing to practice obstetrics. The government, they claim, is paying midwives five times the fee it provides physicians for the same service. The sentiment of some GPs, one physician claimed, is typically: “Why should I do that when I’m not even valued for what I’m doing, why bother?” Other negatives that influence a decision to not practice obstetrics include disruptive on-call hours and insurance premiums that are more expensive for a family doctor who practices obstetrics than for a specialist. Pregnancy and delivery, then, fall increasingly to the domain of the obstetricians. This is not to suggest that obstetricians are paid more than general practitioners or midwives. Being referred to a secondary care physician is simply the natural progression in terms of care.

Within the current system a pregnant woman is likely to come under the gaze of at least three different clinicians: the general practitioner to confirm the pregnancy, then to the obstetrician, or possibly a midwife, until the delivery of the baby, after which her baby will be seen by the hospital pediatrician. As previously indicated, this trajectory can become far more complex. Throughout this trajectory, how the patient, or a particular anomaly, is regarded by a physician changes depending on the doctor’s training and specialization. The different perspectives from which a patient is viewed is meant to provide a fuller picture of the patient and her presenting complaints. Thus, the patient is provided specialized and presumably better treatment and care. However, the obstetric-pediatric rift regarding alcohol and pregnancy illustrates that different medical perspectives can erupt in a clash between points-of-view rather than operate as a team of networks.

The differing opinions about risk and the alternate readings of the literature, represent a paradox of the knowledge system of medicine. The macro-knowledge system of medicine provides an overarching paradigm from which to operate: a fact based empirical and objective science. At the same time other ways
of seeing and knowing, micro systems of medical specialties, function within. When viewed within the context of pediatrics the ‘end product’ and ‘functioning problems’ of FAS are the primary objects of the physician’s gaze. Within the obstetrical context the woman’s plight during pregnancy takes precedence and the prevention of FAS is considered from that angle. The point here is not to determine the best perspective by judging one or the other’s argument as empirically sound. Rather, the point is to consider the situated meanings of FAS that erupt and clash within the medical system.

Michelle Foucault (1973) refers to this specialized way of seeing and speaking as la regard- the gaze. Foucault (1973) charts a major turning point in the history of medicine as its shift away from the “medicine of symptoms” where symptoms were considered actual constituents of the disease, to the “anatomo-clinical method” where symptoms are seen as signifiers of a process first seen in the anatomy of the organs, later in the relationships between organ systems and finally in the finer anatomy of tissues, cells and membranes (Kupers 1975: 236). Medicine has continued along this path of relating symptoms to the complex processes of the human body, as well as the environmental impacts on that relationship. This has resulted in the organization of medicine into increasingly specialized fields of practice.

From a strictly biomedical point of view, the etiology of Fetal Alcohol Syndrome is located within the mother. In terms of treatment and prevention, it would be beneficial to identify the mother at risk and provide her and her baby, as a unit, with the necessary care and support before, during and after her pregnancy (Loock 2000). However, even when she does present as a unit, specialized ways of knowing prevent a truly holistic perspective. Parts of ‘the unit’ are illuminated or erased according to the particular regard a physician holds for the patient. A truly holistic perspective is difficult to achieve as the trajectory merely delineates the efforts to reduce the parts of the mother, her presenting problem or problems, to specific etiology.

The trajectory of care for a pregnant woman who is abusing alcohol will often include the involvement of the Ministry for Children and Families (MCF). Social workers practicing within MCF, particularly in the areas of child protection or adoptive services, walk a tight rope in trying to balance ethics and values. When confronted with a client who is abusing drugs or alcohol prenatally, workers have an obligation to promote client self determination, privacy and access to services, as well as a responsibility to intervene coercively to protect vulnerable people (Bowerman 1997). The practice of apprehending children
is a cultural practice that contributes to a cultural meaning system within which FAS is understood. Similar to the privileged fetus, within the current system of social services the vulnerable child is afforded more status than the mother. The ‘addicted mother’ is removed from the gaze of the social worker vis-à-vis the apprehension of the child. The mother’s status will be restored to that of mother only when she can meet the criteria that better reflects the quintessential nurturing mother. Few supports are available to prevent her from getting lost within a system that is both foreign and barren.

That mothers are giving birth then sneaking home by curfew, phoning after hours, and receiving services within the shelter of their own home attests to the shame, stigma and fear that women in this category struggle with. Shame has been identified as a barrier to women seeking help for their addictions (Poole and Isaac 2000). The management of shameful or stigmatizing information that these women harbor is a process that Goffman refers to as “passing” (1963: 42). The disclosed information is kept under raps outside of these secret milieus in order that the woman can “pass” as the socially constructed person that others have come to associate her with. Given the ways in which mothers are currently portrayed within the popular and professional discourse about FAS, as well as the oppressive activities and practices made on behalf of the discourse, the ‘addicted mom’ has much to gain by “passing” as someone who is not that.

