Binge drinking during pregnancy: Who are the women at risk?

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Editorial

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Résumé

UNE CONSOMMATION EXCESSIVE D'ALCOOL au cours de la grossesse représente un sérieux problème de santé publique. Dans le présent numéro (page 789), Jonathan Gladstone et ses collaborateurs définissent certaines des caractéristiques des femmes qui ont signalé leurs épisodes de consommation excessive d'alcool à un service de conseil sur la grossesse de Toronto. L'auteur de cette éditorial soutient qu'il est crucial pour élaborer des programmes de prévention bien ciblés de comprendre plus clairement les facteurs de risque socio-économiques d'abus d'alcool au cours de la grossesse. Ces programmes doivent être de nature communautaire et porter sur des facteurs comme la pauvreté, le mauvais état de santé, les toxicomanies et la violence familiale.

Excessive alcohol consumption during pregnancy is recognized as the cause of the birth defects and developmental delays described as fetal alcohol syndrome and fetal alcohol effects.[1] Many women who consume alcohol excessively during pregnancy do not drink every day but "binge" on one or more occasions.[2] It is likely that binge drinking — the consumption of alcohol equivalent to 5 or more standard drinks per occasion — is more toxic to the fetus than drinking the same amount over several days.

Because no safe limit of alcohol consumption during pregnancy has been established, women who are pregnant or wish to conceive are advised to abstain from alcohol completely.[1,2] The challenge is to identify women at risk of binge drinking and then assist them to avoid becoming pregnant or to abstain from alcohol during the preconception stage and throughout pregnancy.

The findings reported by Jonathan Gladstone and colleagues in this issue (page 789) can help physicians and other health care professionals to identify women at high risk of binge drinking during pregnancy. Their study involved women who sought information from the Motherisk counselling service in Toronto concerning exposure to teratogens. Women who reported that they had binged on alcohol once or more during their pregnancy (the study group) were more likely than other women who contacted the service (controls) to be young, single and white and to abuse other drugs. Unfortunately, Gladstone and colleagues do not provide information about other factors, such as socioeconomic status, employment history and education, that might help to identify women whose children are most likely to be affected by prenatal exposure to alcohol. One might assume that many of the study participants lived in greater Toronto. Given the city's multiethnic nature, it would be interesting to know if they had attended schools in Canada. Other researchers have called for better education of teenagers about the risks of alcohol and other drugs during pregnancy;[3] if it were known that many women at high risk do not attend school in Canada, then other venues for early prevention programs would have to be found.

The design of Gladstone and colleagues' study prevents us from comparing the characteristics of the women who reported binge drinking with those of women who did not use the counselling service. It is possible, and even likely, that the women at highest risk did not call the service; many women with alcohol dependence receive little or no prenatal care.

Gladstone and colleagues point out that binge drinking is often followed by unplanned and unprotected sexual activity and suggest that some pregnancies

in which excessive alcohol intake is a problem are the result of such encounters. Women that I see at a fetal alcohol syndrome clinic in Saskatoon frequently report that their pregnancies were unplanned, unwanted and, in some cases, the result of sexual assault. For many such women, drinking during pregnancy is a way of coping with emotional pain; they are too traumatized to consider the risks to themselves or their child that excessive drinking presents.

Very little is known about the characteristics of women whose children are affected by fetal alcohol syndrome or fetal alcohol effects, especially in Canada. This information is critical for the development of well-targeted prevention programs. Habbick and associates[4] have called for community-based initiatives to prevent alcohol-related birth defects. Their study showed that in Saskatchewan the incidence of fetal alcohol syndrome remained unchanged over a 20-year period in spite of several provincial and national education campaigns designed to raise public awareness of the dangers of excessive alcohol consumption during pregnancy. In November 1996 Saskatchewan Health Minister Eric Cline announced funding for community-based prevention programs targeted toward women at high risk, their partners and their communities. Several other provinces have implemented similar programs.

The women described by Habbick and associates were mostly of aboriginal descent.[4] Again, information about education, socioeconomic status and employment history was lacking. Reviewing studies from around the world, Abel[5] noted that fetal alcohol syndrome most commonly affected children whose mothers had low socioeconomic status. In North America, certain ethnic minority groups (primarily black and aboriginal people in the United States and aboriginal people in Canada) are overrepresented in studies of people with fetal alcohol syndrome and fetal alcohol effects. Abel and Hannigan[6] have argued that low socioeconomic status rather than race is a critical factor, in that it enables other risk factors such as drug abuse, multiple parity and poor nutrition to compound the effects of alcohol on the fetus.

If Abel and Hannigan are correct, efforts to improve the overall health of young, poor women should reduce the incidence of alcohol-related birth defects in Canada. By various measures, aboriginal people have a lower health status than other Canadians, and poverty and substance abuse are covariates in many of the health problems that they experience.[7,8] Thus the prevention of fetal alcohol syndrome must be seen in the context of improving the overall health of impoverished aboriginal — and nonaboriginal — families in Canada.

Recent legal cases in Manitoba and Ontario have focused attention on the conflict between the rights of women and the right of society to protect children, and on the question of whether society's right to protect children extends to those not yet born. What is missing in this debate is a realization that women rarely wish to harm their children. Substance abuse and mental illness can so cloud one's thinking that harmful actions seem reasonable. Women whose behaviour poses a risk to their fetuses need our compassion and support. Laws designed to force these women into treatment will drive them away from the health care system and compel health care professionals to act as law enforcement officials rather than health care providers.

Women who seek treatment for binge drinking and other forms of substance abuse during pregnancy face many barriers. Most Canadian programs are based on a 28-day inpatient model that forces women to separate from their families. Given that substance abuse frequently coexists with poverty and family violence, many women are reluctant to leave their children and consequently delay treatment until their substance abuse is severe and difficult to treat. Only a handful of programs in Canada offer family-centred treatment programs in which children are integrated. Once discharged from a program, many women return to families and communities where substance abuse is common and where there is little support for maintaining sobriety. In addition, other problems such as poverty and family violence will remain — now to be confronted without the numbing effects of alcohol. This again points to the need for multifaceted, community-based prevention programs designed for and by the communities in which women at high risk live.

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