The professionals and others who do become privy to the secret life of the addicted mom are “wise”, to borrow a term from Goffman (1963: 28-29). The “wise” occupy a privileged position as they are both attuned to and have sympathy for the stigmatized person. Physicians, social workers and representatives of support agencies are all in a position to become “wise”. However, the testimony of the mother in the last vignette, (“why doesn’t anybody ask us?”) indicates that there is an actual or perceived lack of “wise” people to whom women can turn. In sharing their stories with an audience of professionals these women are attempting to cultivate more “wise” people to whom they, and others like them, can confide. Systems problems such as the mechanistic and specialized medical system, and the child focused social service system, will prevent a number of professionals from achieving this status. Until those barriers are changed women will continue to manage their stigma by “passing”, and only disclosing in secret to the few and trusted “wise.”


CONCLUSION

The discoveries made through this inquiry support the initial presumption that Fetal Alcohol Syndrome derives its meaning not simply from the diagnostic label that was invented by Jones et al. in 1973. However, the value of this study is not that it simply reveals that FAS is socially constructed. The findings of this inquiry are important because they reveal where FAS is located within the broader socio-political context. The category of FAS is tied to values and ideologies about mothers, children, the fetus, and alcohol, among others. These are the sites of oppression from which hegemonic discourses stem. Diagnostic practices, social work practices, and efforts to raise awareness about FAS are activities that drive, as much as they are driven by, these discourses.

In mapping the social relations of FAS the discourses of FAS are disclosed. That there are multiple discourses stemming from various sites partly relieves medicine and science as the sole perpetrators of the hegemony surrounding FAS. As Treichler argues, “science is not the true material base generating our merely symbolic superstructure” (1987: 35). The relationship between popular and biomedical discourse is not a dichotomous one, rather, the two form part of a continuum. As Csordas asserts, “hegemony is immanent in biomedicine, but not that there is a biomedical hegemony” (1992). Biomedicine is one technology of hegemony among many located throughout different sectors in society.

This declaration does not relieve those who operate within biomedicine from taking some responsibility for the oppressive ideologies that plague mothers of children with FAS. Taking such responsibility could start by interrogating the facade of objectivity to which biomedicine claims to adhere. Given that FAS is an ideological code, is it possible for those who are associated with that category to experience a clinical encounter that is truly bias free? If not, is this so bad? The impossibility of an unbiased clinical encounter may not be so bad if that bias stemmed from a political engagement with issues outlined in this paper. Such an engagement identifies and then takes action when confronted with oppressive language and images. It questions and thinks critically about those things and challenges them within both the professional and public realms.

Through mapping the social relations that collide and sometimes collude to create the discourses of FAS it is also apparent how “changes in biomedical practices can create instability in the meanings that are attached to the object” of its gaze (Casper 1999). The multiple clinical gazes under which a ‘mother at
risk' is viewed, prevent all of her to be seen at a given time. Parts of the mother-baby unit get dissected in a web of contested meanings. This same unit is again dissected within the bureaucratic web of the social service sector. This erasure effect of both the medical system and social service system is a product of ideologically and structurally confined activities.

The quintessential mother that Ginsburg (1987), Kline (1995), Rich (1976), and others (see Arnup 1994, Hrdy 1999, O'Connor 1993) articulate, particularly the expectation that motherhood is a moral duty, is tied to the development of pre-natal care. While the category of the nurturing mother appears salient, the moral boundaries and activities associated with that category transform according to current medical knowledge, and also according to the entities and behaviors deemed valued in society. Pregnant women, then, have historically come under both public and medical scrutiny. Both the fetal and mother images associated with FAS feed into long held notions of, on the one hand, the woman's body as defiled, a potential container of venom for the fetus, and on the other, the mother is self sacrificing and nurturing.

Assumptions about who the mother of a child with FAS is are drawn from both the perceived and the real. Prior to the development of fetal and reproductive technologies the fetus was invisible. Medical progress, the pro-life movement, and the name and naming of the diagnostic category Fetal Alcohol Syndrome, all intersect to, intentionally or not, reify the subject(ing) of the fetus who overshadows the mother. It is the status of the perfect baby, along with notions of the quintessential mother, that determine the status of babies affected with FAS and the mothers that bear them. The values attached to these objects dictate the status of what goes in the body of the woman and what comes out.

The stigma associated with categories like FAS and 'the alcoholic mother' influences the clinical encounter as clinicians struggle to preserve the doctor-patient relationship. The efforts to 'save face', the lack a precise medical category within which to compartmentalize her, popular notions about who she might be, along with the socio-cultural locations of both the patient and doctor intersect to both produce and (re)produce meaning. The result of this collision is a gap in service as 'the mother at risk' is presumed to be 'not in my practice'. Although women's bodies have been overly scrutinized, women do have the right to make informed choices about their prenatal care. However, discourse and interpersonal sensitivity impact the clinical encounter in such a way that neither the patient nor the doctor are getting the information they want and/or need.
The findings of this inquiry also raise questions with regards to nosology. In theory, and to a large extent in practice, delineating a set of clearly and narrowly defined criteria does assist in arriving at a diagnosis and subsequent course of treatment. But, within the context of mothers at risk, can this mode of practice accurately reduce complex social beings in a social world fraught with nuances and ambivalences into ordered categories? Do biological mothers of children with FAS have to be characterized as a medical prototype in order to be seen and to be legitimized? Would they even want to be - given the stigma associated with that category? Are the efforts and resources put towards reducing diagnostic ambiguities of the facial phenotype perhaps misplaced? Would resources and efforts be better spent on recognizing mothers at risk, determining their individual needs and reducing the stigma associated with them?

The first step towards such efforts is to restore women to a central place in the pregnancy scene in both professional and public discourse about FAS. In order to do this, “fetal images must be placed back in the uterus, and the uterus back into the woman’s body, and her body back into social space” (Petchesky 1987).
Notes

1 Although a significant number of women continue to drink during pregnancy (Blume 1996), and the incidence of FAS is on the rise (Cardero et al., 1994), the numbers alone can not provide an accurate picture. Both the increased awareness about FAS and the increased ability to recognize and diagnose it should be considered when interpreting the prevalence figures.

2 Static encephalopathy consists of microcephaly and/or abnormalities on brain images diagnostic of prenatal alteration, and/or evidence or persistent neurologic findings likely to be of prenatal origin, and/or I.Q. score of 60 or less. Static encephalopathy refers to “multiple deficiencies or discrepancies across multiple areas of brain performance such as cognition, achievement, adaptation, neurologic soft signs, and language. Generally three or more areas should be found aberrant”. Neurobehavioural disorder refers to the possibility of brain based upon history information and personal observations (Astley and Clarren 1999: 34).

3 Levels of alcohol consumption that are considered excessive are variously operationalized in the literature: “over 14 drinks per day (Abel 1990),... a bottle of liquor a day (Beattie, Day, Cockburn, and Garg 1983); one gallon of wine and a half case of beer every Friday and Saturday evening (Ernhart 1991)...” (Abel 1998: 16). Despite the lack of continuity in operationalizing the term excessive drinking, the consumption levels reported are “obviously far greater than what is implied by drinking terms other than alcohol abuse or alcoholism.” (Abel 1998: 16). See also foot note 4.

4 Substance abuse is defined in the Diagnostic and Statistical Manual (4th edition) as the “maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances” (American Psychiatric Association 1994: 182). Alcohol abuse is similarly defined with intoxication and/or the aftereffects of drinking as resulting in adverse consequences such as absences from job or school, neglect of personal responsibilities in the home or in the community, driving or operating hazardous machinery while intoxicated, and the continued use of alcohol despite the knowledge that continued consumption poses significant interpersonal problems (ibid.; 196). Alcohol dependence is indicated when these problems are also associated with tolerance, withdrawal, or compulsive behaviour related to alcohol use (ibid.).

5 The BCLDB does not keep per capita statistics on alcohol sales. The per capita data that are available through Statistics Canada can not be analyzed in terms of actual drinking patterns. A recent study comparing the per capita alcohol consumption figures with survey based measures of drinking patterns found only a weak association (Smart et al. 2000).

6 For a related discussion on the “criminalization of FAS” see LaBerge 2000.

7 The current study can be accused of not being “wise” as the stories of biological mothers have for the most part not been solicited. This choice is due only to spatial constraints. The current requirements and guidelines for M.A. thesis (anthropology) in the Department of Anthropology and Sociology stipulate strict limitations in length: no longer than 50 pages (not including appendices). Another project is currently in the design stage and will look specifically at the prenatal and postnatal experiences of biological mothers of children with fetal alcohol syndrome.
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Top: Set of information/work booklets prepared by the FAS Program, Vancouver Aboriginal Friendship Centre Society (VAFCS).

Bottom left: From work booklet *What everyone should know about alcohol and pregnancy*, for children ages 11-14 (VAFCS).

Bottom right: From work booklet *What everyone should know about alcohol and pregnancy*, for children ages 8 - 11 (VAFCS).
APPENDIX B
QUINTESSENTIAL MOTHER

Top left: “Alcohol Can Hurt Your Baby” (British Columbia Liquor Distribution Branch 1999).

Top right: from pamphlet: You can Make a Difference to your Child’s Health (YWCA FAS/NAS Prevention Project, Vancouver, BC).

APPENDIX C
NURTURING THEME

you can
make a
difference
to your
Child's
Health

Prevent Birth Defects
Caused by Drugs & Alcohol

YWCA
CRABTREE CORNER
121 East Cordova St.
Ph: 604-290-5400
Fax: 604-5401

FAS/NAS Prevention Project, YWCA Crabtree Corner
APPENDIX D
ALCOHOL AS TERATOGEN

Both diagrams taken from: What everyone should know about alcohol and pregnancy. (Vancouver Aboriginal Friendship Centre Society).
APPENDIX E
FETAL IMAGES

2. “She’ll have what you’re having” (Molson Brewery).
Look Who's In Jail!

FAS "Jail Baby"

FAS Community Resource Center, 1999.